PRIOR AUTHORIZATION-EXPERIMENTAL/INVESTIGATIONAL-NONCOVERED SERVICES

This code listing does not certify benefits or authoirzation of benefits, which is designated by each individual policyholder terms,conditions, exclusions, and limitations contract. It does not constitute a contract or guarantee regarding coverage or reimbursement/payment. Self-insured group specific policy will supersede this general policy when group supplementary plan document or individual plan decision directs otherwise. ***Effective 04/01/2024, Paramount will no longer accept S-codes, for all product lines.***

Prior authorization requests may be submitted via fax, e-mail, or electronically. Electronic submission is preferred. Paramount prior authorization request forms are available to assist with requesting services. https://www.paramounthealthcare.com/services/providers/tools-and-resources/documents-and-forms

Electronic prior authorization can be submitted at https://www.myparamount.org/
Fax prior authorization requests and supporting clinical documentation to the appropriate fax number. This will assist with your request arriving in the correct area for prompt review.

General- 567-661-0842

Medical Policy PG0043 Experimental/Investigational Procedures/Services: Services that are experimental/investigational, as listed in this policy, are not eligible for reimbursement consideration. Paramount does not cover experimental/investigational medical or surgical services/procedures that are not medically necessary and have not been strongly supported in research and for which there is a safe and medically accepted alternative available. Is not an all-inclusive listing.

InterQual criteria - https://identity.onehealthcareid.com/oneapp/index.html#login Medical Policies - https://www.paramounthealthcare.com/providers/medical-policies/policy-library

UPDATED 08/14/2024

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
00170	Anesthesia for intraoral procedures, including biopsy; not otherwise specified	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0536 Anesthesia Services for Dental Procedures in the Facility	Effective 10/01/2024 – Prior authorization is required for CPT codes 00170 and 41899, when related to dental procedures in the facility setting
11980	Subcutaneous hormone pellet implantation (implantation of Estradiol and/or testosterone	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0225 Implantable Testosterone Pellets (Testopel®)	
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears,	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	The purpose of this policy is to supplement coverage guidance for surgical procedures with cosmetic aspects that may not be contained in a separate clinical policy. If there is a discrepancy between this policy
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears,	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	The purpose of this policy is to supplement coverage guidance for surgical procedures with cosmetic aspects that may not be contained in a separate clinical policy. If there is a discrepancy between this policy
15820	Blepharoplasty, lower eyelid	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift - Medical Policy Archived 06/01/2024. Maintain Prior	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift is going to be archived. The procedure codes 15820, 15821, 15822, 15823, 67900, 67901-67909, 67911 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift - Medical Policy Archived 06/01/2025. Maintain Prior	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift is going to be archived. The procedure codes 15820, 15821, 15822, 15823, 67900, 67901-67909, 67911 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the
15822	Blepharoplasty, upper eyelid	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift - Medical Policy Archived 06/01/2025. Maintain Prior	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift is going to be archived. The procedure codes 15820, 15821, 15822, 15823, 67900, 67901-67909, 67911 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift - Medical Policy Archived 06/01/2025. Maintain Prior	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift is going to be archived. The procedure codes 15820, 15821, 15822, 15823, 67900, 67901-67909, 67911 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the

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15830	Excision, excessive skin, and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0299 Abdominoplasty, Panniculectomy and Liposuction	PG0104 Cosmetic and Reconstructive Surgery
15876	Suction assisted lipectomy; head/neck	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	The purpose of this policy is to supplement coverage guidance for surgical procedures with cosmetic aspects that may not be contained in a separate clinical policy. If there is a discrepancy between this policy
15878	Suction assisted lipectomy; upper extremity	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	The purpose of this policy is to supplement coverage guidance for surgical procedures with cosmetic aspects that may not be contained in a separate clinical policy. If there is a discrepancy between this policy
15879	Suction assisted lipectomy; lower extremity	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	The purpose of this policy is to supplement coverage guidance for surgical procedures with cosmetic aspects that may not be contained in a separate clinical policy. If there is a discrepancy between this policy and a member's plan of benefits, then the provision of the benefits will govern and rule. Reconstructive Services are covered when medical
19300	Mastectomy for gynecomastia	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0221 Mastectomy for Gynecomastia Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0221 Mastectomy for Gynecomastia is going to be archived. The procedure code 19300 requires a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel spreadsheet. Additional coverage reference at
19303	Simple complete mastectomy	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0251 Prophylactic Mastectomy	Procedure codes 19301, 19302, 19303, 19304, 19305, 19306, 19307 when performed for diagnosis V50.41-Encouter for Prophylactic Removal of Breast. PG0104 Cosmetic nd Reconstructive Surgery
19304	Subcutaneous mastectomy	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0251 Prophylactic Mastectomy	Procedure codes 19301, 19302, 19303, 19304, 19305, 19306, 19307 when performed for diagnosis V50.41-Encouter for Prophylactic Removal of Breast.
19318	Reduction mammoplasty	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0054 Reduction Mammoplasty - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0054 Reduction Mammoplasty is going to be archived. The procedure code 19318 requires a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel spreadsheet. Additional coverage reference PG0104
19328	Removal of intact mammary implant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0012 Breast Implant Removal and Reimplantation	PG0012 Breast Implant Removal and Reimplantation Exception: breast implant removal and reimplantation (19328, 19330, 19340, 19342, 19370, and 19371) will be reimbursed WITHOUT PRIOR AUTHORIZATION, when there is a predetermined cancer diagnosis, as listed in the medical policy.
19330	Removal of ruptured breast implant, including implant contents (e.g., saline, silicone gel)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0012 Breast Implant Removal and Reimplantation	PG0012 Breast Implant Removal and Reimplantation Exception: breast implant removal and reimplantation (19328, 19330, 19340, 19342, 19370, and 19371) will be reimbursed WITHOUT PRIOR AUTHORIZATION, when there is a predetermined cancer diagnosis, as listed in the medical policy.
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0012 Breast Implant Removal and Reimplantation	PG0012 Breast Implant Removal and Reimplantation Exception: breast implant removal and reimplantation (19328, 19330, 19340, 19342, 19370, and 19371) will be reimbursed WITHOUT PRIOR AUTHORIZATION, when there is a predetermined cancer diagnosis, as listed in the medical policy.
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy, or in reconstruction	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0012 Breast Implant Removal and Reimplantation	PG0012 Breast Implant Removal and Reimplantation Exception: breast implant removal and reimplantation (19328, 19330, 19340, 19342, 19370, and 19371) will be reimbursed WITHOUT PRIOR AUTHORIZATION, when there is a predetermined cancer diagnosis, as listed in the medical policy.
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0012 Breast Implant Removal and Reimplantation	PG0012 Breast Implant Removal and Reimplantation Exception: breast implant removal and reimplantation (19328, 19330, 19340, 19342, 19370, and 19371) will be reimbursed WITHOUT PRIOR AUTHORIZATION, when there is a predetermined cancer diagnosis, as listed in the medical policy.
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0012 Breast Implant Removal and Reimplantation	PG0012 Breast Implant Removal and Reimplantation Exception: breast implant removal and reimplantation (19328, 19330, 19340, 19342, 19370, and 19371) will be reimbursed WITHOUT PRIOR AUTHORIZATION, when there is a predetermined cancer diagnosis, as listed in the medical policy.

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20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	NON-COVERED - Dry needling, also known as intramuscular stimulation, involves the use of solid 'noninjection' needles which are used to penetrate the skin and stimulate specific triggerpoints, muscles and connective tissue. Dry needling is intended to reduce pain and improve range of motion, however more studies are needed to demonstrate its safety and effectiveness.	Paramount will cover acupuncture dry needling for Medicare Asvantage Plans with chronic lower back pain within specific guidelines in accordance with CMS as documented in Medical Policy PG0382 Acupuncture	PG0382 Acupuncture	
20561	Needle insertion(s) without injection(s); 3 or more muscle(s)	NON-COVERED - Dry needling, also known as intramuscular stimulation, involves the use of solid 'noninjection' needles which are used to penetrate the skin and stimulate specific triggerpoints, muscles and connective tissue. Dry needling is intended to reduce pain and improve range of motion, however more studies are needed to demonstrate its safety and effectiveness.	Paramount will cover acupuncture dry needling for Medicare Asvantage Plans with chronic lower back pain within specific guidelines in accordance with CMS as documented in Medical Policy PG0382 Acupuncture	PG0382 Acupuncture	
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0365 Bone Graft Substitutes	When unlisted procedure-musculoskeletal (20999), unlisted procedure –spine (22899), unlisted procedure-humerus or elbow (24999), unlisted procedure-forearm or wrist (25999), unlisted procedure-hands or fingers (26989), unlisted procedure-femur or knee (27599), or unlisted procedure-leg or ankle (27899) and 20930, Allograft, is determined to be recombinant human bone
20999	Unlisted procedure, musculoskeletal system, general	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0365 Bone Graft Substitutes	When unlisted procedure-musculoskeletal (20999), unlisted procedure –spine (22899), unlisted procedure-humerus or elbow (24999), unlisted procedure-forearm or wrist (25999), unlisted procedure-hands or
21073	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an	NON-COVERED	NON-COVERED	PG0422 Manipulation Under Anesthesia	
21120	Genioplasty; Augmentation	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21121	Genioplasty; Sliding Osteotomy	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21122	Genioplasty; Sliding Osteotomies	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21123	Genioplasty; Sliding Augmentation	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery

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21125	Augmentation Mandibular Body; Prosthetic Mat	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21127	Augmentation Mandibular Body; with bone graft	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for long face syndrome), without bone graft	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21142	Reconstruction midface, LeFort I;2 pieces, segment movement in any direction, without bone graft	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21146	Lefort I Recon; two pieces with bone graft	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21147	Lefort I Recon; three or more pieces with bone graft	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21150	Lefort II Recon; anterior intrustion	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for	PG0104 Cosmetic and Reconstructive Surgery
21151	Lefort II Recon; any direction with grafts	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for	PG0104 Cosmetic and Reconstructive Surgery
21154	Lefort III Recon; with bone grafts without Lefort I	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for	PG0104 Cosmetic and Reconstructive Surgery
21155	Lefort III Recon; with bone grafts with Lefort I	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for	PG0104 Cosmetic and Reconstructive Surgery
21159	Lefort III Recon; with forhead adv without Lefort I	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery	PG0104 Cosmetic and Reconstructive Surgery
21160	Lefort III Recon; with forhead adv without Lefort I	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for	PG0104 Cosmetic and Reconstructive Surgery
21181	Recon by contouring of cranioal bones	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for	PG0104 Cosmetic and Reconstructive Surgery

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21182	Recon orbital rims/forehead/with grafts less 40 cm	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for	PG0104 Cosmetic and Reconstructive Surgery
21183	Recon orbital rims/forehead/with grafts 40-80 cm	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for	PG0104 Cosmetic and Reconstructive Surgery
21184	Recon orbital rims/forehead/with grafts 80 cm or more	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for	PG0104 Cosmetic and Reconstructive Surgery
21188	Recon midface osteotomies and bone grafts	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21193	Reconstruction of mandibular rami, horizontal, vertical, C or L osteotomy; without bone graft	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21194	Reconstruction of mandibular rami, horizontal, vertical, C or L osteotomy; with bone graft	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21198	Osteotomy mandible; segmental	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21199	Osteotomy, mandible, segmental; with genioglossus advancement	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21206	Segmental Osteotomy	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21208	Facial Osteoplasty	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21209	Facial Osteoplasty reduction	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for	PG0104 Cosmetic and Reconstructive Surgery
21210	Nasal bone graft	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery

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21215	Nasal bone graft	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21230	Autogenous graft rib to face	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21240	Arthroplasty, temporomandibular joint	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21244	Reconstruction of mandible extraoral	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21245	Reconstruction of mandible partial	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21246	Reconstruction of mandible complete	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21247	Reconstruction of mandibular condyle	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21248	Reconstruction of mandible with implant partial	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21249	Reconstruction of mandible with implant complete	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21255	Reconstruction of zygomatic arch	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	PG0104 Cosmetic and Reconstructive Surgery
21270	Malar augmentation, prosthetic material	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for	PG0104 Cosmetic and Reconstructive Surgery
21275	Secondary revision of orbital cranifacial Recon	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for	PG0104 Cosmetic and Reconstructive Surgery
21295	Reduction of masseter muscle/bone; extraoral	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for	PG0104 Cosmetic and Reconstructive Surgery
21296	Reduction of masseter muscle/bone; intraoral	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery and PG0056 Surgical Treatments for	PG0104 Cosmetic and Reconstructive Surgery

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21685	Hyoid myotomy and suspension	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including	NON-COVERED	NON-COVERED	PG0026 Discogenic Pain Treatment; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including	NON-COVERED	NON-COVERED	PG0026 Discogenic Pain Treatment; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
22532	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0463 Spinal Fusion	Cervical Fusion: 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614. Thoracic Fusion: 22532, 22534, 22556, 22585, 22610, 22614. Lumbar Fusion: 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0463 Spinal Fusion	Cervical Fusion: 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614. Thoracic Fusion: 22532, 22534, 22556, 22585, 22610, 22614. Lumbar Fusion: 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634
22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace; thoracic or lumbar, each additional vertebral segment (List separately	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0463 Spinal Fusion	Cervical Fusion: 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614. Thoracic Fusion: 22532, 22534, 22556, 22585, 22610, 22614. Lumbar Fusion: 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634
22548	Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2, with or without excision of odontoid process	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0463 Spinal Fusion	Cervical Fusion: 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614. Thoracic Fusion: 22532, 22534, 22556, 22585, 22610, 22614. Lumbar Fusion: 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0463 Spinal Fusion	Cervical Fusion: 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614. Thoracic Fusion: 22532, 22534, 22556, 22585, 22610, 22614. Lumbar Fusion: 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634
22552	Arthrodesis, anterior interbody, including disc space preparation, disectomy, osteophytectomy, and decompression of spinal cord and/or nerve roots; cervical below	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0463 Spinal Fusion	Cervical Fusion: 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614. Thoracic Fusion: 22532, 22534, 22556, 22585, 22610, 22614. Lumbar Fusion: 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0463 Spinal Fusion	Cervical Fusion: 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614. Thoracic Fusion: 22532, 22534, 22556, 22585, 22610, 22614. Lumbar Fusion: 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634
22556	Arthrodesis, an anterior interbody technique including minimal discectomy to prepare the thoracic interspace (other than for decompression)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0463 Spinal Fusion	Cervical Fusion: 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614. Thoracic Fusion: 22532, 22534, 22556, 22585, 22610, 22614. Lumbar Fusion: 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634
22558	Arthrodesis, an anterior interbody technique including minimal discectomy to prepare the interspace (other than for decompression) in the lumbar	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0463 Spinal Fusion	Cervical Fusion: 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614. Thoracic Fusion: 22532, 22534, 22556, 22585, 22610, 22614. Lumbar Fusion: 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0463 Spinal Fusion	Cervical Fusion: 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614. Thoracic Fusion: 22532, 22534, 22556, 22585, 22610, 22614. Lumbar Fusion: 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
22590	Arthrodesis, posterior technique, craniocervical (Occiput - C2)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0463 Spinal Fusion	Cervical Fusion: 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614. Thoracic Fusion: 22532, 22534, 22556, 22585, 22610, 22614. Lumbar Fusion: 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634
22595	Arthrodesis, posterior technique, atlas-axis (C1-C2)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0463 Spinal Fusion	Cervical Fusion: 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614. Thoracic Fusion: 22532, 22534, 22556, 22585, 22610, 22614. Lumbar Fusion: 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634
22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0463 Spinal Fusion	Cervical Fusion: 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614. Thoracic Fusion: 22532, 22534, 22556, 22585, 22610, 22614. Lumbar Fusion: 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634
22610	Arthrodesis, posterior or posterolateral technique, single level; thoracic (with lateral transverse technique, when performed)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0463 Spinal Fusion	Cervical Fusion: 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614. Thoracic Fusion: 22532, 22534, 22556, 22585, 22610, 22614. Lumbar Fusion: 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0463 Spinal Fusion	Cervical Fusion: 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614. Thoracic Fusion: 22532, 22534, 22556, 22585, 22610, 22614. Lumbar Fusion: 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634
22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment. (List separately in addition to code for primary	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0463 Spinal Fusion	Cervical Fusion: 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614. Thoracic Fusion: 22532, 22534, 22556, 22585, 22610, 22614. Lumbar Fusion: 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace, single interspace (other than for decompression);	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0463 Spinal Fusion	Cervical Fusion: 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614. Thoracic Fusion: 22532, 22534, 22556, 22585, 22610, 22614. Lumbar Fusion: 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace, single interspace (other than for decompression);	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0463 Spinal Fusion	Cervical Fusion: 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614. Thoracic Fusion: 22532, 22534, 22556, 22585, 22610, 22614. Lumbar Fusion: 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0463 Spinal Fusion	Cervical Fusion: 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614. Thoracic Fusion: 22532, 22534, 22556, 22585, 22610, 22614. Lumbar Fusion: 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0027 Artificial Intervertebral Disc Replacement	
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0027 Artificial Intervertebral Disc Replacement	
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0213 Interspinous and Interlaminar Stabilization/Distraction Devices (Spacers)-Archived	
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0213 Interspinous and Interlaminar Stabilization/Distraction Devices (Spacers)-Archived	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0213 Interspinous and Interlaminar Stabilization/Distraction Devices (Spacers)-Archived	
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0213 Interspinous and Interlaminar Stabilization/Distraction Devices (Spacers)-Archived	
22899	Unlisted procedure –spine	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0365 Bone Graft Substitutes	When unlisted procedure-musculoskeletal (20999), unlisted procedure –spine (22899), unlisted procedure-humerus or elbow (24999), unlisted procedure-forearm or wrist (25999), unlisted procedure-hands or
24999	Unlisted procedure-humerus or elbow	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0365 Bone Graft Substitutes	When unlisted procedure-musculoskeletal (20999), unlisted procedure –spine (22899), unlisted procedure-humerus or elbow (24999), unlisted procedure-forearm or wrist (25999), unlisted procedure-hands or
25999	Unlisted procedure-forearm or wrist	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0365 Bone Graft Substitutes	When unlisted procedure-musculoskeletal (20999), unlisted procedure –spine (22899), unlisted procedure-humerus or elbow (24999), unlisted procedure-forearm or wrist (25999), unlisted procedure-hands or
26989	Unlisted procedure-hands or fingers	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0365 Bone Graft Substitutes	When unlisted procedure-musculoskeletal (20999), unlisted procedure –spine (22899), unlisted procedure-humerus or elbow (24999), unlisted procedure-forearm or wrist (25999), unlisted procedure-hands or
27125	Hemiarthroplasty, hip, partial (e.g., femoral stem prosthesis, bipolar arthroplasty)	ProMedica Employee Health Plans Administered by Paramount PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION **NOT** REQUIRED	PG0454 Hip Replacement and Resurfacing Surgery (Arthroplasty) - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0454 Hip Replacement and Resurfacing Surgery (Arthroplasty) is going to be archived. The procedure codes 27125, 27130. 27132, 27134, 27137, 27138 will remain to require a prior authorization, ONLY for the ProMedica Employee Health Plans Administered by Paramount and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel spreadsheet
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip	ProMedica Employee Health Plans Administered by Paramount PRIOR AUTHORIZATION	PRIOR AUTHORIZATION **NOT** REQUIRED	PG0454 Hip Replacement and Resurfacing Surgery (Arthroplasty) - Archived	Medical Policy PG0454 Hip Replacement and Resurfacing Surgery (Arthroplasty) is going to be archived. The procedure codes 27125, 27130. 27132, 27134, 27137, 27138 will remain to require a prior
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	ProMedica Employee Health Plans Administered by Paramount PRIOR AUTHORIZATION	PRIOR AUTHORIZATION **NOT** REQUIRED	PG0454 Hip Replacement and Resurfacing Surgery (Arthroplasty) - Archived	Medical Policy PG0454 Hip Replacement and Resurfacing Surgery (Arthroplasty) is going to be archived. The procedure codes 27125, 27130. 27132, 27134, 27137, 27138 will remain to require a prior
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	ProMedica Employee Health Plans Administered by Paramount PRIOR AUTHORIZATION	PRIOR AUTHORIZATION **NOT** REQUIRED	PG0454 Hip Replacement and Resurfacing Surgery (Arthroplasty) - Archived	Medical Policy PG0454 Hip Replacement and Resurfacing Surgery (Arthroplasty) is going to be archived. The procedure codes 27125, 27130. 27132, 27134, 27137, 27138 will remain to require a prior
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft	ProMedica Employee Health Plans Administered by Paramount PRIOR AUTHORIZATION	PRIOR AUTHORIZATION **NOT** REQUIRED	PG0454 Hip Replacement and Resurfacing Surgery (Arthroplasty) - Archived	Medical Policy PG0454 Hip Replacement and Resurfacing Surgery (Arthroplasty) is going to be archived. The procedure codes 27125, 27130. 27132, 27134, 27137, 27138 will remain to require a prior
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft	ProMedica Employee Health Plans Administered by Paramount PRIOR AUTHORIZATION	PRIOR AUTHORIZATION **NOT** REQUIRED	PG0454 Hip Replacement and Resurfacing Surgery (Arthroplasty) - Archived	Medical Policy PG0454 Hip Replacement and Resurfacing Surgery (Arthroplasty) is going to be archived. The procedure codes 27125, 27130. 27132, 27134, 27137, 27138 will remain to require a prior
27275	Manipulation, hip joint, requiring general anesthesi	NON-COVERED	NON-COVERED	PG0422 Manipulation Under Anesthesia	
27412	Autologous chondrocyte implantation, knee	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0190 Focal Articular Cartilage of the Knee	
27415	Osteochondral allograft, knee, open	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0190 Focal Articular Cartilage of the Knee	As of 1/1/2020 procedures 27415, 27416, 29866, 29867, 27599 also require a prior authorization
27416	Osteochondral autograft(s), knee, open (e.g., mosaicplasty)(includes harvesting of autograft(s))[except to repair chondral defects of the patella] [excludes synthetic	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0190 Focal Articular Cartilage of the Knee	As of 1/1/2020 procedures 27415, 27416, 29866, 29867, 27599 also require a prior authorization

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
27445	Arthroplasty, knee, hinge prosthesis (e.g., Walldius type)	ProMedica Employee Health Plans Administered by Paramount PRIOR AUTHORIZATION	PRIOR AUTHORIZATION NOT REQUIRED	PG0452 Knee Replacement Surgery (Arthroplasty) - Archived	Medical Policy PG0452 Knee Replacement Surgery (Arthroplasty) is going to be archived. The procedure codes 27445, 27446, 27447, 27486, 27487 require a prior authorization, ONLY for the ProMedica
27446	Arthroplasty, knee, condyle and plateau; medial or lateral compartment	ProMedica Employee Health Plans Administered by Paramount PRIOR AUTHORIZATION	PRIOR AUTHORIZATION NOT REQUIRED	PG0452 Knee Replacement Surgery (Arthroplasty) - Archived	Medical Policy PG0452 Knee Replacement Surgery (Arthroplasty) is going to be archived. The procedure codes 27445, 27446, 27447, 27486, 27487 require a prior authorization, ONLY for the ProMedica
27447	Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without	ProMedica Employee Health Plans Administered by Paramount PRIOR AUTHORIZATION	PRIOR AUTHORIZATION NOT REQUIRED	PG0452 Knee Replacement Surgery (Arthroplasty) - Archived	Medical Policy PG0452 Knee Replacement Surgery (Arthroplasty) is going to be archived. The procedure codes 27445, 27446, 27447, 27486, 27487 require a prior authorization, ONLY for the ProMedica
27486	Revision of total knee arthroplasty, with or without allograft; 1 component	ProMedica Employee Health Plans Administered by Paramount PRIOR AUTHORIZATION	PRIOR AUTHORIZATION NOT REQUIRED	PG0452 Knee Replacement Surgery (Arthroplasty) - Archived	Medical Policy PG0452 Knee Replacement Surgery (Arthroplasty) is going to be archived. The procedure codes 27445, 27446, 27447, 27486, 27487 require a prior authorization, ONLY for the ProMedica
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	ProMedica Employee Health Plans Administered by Paramount PRIOR AUTHORIZATION	PRIOR AUTHORIZATION NOT REQUIRED	PG0452 Knee Replacement Surgery (Arthroplasty) - Archived	Medical Policy PG0452 Knee Replacement Surgery (Arthroplasty) is going to be archived. The procedure codes 27445, 27446, 27447, 27486, 27487 require a prior authorization, ONLY for the ProMedica
27599	Unlisted procedure, femur or knee, when related to Focal Articular Cartilage Repair of the Knee	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0190 Focal Articular Cartilage of the Knee	As of 1/1/2020 procedures 27415, 27416, 29866, 29867, 27599 also require a prior authorization
27599	Unlisted procedure-femur or knee	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0365 Bone Graft Substitutes	When unlisted procedure-musculoskeletal (20999), unlisted procedure –spine (22899), unlisted procedure-humerus or elbow (24999), unlisted procedure-forearm or wrist (25999), unlisted procedure-hands or fingers (26989), unlisted procedure-femur or knee (27599), or unlisted procedure-leg or ankle (27899) and 20930, Allograft, is determined to
27702	Arthroplasty, ankle; with implant (total ankle)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0151 Total Ankle Arthroplasty	
27703	Arthroplasty, ankle; revision, total ankle	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0151 Total Ankle Arthroplasy	
27899	Unlisted procedure, leg or ankle	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0365 Bone Graft Substitutes	When unlisted procedure-musculoskeletal (20999), unlisted procedure –spine (22899), unlisted procedure-humerus or elbow (24999), unlisted procedure-forearm or wrist (25999), unlisted procedure-hands or
28890	Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than	NON-COVERED	NON-COVERED	PG0004 Extracorporeal Shock Wave Therapy for Musculoskeletal Conditions	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
29866	Arthroscopy, knee, surgical; implantation of osteochodral autograft(s) (e.g.,mosaicplasty) (includes harvesting of autografts) [except to repair chondral defects	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0190 Focal Articular Cartilage of the Knee	As of 1/1/2020 procedures 27415, 27416, 29866, 29867, 27599 also require a prior authorization
29867	Arthroscopy, knee, surgical; osteochondral allograft (e.g., mosaicplasty	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0190 Focal Articular Cartilage of the Knee	As of 1/1/2020 procedures 27415, 27416, 29866, 29867, 27599 also require a prior authorization
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0009 Rhinoplasty and Septoplasty	PG0104 Cosmetic and Reconstructive Surgery
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0009 Rhinoplasty and Septoplasty	PG0104 Cosmetic and Reconstructive Surgery

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
30420	Rhinoplasty, primary; including major septal repair	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0009 Rhinoplasty and Septoplasty	PG0104 Cosmetic and Reconstructive Surgery
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0009 Rhinoplasty and Septoplasty	PG0104 Cosmetic and Reconstructive Surgery
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0009 Rhinoplasty and Septoplasty	PG0104 Cosmetic and Reconstructive Surgery
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0009 Rhinoplasty and Septoplasty	PG0104 Cosmetic and Reconstructive Surgery
30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial	NON-COVERED	NON-COVERED	PG0316 Bronchial Thermoplasty; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial	NON-COVERED	NON-COVERED	PG0316 Bronchial Thermoplasty; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
32664	Thoracoscopy, surgical; with thoracic sympathectomy	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0466 Hyperhidrosis Treatment (excluding Botox)	Endoscopic transthoracic sympathectomy (ETS), procedure 32664, requires a prior authorization for the treatment of hyperhidrosis, diagnosis codes L74.510-L74.519, L74.52, R61. Procedure 97033 is noncovered with diagnosis codes L74.510-L74.519, L74.52, R61.
33269	Exclusion of left atrial appendage, thoracoscopic, any method (e.g., excision, isolation via stapling,	NON-COVERED	NON-COVERED	PG0366 Left Atrial Appendage Closure (LAAC) (Occlusion);	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
33274	Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is participating in an FDA approved post approval trial that is registered.	PG0395 Leadless Cardiac Pacemakers; PG0043 Experimental Investigational Procedures Services - Archived	Paramount Medicare Advantage Plans - Leadless Cardiac Pacemaker Systems (i.e., MicraTM Transcatheter Pacemaker System, Aveir VR Leadless System). Leadless cardiac pacemaker systems are miniaturized, full featured single or dual chamber pacemakers that are implanted directly in the right ventricle and right atrium in the case of dual chamber pacemakers. They are thought to provide treatment options for patients with Class I or Class II indication for bradycardia
33275	Trancatheter removal of permanent leadless pacemaker, right ventricular	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is participating in an FDA approved post approval trial that is registered.	PG0395 Leadless Cardiac Pacemakers; PG0043 Experimental Investigational Procedures Services - Archived	Paramount Medicare Advantage Plans - Leadless Cardiac Pacemaker Systems (i.e., MicraTM Transcatheter Pacemaker System, Aveir VR Leadless System). Leadless cardiac pacemaker systems are miniaturized, full featured single or dual chamber pacemakers that are implanted directly in the right ventricle and right atrium in the case of dual chamber pacemakers. They are thought to provide treatment options for patients with Class I or Class II indication for bradycardia pacing therapy without the increased risk for infection. For Medicare
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0039 Ambulatory External and Implantable Electrocardiographic Monitoring	Effective 06/01/2021 procedure 33285 requires a prior authorization
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor for longterm hemodynamic	NON-COVERED	NON-COVERED	PG0377 Pulmonary Artery Pressure Monitoring (CardioMEMS); PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
33370	Transcatheter placement and subsequent removal of cerebral embolic protection device(s),	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
40806	Incision of labial frenum (frenotomy)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
40819	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
41512	Tongue base suspension, permanent suture technique	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA); PG0043 Experimental Investigational Procedures	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA); PG0043 Experimental Investigational Procedures	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
41899	Unlisted procedure, dentoalveolar structures	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		A Dental Provider prior authorization for medical services utilized under anesthesia in the outpatient setting, is required. The CPT code requiring the Prior Authorization is the unlisted procedure 41899. Pediatric dental care requiring general anesthesia in an outpatient setting (over age 6)
43236	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or	NON-COVERED	NON-COVERED	PG0166 Endoscopic Therapies for Gastroesophageal Reflux	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon	NON-COVERED	NON-COVERED	PG0163 Metabolic and Bariatric Surgery; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)	NON-COVERED	NON-COVERED	PG0163 Metabolic and Bariatric Surgery; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
43497	Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0379 Peroral Endoscopic Myotomy (POEM) for Treatment of Esophageal Achalasia-Archived 08/01/2024	Prior authorization required effective May 1, 2022. NOTE: The Company has determined that the following peroral endoscopic myotomy (POEM) procedures are considered investigational and not eligible for reimbursement: • Diverticular peroral endoscopic myotomy (D-POEM) • Zenker peroral endoscopic myotomy (Z-POEM)
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0163 Metabolic and Bariatric Surgery	PG0104 Cosmetic and Reconstructive Surgery
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0163 Metabolic and Bariatric Surgery	PG0104 Cosmetic and Reconstructive Surgery
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0235 Gastric Electrical Stimulation (GES)	
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0235 Gastric Electrical Stimulation (GES)	
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (e.g., gastric band and subcutaneous port components)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0163 Metabolic and Bariatric Surgery	PG0104 Cosmetic and Reconstructive Surgery

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0163 Metabolic and Bariatric Surgery	PG0104 Cosmetic and Reconstructive Surgery
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0163 Metabolic and Bariatric Surgery	PG0104 Cosmetic and Reconstructive Surgery
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0163 Metabolic and Bariatric Surgery	PG0104 Cosmetic and Reconstructive Surgery
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0163 Metabolic and Bariatric Surgery	PG0104 Cosmetic and Reconstructive Surgery
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0163 Metabolic and Bariatric Surgery	PG0104 Cosmetic and Reconstructive Surgery
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical banded	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0163 Metabolic and Bariatric Surgery	PG0104 Cosmetic and Reconstructive Surgery
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical banded	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0163 Metabolic and Bariatric Surgery	PG0104 Cosmetic and Reconstructive Surgery
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0163 Metabolic and Bariatric Surgery	PG0104 Cosmetic and Reconstructive Surgery
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150cm or less) Roux-en-Y gastroenterostomy	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0163 Metabolic and Bariatric Surgery	PG0104 Cosmetic and Reconstructive Surgery
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0163 Metabolic and Bariatric Surgery	PG0104 Cosmetic and Reconstructive Surgery
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0163 Metabolic and Bariatric Surgery	PG0104 Cosmetic and Reconstructive Surgery
43850	Revision of gastroduodenal anastomosis (gastroduodenostomy) with	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0163 Metabolic and Bariatric Surgery	
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0235 Gastric Electrical Stimulation (GES)	
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0235 Gastric Electrical Stimulation (GES)	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0163 Metabolic and Bariatric Surgery	PG0104 Cosmetic and Reconstructive Surgery
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0163 Metabolic and Bariatric Surgery	PG0104 Cosmetic and Reconstructive Surgery
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0163 Metabolic and Bariatric Surgery	PG0104 Cosmetic and Reconstructive Surgery
46948	Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more	NON-COVERED	NON-COVERED	PG0329 Hemorrhoidal Dearterialization; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
48160	And Emborrhiod technique	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	NON-COVERED	PG0415 Pancreatic Islet Cell Transplantation	Autologous pancreatic islet cell transplantation is non-covered (48160). Allogeneic is covered when in a clinical investigation trial. Specifically, Medicare will cover transplantation of pancreatic islet cells, the insulin
52284	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
53451	Periurethral transperineal adjustable balloon continence device; bilateral insertion, including	NON-COVERED	NON-COVERED	PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
53452	Periurethral transperineal adjustable balloon continence device; unilateral insertion,	NON-COVERED	NON-COVERED	PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
53453	Periurethral transperineal adjustable balloon continence device; removal, each balloon	NON-COVERED	NON-COVERED	PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
53454	Periurethral transperineal adjustable balloon continence device; percutaneous adjustment	NON-COVERED	NON-COVERED	PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
55880	Ablation of malignant prostate tissue, transrectal, with high-intensity focused ultrasound (HIFU), including ultrasound guidance	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0504 High-Intensity Focused Ultrasound (HIFU)	
55970	Intersex surgery; male to female	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0311 Gender Reassignment Surgery	55970, 55980, and all additional services when performed for gender reassignment surgery.
55980	Intersex surgery, female to male	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0311 Gender Reassignment Surgery	55970, 55980, and all additional services when performed for gender reassignment surgery.
58563	Hysteroscopy, surgical; with endometrial ablation (e.g., endometrial resection, electrosurgical ablation, thermoablation)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0388 Endometrial Ablation	
61736	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED -MEDICAL POLICY	PG0206 Laser Interstitial Thermal Therapy (LITT)	Coverage changed from noncovered to covered with a prior authorization for all product lines. Effective 07/01/2024 procedures 61736 and 61737, and unlisted procedures used to report laser interstitial thermal therapy, to require a prior authorization.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
61737	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed;	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0206 Laser Interstitial Thermal Therapy (LITT)	Coverage changed from noncovered to covered with a prior authorization for all product lines. Effective 07/01/2024 procedures 61736 and 61737, and unlisted procedures used to report laser interstitial thermal therapy, to require a prior authorization.
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method	NON-COVERED	NON-COVERED	PG0026 Discogenic Pain Treatment	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
63650	Percutaneous implantation of neurostimulator electrode array, epidural	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0253 Neurostimulation, Spinal Cord/Dorsal Column and Dorsal Root Ganglion	
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0253 Neurostimulation, Spinal Cord/Dorsal Column and Dorsal Root Ganglion	
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0253 Neurostimulation, Spinal Cord/Dorsal Column and Dorsal Root Ganglion	
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0253 Neurostimulation, Spinal Cord/Dorsal Column and Dorsal Root Ganglion	
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0253 Neurostimulation, Spinal Cord/Dorsal Column and Dorsal Root Ganglion	
64405	Injection, anesthetic agent; greater occipital nerve	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0389 Occipital Nerve Block Therapy for the Treatment of Headache	Prior authorization is required for seven (7) injections or more per calendar year
64454	Injection(s), anesthetic agent(s) and/or steroid nerves innervating the genicular nerve branches,	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0471 Genicular Nerve Blocks and Ablation for Chronic Knee Pain	
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0471 Genicular Nerve Blocks and Ablation for Chronic Knee Pain	
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (fluoroscopy or	NON-COVERED	NON-COVERED	PG0361 Radiofrequency Methods of Denervation for Chronic Spinal Pain;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral (eff. 01/01/2022)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0512 Thermal Destruction of the Intraosseous Basivertebral Nerve (BVN) for Vertebrogenic Lower Back	Effective 11/01/2022 procedure codes 64628, 64629REQUIRES A PRIOR AUTHORIZATION. Coverage went from non-covered to covered with a PA
64629	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (List separately in	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0512 Thermal Destruction of the Intraosseous Basivertebral Nerve (BVN) for Vertebrogenic Lower Back	Effective 11/01/2022 procedure codes 64628, 64629REQUIRES A PRIOR AUTHORIZATION. Coverage went from non-covered to covered with a PA
65785	Implantation of intrastromal corneal ring segments	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0289 Refractive Surgery	
67299	Unlisted procedure, posterior segment	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0149 Transpupillary Thermotherapy (TTT)	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
67516	Suprachoroidal space injection of pharmacologic agent (separate procedure)-	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift - Archived 06/01/2024. Maintain Prior	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift is going to be archived. The procedure codes 15820, 15821, 15822, 15823, 67900, 67901-67909, 67911 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift - Archived 06/01/2024. Maintain Prior	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift is going to be archived. The procedure codes 15820, 15821, 15822, 15823, 67900, 67901-67909, 67911 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift - Archived 06/01/2024. Maintain Prior	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift is going to be archived. The procedure codes 15820, 15821, 15822, 15823, 67900, 67901-67909, 67911 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift - Archived 06/01/2024. Maintain Prior	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift is going to be archived. The procedure codes 15820, 15821, 15822, 15823, 67900, 67901-67909, 67911 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift - Archived 06/01/2024. Maintain Prior	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift is going to be archived. The procedure codes 15820, 15821, 15822, 15823, 67900, 67901-67909, 67911 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift - Archived 06/01/2024. Maintain Prior	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift is going to be archived. The procedure codes 15820, 15821, 15822, 15823, 67900, 67901-67909, 67911 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift - Archived 06/01/2024. Maintain Prior	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift is going to be archived. The procedure codes 15820, 15821, 15822, 15823, 67900, 67901-67909, 67911 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the
67909	Reduction of overcorrection of ptosis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift - Archived 06/01/2024. Maintain Prior	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift is going to be archived. The procedure codes 15820, 15821, 15822, 15823, 67900, 67901-67909, 67911 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the
67911	Correction of lid retraction	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift - Archived 06/01/2024. Maintain Prior	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift is going to be archived. The procedure codes 15820, 15821, 15822, 15823, 67900, 67901-67909, 67911 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the
68841	Insertion of drug-eluting implant, including punctal dilation when performed, into lacrimal	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
69300	Otoplasty, protruding ear, with or without size reduction	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0376 Otoplasty	PG0104 Cosmetic and Reconstructive Surgery
69710	Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0218 Implantable Bone Conduction and Bone-Anchored Hearing Aids	Effective 01/01/2023 CMS has indicated procedure 69710 as reimbursement Status N-noncovered
69711	Removal or repair of electromagnetic bone conduction hearing device in temporal bone	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0218 Implantable Bone Conduction and Bone-Anchored Hearing Aids	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
69714	Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0218 Implantable Bone Conduction and Bone-Anchored Hearing Aids	
69716	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or resulting in	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0218 Implantable Bone Conduction and Bone-Anchored Hearing Aids	Effective 04/01/2023 procedures 69716, 69719, 69729 and 69730 require a prior authorization.
69717	Replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0218 Implantable Bone Conduction and Bone-Anchored Hearing Aids	
69719	Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech process, within	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0218 Implantable Bone Conduction and Bone-Anchored Hearing Aids	Effective 04/01/2023 procedures 69716, 69719, 69729 and 69730 require a prior authorization.
69729	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0218 Implantable Bone Conduction and Bone-Anchored Hearing Aids	Effective 04/01/2023 procedures 69716, 69719, 69729 and 69730 require a prior authorization.
69730	Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0218 Implantable Bone Conduction and Bone-Anchored Hearing Aids	Effective 04/01/2023 procedures 69716, 69719, 69729 and 69730 require a prior authorization.
69930	Cochlear device implantation, with or without mastoidectomy	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0281 Cochlear and Auditory Brainstem Implants - Archived 06/01/2024. Maintain Prior Authorization per InterQual	Medical Policy PG0281 Cochlear and Auditory Brainstem Implants is going to be archived. The procedure codes 69930, L8614-L8624, L8627-L8629 and L8625 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel
70546	Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0487 Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) Archived 06/01/2024.	Medical Policy PG0487 Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) to be archived. The present procedure codes on the medical policy, 70546, 70552, 72142, 72157, 72158, 72196, 73723, will continue to require a prior authorization, they will follow the InterQual coverage criteria and are listed as such on the
70552	Magnetic resonance (e.g., proton) imaging, brain (including brain stem); with contrast material(s)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0487 Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) Archived 06/01/2024.	Medical Policy PG0487 Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) to be archived. The present procedure codes on the medical policy, 70546, 70552, 72142, 72157, 72158, 72196, 73723, will continue to require a prior authorization, they will follow the InterQual coverage criteria and are listed as such on the
72142	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, cervical; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0487 Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) Archived 06/01/2024.	Medical Policy PG0487 Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) to be archived. The present procedure codes on the medical policy, 70546, 70552, 72142, 72157, 72158, 72196, 73723, will continue to require a prior authorization, they will follow the InterQual coverage criteria and are listed as such on the
72157	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0487 Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) Archived 06/01/2024.	Medical Policy PG0487 Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) to be archived. The present procedure codes on the medical policy, 70546, 70552, 72142, 72157, 72158, 72196, 73723, will continue to require a prior authorization, they will follow the InterQual coverage criteria and are listed as such on the

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
72158	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0487 Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) Archived 06/01/2024.	Medical Policy PG0487 Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) to be archived. The present procedure codes on the medical policy, 70546, 70552, 72142, 72157, 72158, 72196, 73723, will continue to require a prior authorization, they will follow the InterQual coverage criteria and are listed as such on the
72196	Magnetic resonance (e.g., proton) imaging, pelvis; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0487 Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) Archived 06/01/2024.	Medical Policy PG0487 Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) to be archived. The present procedure codes on the medical policy, 70546, 70552, 72142, 72157, 72158, 72196, 73723, will continue to require a prior authorization, they will follow the InterQual coverage criteria and are listed as such on the
73723	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material(s), followed by contrast material(s) and further sequences	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0487 Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) Archived 06/01/2024.	Medical Policy PG0487 Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) to be archived. The present procedure codes on the medical policy, 70546, 70552, 72142, 72157, 72158, 72196, 73723, will continue to require a prior authorization, they will follow the InterQual coverage criteria and are listed as such on the
74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0182 Virtual Colonoscopy Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0182 Virtual Colonoscopy to be archived. The present procedure codes on the medical policy, 74261-74263, will continue to require a prior authorization, they will follow the InterQual coverage criteria and are listed as such on the prior authorization excel spreadsheet.
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0182 Virtual Colonoscopy Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0182 Virtual Colonoscopy to be archived. The present procedure codes on the medical policy, 74261-74263, will continue to require a prior authorization, they will follow the InterQual coverage criteria and are listed as such on the prior authorization excel spreadsheet.
74263	Computed tomographic (CT) colonography, screening, including image postprocessing	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0182 Virtual Colonoscopy Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0182 Virtual Colonoscopy to be archived. The present procedure codes on the medical policy, 74261-74263, will continue to require a prior authorization, they will follow the InterQual coverage criteria and are listed as such on the prior authorization excel spreadsheet.
75571	CT, heart, without contrast with quantitative evaluation of coronary calcium	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0482 Computed Tomography and Computed Tomography Angiography Scans; PG0043 Experimental	~~NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL, NOW~~ Covered with a prior authorization effective 06/01/2024, for all product lines, following InterQual criteria coverage review.
77089	Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual X ray	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
77090	Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
77091	Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
77092	Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
78350	Bone density (bone mineral content) study, 1 or more sites; single photon absorptiometry	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
78351	Bone density (bone mineral content) study, 1 or more sites; dual photon absorptiometry, 1 or	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0450 Positron Emission Tomography (PET) Oncology and Miscellaneous Applications Archived 06/01/2024.	Effective 08/01/2021, an additional option for outpatient imaging prior authorization requests from Paramount participating in-plan providers; Paramount is recognizing the Protecting Access to Medicare Act (PAMA) scores greater than or equal to a score of 8, for administrative approvals across all product lines. The request form can be located at:

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0450 Positron Emission Tomography (PET) Oncology and Miscellaneous Applications Archived 06/01/2024.	Effective 08/01/2021, an additional option for outpatient imaging prior authorization requests from Paramount participating in-plan providers; Paramount is recognizing the Protecting Access to Medicare Act (PAMA) scores greater than or equal to a score of 8, for administrative approvals across all product lines. The request form can be located at:
78811	Positron emission tomography (PET) imaging; limited area (e.g., chest, head/neck)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0450 Positron Emission Tomography (PET) Oncology and Miscellaneous Applications Archived 06/01/2024.	Effective 08/01/2021, an additional option for outpatient imaging prior authorization requests from Paramount participating in-plan providers; Paramount is recognizing the Protecting Access to Medicare Act (PAMA) scores greater than or equal to a score of 8, for administrative approvals across all product lines. The request form can be located at:
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0450 Positron Emission Tomography (PET) Oncology and Miscellaneous Applications Archived 06/01/2024.	Effective 08/01/2021, an additional option for outpatient imaging prior authorization requests from Paramount participating in-plan providers; Paramount is recognizing the Protecting Access to Medicare Act (PAMA) scores greater than or equal to a score of 8, for administrative approvals across all product lines. The request form can be located at:
78813	Positron emission tomography (PET) imaging; whole body	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0450 Positron Emission Tomography (PET) Oncology and Miscellaneous Applications Archived 06/01/2024.	Effective 08/01/2021, an additional option for outpatient imaging prior authorization requests from Paramount participating in-plan providers; Paramount is recognizing the Protecting Access to Medicare Act (PAMA) scores greater than or equal to a score of 8, for administrative approvals across all product lines. The request form can be located at:
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging;	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0450 Positron Emission Tomography (PET) Oncology and Miscellaneous Applications Archived 06/01/2024.	Effective 08/01/2021, an additional option for outpatient imaging prior authorization requests from Paramount participating in-plan providers; Paramount is recognizing the Protecting Access to Medicare Act (PAMA) scores greater than or equal to a score of 8, for administrative approvals across all product lines. The request form can be located at:
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging;	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0450 Positron Emission Tomography (PET) Oncology and Miscellaneous Applications Archived 06/01/2024.	Effective 08/01/2021, an additional option for outpatient imaging prior authorization requests from Paramount participating in-plan providers; Paramount is recognizing the Protecting Access to Medicare Act (PAMA) scores greater than or equal to a score of 8, for administrative approvals across all product lines. The request form can be located at:
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging;	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0450 Positron Emission Tomography (PET) Oncology and Miscellaneous Applications Archived 06/01/2024.	Effective 08/01/2021, an additional option for outpatient imaging prior authorization requests from Paramount participating in-plan providers; Paramount is recognizing the Protecting Access to Medicare Act (PAMA) scores greater than or equal to a score of 8, for administrative approvals across all product lines. The request form can be located at:
80145	Adalimumab	NoN-COVERED	NON-COVERED	PG0341 Measurement of Serum Drug Antibodies to Infliximab, Adalimumab, Vedolizumab &	
80230	Infliximab	NoN-COVERED	NON-COVERED	PG0341 Measurement of Serum Drug Antibodies to Infliximab, Adalimumab, Vedolizumab &	
80280	Vedolizumab	NoN-COVERED	NON-COVERED	PG0341 Measurement of Serum Drug Antibodies to Infliximab, Adalimumab, Vedolizumab &	
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only (e.g.,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; read by instrument assisted direct optical observation (e.g., utilizing	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g.,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80320	Alcohols	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80321	Alcohol biomarkers; 1 or 2	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80322	Alcohol biomarkers; 3 or more	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80323	Alkaloids, not otherwise specified	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80324	Amphetamines; 1 or 2	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80325	Amphetamines; 3 or 4	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80326	Amphetamines; 5 or more	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80327	Anabolic steroids; 1 or 2	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80328	Anabolic steroids; 3 or more	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80329	Analgesics, non-opioid; 1 or 2	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
80330	Analgesics, non-opioid; 3-5	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80331	Analgesics, non-opioid; 6 or more	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80332	Antidepressants, serotonergic class, 1 or 2	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0069 Drug Testing	
80333	Antidepressants, serotonergic class; 3-5	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0069 Drug Testing	
80334	Antidepressants, serotonergic class; 6 or more	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0069 Drug Testing	
80335	Antidepressants, tricyclic and other cyclical; 1 or 2	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0069 Drug Testing	
80336	Antidepressants, tricyclic and other cyclical; 3-5	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0069 Drug Testing	
80337	Antidepressants, tricyclic and other cyclical; 6 or more	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0069 Drug Testing	
80338	Antidepressants, not otherwise classified	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0069 Drug Testing	
80339	Antiepileptics, not otherwise specified; 1-3	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80340	Antiepileptics, not otherwise specified; 4-6	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80341	Antiepileptics, not otherwise specified; 7 or more	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80342	Antipsychotics, not otherwise specified; 1-3	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0069 Drug Testing	
80343	Antipsychotics, not otherwise specified; 4-6	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0069 Drug Testing	
80344	Antipsychotics, not otherwise specified; 7 or more	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0069 Drug Testing	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
80345	Barbiturates	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80346	Benzodiazepines; 1-12	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80347	Benzodiazepines; 13 or more	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80348	Buprenorphine	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80349	Cannabinoids, natural	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80350	Cannabinoids, synthetic; 1-3	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80351	Cannabinoids, synthetic; 4-6	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80352	Cannabinoids, synthetic; 7 or more	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80353	Cocaine	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80354	Fentanyl	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80355	Gabapentin, non-blood	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
80356	Heroin metabolite	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80357	Ketamine and norketamine	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80358	Methadone	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80359	Methylenedioxyamphetamines (MDA, MDEA, MDMA)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80360	Methyphenidate	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80361	Opiates, 1 or more	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80362	Opioids and opiate analogs; 1 or 2	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80363	Opioids and opiate analogs; 3 or 4	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80364	Opioids and opiate analogs; 5 or more	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80365	Oxycodone	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80366	Pregabalin	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
80367	Propoxyphene	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80368	Sedative hypnotics (non-benzodiazepines)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80369	Skeletal muscle relaxants; 1 o 2	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80370	Skeletal muscle relaxants; 3 or more	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80371	Stimulants, synthetic	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80372	Tapentadol	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80373	Tramadol	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80374	Stereoisomer (enantiomer) analysis, single drug class	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80375	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1-3	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80376	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4-6	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
80377	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81105	Human Platelet Antigen 1 genotyping (HPA-1), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81106	Human Platelet Antigen 2 genotyping (HPA-2), GP1BA (glycoprotein Ib [platelet], alpha polypeptide [GPIba]) (eg, neonatal alloimmune thrombocytopenia	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81107	Human Platelet Antigen 3 genotyping (HPA-3), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex], antigen CD41 [GPIIb]) (eg,	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81108	Human Platelet Antigen 4 genotyping (HPA-4), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81109	Human Platelet Antigen 5 genotyping (HPA-5), ITGA2 (integrin, alpha 2 [CD49B, alpha 2 subunit of VLA-2 receptor] [GPIa]) (eg, neonatal alloimmune	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81110	Human Platelet Antigen 6 genotyping (HPA-6w), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa, antigen CD61] [GPIIIa]) (eg, neonatal alloimmune	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81111	Human Platelet Antigen 9 genotyping (HPA-9w), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex, antigen CD41] [GPIIb]) (eg,	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81112	Human Platelet Antigen 15 genotyping (HPA-15), CD109 (CD109 molecule) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura),	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81120	IDH1 (isocitrate dehydrogenase 1 [NADP+], soluble) (eg, glioma), common variants (eg, R132H,	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	
81121	IDH2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial) (eg, glioma), common variants (eg,	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	
81161	DMD (dystrophin) (e.g., Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0411 Genetic Testing for Dystrophinopathies (Duchenne and Becker	Prior authorization is required for ALL genetic testing unless otherwise noted.
81162	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0067 Genetic Testing for Hereditary Breast and Ovarian Cancer Syndrome (HBOC)-Archived 090124	Prior authorization is required for ALL genetic testing unless otherwise noted.

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81163	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0067 Genetic Testing for Hereditary Breast and Ovarian Cancer Syndrome (HBOC)-	Prior authorization is required for ALL genetic testing unless otherwise noted.
81164	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0067 Genetic Testing for Hereditary Breast and Ovarian Cancer Syndrome (HBOC)-	Prior authorization is required for ALL genetic testing unless otherwise noted.
81165	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0067 Genetic Testing for Hereditary Breast and Ovarian Cancer Syndrome (HBOC)-	Prior authorization is required for ALL genetic testing unless otherwise noted.
81166	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0067 Genetic Testing for Hereditary Breast and Ovarian Cancer Syndrome (HBOC)-	Prior authorization is required for ALL genetic testing unless otherwise noted.
81167	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0067 Genetic Testing for Hereditary Breast and Ovarian Cancer Syndrome (HBOC)-	Prior authorization is required for ALL genetic testing unless otherwise noted.
81168	CCND1/IGH (t(11;14)) (eg, mantle cell lymphoma) translocation analysis, major breakpoint,	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81170	ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (eg, acquired imatinib tyrosine kinase	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81171	AFF2 (AF4/FMR2 family, member 2 [FMR2]) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81172	AFF2 (AF4/FMR2 family, member 2 [FMR2]) (eg, fragile X mental retardation 2 [FRAXE]) gene analysis; characterization of alleles (eg, expanded size and	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81173	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; full gene sequence	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81174	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; known familial variant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81175	ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia),	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81176	ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia),	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81177	ATN1 (atrophin 1) (eg, dentatorubral-pallidoluysian atrophy) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81178	ATXN1 (ataxin 1) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81179	ATXN2 (ataxin 2) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81180	ATXN3 (ataxin 3) (eg, spinocerebellar ataxia, Machado-Joseph disease) gene analysis, evaluation to detect abnormal (eg, expanded)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81181	ATXN7 (ataxin 7) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81182	ATXN8OS (ATXN8 opposite strand [non-protein coding]) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81183	ATXN10 (ataxin 10) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81184	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81185	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; full gene sequence	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81186	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; known familial variant	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81187	CNBP (CCHC-type zinc finger nucleic acid binding protein) (eg, myotonic dystrophy type 2) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81188	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0467 Genetic Testing for Epilepsy	Prior authorization is required for ALL genetic testing unless otherwise noted.
81189	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; full gene sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0467 Genetic Testing for Epilepsy	Prior authorization is required for ALL genetic testing unless otherwise noted.
81190	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; known familial variant(s)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0467 Genetic Testing for Epilepsy	Prior authorization is required for ALL genetic testing unless otherwise noted.
81191	NTRK1 (neurotrophic receptor tyrosine kinase 1) (eg, solid tumors) translocation analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81192	NTRK2 (neurotrophic receptor tyrosine kinase 2) (eg, solid tumors) translocation analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81193	NTRK3 (neurotrophic receptor tyrosine kinase 3) (eg, solid tumors) translocation analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81194	NTRK (neurotrophic-tropomyosin receptor tyrosine kinase 1, 2, and 3) (eg, solid tumors) translocation analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81200	ASPA (aspartoacylase) (e.g., Canavan disease) gene analysis, common variants (e.g., E285A, Y231X)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.
81201	APC (adenomatous polyposis coli) (e.g., familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes Archived	Prior authorization is required for ALL genetic testing unless otherwise noted.
81202	APC (adenomatous polyposis coli) (e.g., familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes Archived	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81203	APC (adenomatous polyposis coli) (e.g., familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes Archived	Prior authorization is required for ALL genetic testing unless otherwise noted.
81204	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; characterization of alleles (eg,	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81205	BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (e.g., Maple syrup urine disease) gene analysis, common variants (e.g., R183P,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.
81206	BCR/ABL1 (t(9;22)) (e.g., chronic myelogenous leukemia) translocation analysis; major	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81207	BCR/ABL1 (t(9;22)) (e.g., chronic myelogenous leukemia) translocation analysis; minor	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81208	BCR/ABL1 (t(9;22)) (e.g., chronic myelogenous leukemia) translocation analysis; other	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81209	BLM (Bloom syndrome, RecQ helicase-like) (e.g., Bloom syndrome) gene analysis, 2281del6ins7 variant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.
81210	BRAF (B-Raf proto-oncogene, serine/threonine kinase) (eg, colon cancer, melanoma), gene analysis, V600 variant(s)	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes Archived 08/01/24, PG0041 Genetic Testing	
81212	BRCA1, BRCA2 (breast cancer 1 and 2) (e.g., hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC, 6174delT variants	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0067 Genetic Testing for Hereditary Breast and Ovarian Cancer Syndrome -Archived	Prior authorization is required for ALL genetic testing unless otherwise noted.
81215	BRCA1 (breast cancer 1) (e.g., hereditary breast and ovarian cancer) gene analysis; known familial variant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0067 Genetic Testing for Hereditary Breast and Ovarian Cancer Syndrome-Archived	Prior authorization is required for ALL genetic testing unless otherwise noted.
81216	BRCA2 (breast cancer 2) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0067 Genetic Testing for Hereditary Breast and Ovarian Cancer Syndrome-Archived	Prior authorization is required for ALL genetic testing unless otherwise noted.
81217	BRCA2 (breast cancer 2) (e.g., hereditary breast and ovarian cancer) gene analysis; known familial variant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0067 Genetic Testing for Hereditary Breast and Ovarian Cancer Syndrome-Archived	Prior authorization is required for ALL genetic testing unless otherwise noted.
81218	CEBPA (CCAAT/enhancer binding protein [C/EBP], alpha) (eg, acute myeloid leukemia), gene analysis,	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81219	CALR (calreticulin) (eg, myeloproliferative disorders), gene analysis, common variants in exon	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81220	CFTR (cystic fibrosis transmembrane conductance regulator) (e.g., cystic fibrosis) gene analysis; common variants (e.g., ACMG/ACOG guidelines)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0387 Genetic Testing for Cystic Fibrosis-archived 07/01/2024, and PG0442 Carrier Screening for	Prior authorization is required for ALL genetic testing unless otherwise noted.
81221	CFTR (cystic fibrosis transmembrane conductance regulator) (e.g., cystic fibrosis) gene analysis; known familial variants	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0387 Genetic Testing for Cystic Fibrosis-archived 07/01/2024	Prior authorization is required for ALL genetic testing unless otherwise noted.
81222	CFTR (cystic fibrosis transmembrane conductance regulator) (e.g., cystic fibrosis) gene analysis; duplication/deletion variants	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0387 Genetic Testing for Cystic Fibrosis-archived 07/01/2024	Prior authorization is required for ALL genetic testing unless otherwise noted.
81223	CFTR (cystic fibrosis transmembrane conductance regulator) (e.g., cystic fibrosis) gene analysis; full gene sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0387 Genetic Testing for Cystic Fibrosis-archived 07/01/2024	Prior authorization is required for ALL genetic testing unless otherwise noted.
81224	CFTR (cystic fibrosis transmembrane conductance regulator) (e.g., cystic fibrosis) gene analysis; intron 8 poly-T analysis (e.g., male infertility)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0387 Genetic Testing for Cystic Fibrosis-archived 07/01/2024	Prior authorization is required for ALL genetic testing unless otherwise noted.
81225	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (e.g., drug metabolism), gene analysis, common variants (e.g., *2, *3, *4, *8, *17)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0436 CYP2C19 & CYP2D6 Pharmacogenetic Testing Archived 09/01/24	Prior authorization is required for ALL genetic testing unless otherwise noted.
81226	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism), gene analysis, common variants (e.g., *2, *3, *4, *5, *6, *9,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0436 CYP2C19 & CYP2D6 Pharmacogenetic Testing Archived 09/01/24	Prior authorization is required for ALL genetic testing unless otherwise noted.
81227	CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (e.g., drug metabolism), gene analysis, common variants (e.g., *2, *3, *5, *6)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL. Non-covered for warfarin testing	PRIOR AUTHORIZATION REQUIRED - MEDICARE COVERAGE CRITERIA Non-covered for warfarin testing	PG0041 Genetic Testing and PG0390 Genetic Testing for Warfarin Dose Archived 09/01/24	Prior authorization is required for ALL genetic testing unless otherwise noted.
81228	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants, comparative genomic hybridization	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0296 Comparative Genomic Hybridization (CGH)/Chromosomal Microarray Analysis (CMA)-	Prior authorization is required for ALL genetic testing unless otherwise noted.
81229	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number and single nucleotide polymorphism	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0296 Comparative Genomic Hybridization (CGH)/Chromosomal Microarray Analysis (CMA)-	Prior authorization is required for ALL genetic testing unless otherwise noted.
81230	CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (eg, drug metabolism), gene analysis, common variant(s) (eg, *2, *22)	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81231	CYP3A5 (cytochrome P450 family 3 subfamily A member 5) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5 *6, *7)	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81232	DPYD (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis, common variant(s) (eg, *2A, *4,	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81233	BTK (Bruton's tyrosine kinase) (eg, chronic lymphocytic leukemia) gene analysis, common variants	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	
81234	DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; evaluation to detect abnormal (expanded) alleles	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81235	EGFR (epidermal growth factor receptor) (e.g., non- small cell lung cancer) gene analysis, common variants (e.g., exon 19 LREA deletion, L858R, T790M, G719A,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81236	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (eg, myelodysplastic	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	
81237	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (eg, diffuse large B-cell	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	
81238	F9 (coagulation factor IX) (eg, hemophilia B), full gene sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81239	DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; characterization of alleles (eg, expanded size)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81240	F2 (prothrombin, coagulation factor II) (e.g., hereditary hypercoagulability) gene analysis, 20210G>A variant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0355 Genetic Testing for Hereditary Thrombophilia	Prior authorization is required for ALL genetic testing unless otherwise noted.
81241	F5 (coagulation Factor V) (e.g., hereditary hypercoagulability) gene analysis, Leiden variant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0355 Genetic Testing for Hereditary Thrombophilia	Prior authorization is required for ALL genetic testing unless otherwise noted.
81242	FANCC (Fanconi anemia, complementation group C) (e.g., Fanconi anemia, type C) gene analysis, common variant (e.g., IVS4+4A>T)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.

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81243	FMR1 (Fragile X mental retardation 1) (e.g., fragile X mental retardation) gene analysis; evaluation to detect abnormal (e.g., expanded) alleles	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0360 Genetic Testing for Fragile X-Related Disorders-Archived 06/01/2024	Prior authorization is required for ALL genetic testing unless otherwise noted.
81244	FMR1 (Fragile X mental retardation 1) (e.g., fragile X mental retardation) gene analysis; characterization of alleles (e.g., expanded size and methylation	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0360 Genetic Testing for Fragile X-Related Disorders-Archived 06/01/2024	Prior authorization is required for ALL genetic testing unless otherwise noted.
81245	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; internal tandem	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	
81246	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; tyrosine kinase	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	
81247	G6PD (glucose-6-phosphate dehydrogenase) (eg,hemolytic anemia, jaundice), gene analysis; common variant(s) (eg, A, A-)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81248	G6PD (glucose-6-phosphate dehydrogenase) (eg,hemolytic anemia, jaundice), gene analysis; known familial variant(s)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81249	G6PD (glucose-6-phosphate dehydrogenase) (eg,hemolytic anemia, jaundice), gene analysis; full gene sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81250	G6PC (glucose-6-phosphatase, catalytic subunit) (e.g., Glycogen storage disease, Type 1a, von Gierke disease) gene analysis, common variants (e.g., R83C,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.
81251	GBA (glucosidase, beta, acid) (e.g., Gaucher disease) gene analysis, common variants (e.g., N370S, 84GG, L444P, IVS2+1G>A)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.
81252	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (e.g., nonsyndromic hearing loss) gene analysis; full gene sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.
81253	GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (e.g., nonsyndromic hearing loss) gene analysis; known familial variants	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.
81254	GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (e.g., nonsyndromic hearing loss) gene analysis, common variants (e.g., 309kb [del(GJB6- D13S1830)] and	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81255	HEXA (hexosaminidase A [alpha polypeptide]) (e.g., Tay-Sachs disease) gene analysis, common variants(e.g., 1278insTATC, 1421+1G>C, G269S)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.
81256	HFE (hemochromatosis) (e.g., hereditary hemochromatosis) gene analysis, common variants (e.g.,	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81257	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (e.g., alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; common deletions	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.
81258	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (e.g., alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; known familial	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.
81259	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (e.g., alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; full gene sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.
81260	IKBKAP (inhibitor of kappa light polypeptide gene enhancer in B-cells, kinase complex-associated protein) (e.g., familial dysautonomia) gene analysis,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.
81261	IGH@ (Immunoglobulin heavy chain locus) (e.g., leukemias and lymphomas, B-cell), gene	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81262	IGH@ (Immunoglobulin heavy chain locus) (e.g., leukemias and lymphomas, B-cell), gene	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81263	IGH@ (Immunoglobulin heavy chain locus) (e.g., leukemia and lymphoma, B-cell), variable region	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81264	IGK@ (Immunoglobulin kappa light chain locus) (e.g., leukemia and lymphoma, B-cell), gene	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81265	Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81266	Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (e.g.,	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81267	Chimerism (engraftment) analysis, post transplantation specimen (e.g., hematopoietic stem cell),	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81268	Chimerism (engraftment) analysis, post transplantation specimen (e.g., hematopoietic stem cell),	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81269	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis duplication/deletion	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81270	JAK2 (Janus kinase 2) (e.g., myeloproliferative disorder) gene analysis, p.Val617Phe (V617F)	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81271	HTT (huntingtin) (eg, Huntington disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0533 Genetic Testing for Neurodegenerative Disorders	New Medical Policy, PG0533 Genetic Testing for Neurodegenerative Disorders, procedure codes went from noncovered to covered with a prior authorization, effective 02/01/2024
81272	KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, gastrointestinal	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81273	KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, mastocytosis), gene	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81274	HTT (huntingtin) (eg, Huntington disease) gene analysis; characterization of alleles (eg, expanded size)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0533 Genetic Testing for Neurodegenerative Disorders	New Medical Policy, PG0533 Genetic Testing for Neurodegenerative Disorders, procedure codes went from noncovered to covered effective 02/01/2024
81275	KRAS (Kirsten rat sarcoma viral oncogene homolog) (e.g., carcinoma) gene analysis, variants	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81276	(KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis;	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81277	Cytogenomic neoplasia (genome-wide) microarray analysis, interrogation of genomic regions for copy number and loss-of-heterozygosity variants for	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81278	IGH@/BCL2 (t(14;18)) (eg, follicular lymphoma) translocation analysis, major breakpoint region	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81279	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) targeted sequence analysis (eg,	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81283	IFNL3 (interferon, lambda 3) (eg, drug response), gene analysis, rs12979860 variant	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Changed Commercial plans from covered with a prior authorization to noncovered, effective 11/01/2024
81284	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; evaluation to detect abnormal (expanded) alleles	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81285	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; characterization of alleles (eg, expanded size)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81286	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; full gene sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81287	MGMT (O-6-methylguanine-DNA methyltransferase) (e.g., glioblastoma multiforme), methylation analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81288	LH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; promoter methylation	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes Archived	Prior authorization is required for ALL genetic testing unless otherwise noted.
81289	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; known familial variant(s)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81290	MCOLN1 (mucolipin 1) (e.g., Mucolipidosis, type IV) gene analysis, common variants (e.g., IVS3-2A>G, del6.4kb)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.
81291	MTHFR (5, 10-methylenetetrahydrofolate reductase)(e.g., hereditary hypercoagulability) gene analysis, common variants (e.g., 677T,	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0355 Genetic Testing for Hereditary Thrombophilia	Prior authorization is required for ALL genetic testing unless otherwise noted.
81292	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes Archived	Prior authorization is required for ALL genetic testing unless otherwise noted.
81293	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes Archived	Prior authorization is required for ALL genetic testing unless otherwise noted.
81294	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes Archived	Prior authorization is required for ALL genetic testing unless otherwise noted.
81295	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes Archived	Prior authorization is required for ALL genetic testing unless otherwise noted.
81296	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes Archived	Prior authorization is required for ALL genetic testing unless otherwise noted.
81297	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes Archived	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81298	MSH6 (mutS homolog 6 [E. coli]) (e.g. hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes Archived	Prior authorization is required for ALL genetic testing unless otherwise noted.
81299	MSH6 (mutS homolog 6 [E. coli]) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes Archived	Prior authorization is required for ALL genetic testing unless otherwise noted.
81300	MSH6 (mutS homolog 6 [E. coli]) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes Archived	Prior authorization is required for ALL genetic testing unless otherwise noted.
81301	Microsatellite instability analysis (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (e.g.,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes Archived	Prior authorization is required for ALL genetic testing unless otherwise noted.
81302	MECP2 (methyl CpG binding protein 2) (e.g., Rett syndrome) gene analysis; full sequence analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81303	MECP2 (methyl CpG binding protein 2) (e.g., Rett syndrome) gene analysis; known familial variant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81304	MECP2 (methyl CpG binding protein 2) (e.g., Rett syndrome) gene analysis; duplication/ deletion variants	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81305	MYD88 (myeloid differentiation primary response 88) (eg, Waldenstrom's macroglobulinemia,	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81306	NUDT15 (nudix hydrolase 15) (eg, drug metabolism) gene analysis, common variant(s) (eg, *2, *3, *4, *5, *6)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81307	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) gene analysis; full gene sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81308	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) gene analysis; known familial variant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81309	PIK3CA (phosphatidylinositol-4, 5-biphosphate 3-kinase, catalytic subunit alpha) (eg, colorectal and breast cancer) gene analysis, targeted sequence analysis (eg,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81310	NPM1 (nucleophosmin) (e.g., acute myeloid leukemia) gene analysis, exon 12 variants	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81311	NRAS (neuroblastoma RAS viral [v-ras] oncogene homolog) (eg, colorectal carcinoma), gene	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81312	PABPN1 (poly[A] binding protein nuclear 1) (eg, oculopharyngeal muscular dystrophy) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81313	PCA3/KLK3 (prostate cancer antigen 3 [non-protein coding]/kallikrein-related peptidase 3 [prostate specific antigen]) ratio (eg, prostate cancer)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate	Prior authorization is required for ALL genetic testing unless otherwise noted.
81314	PDGFRA (platelet-derived growth factor receptor, alpha polypeptide) (eg, gastrointestinal stromal tumor	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81315	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (e.g.,	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81316	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (e.g.,	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81317	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes	Prior authorization is required for ALL genetic testing unless otherwise noted.
81318	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes	Prior authorization is required for ALL genetic testing unless otherwise noted.
81319	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes	Prior authorization is required for ALL genetic testing unless otherwise noted.
81320	PLCG2 (phospholipase C gamma 2) (eg, chronic lymphocytic leukemia) gene analysis, common	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81321	PTEN (phosphatase and tensin homolog) (e.g., Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0336 PTEN Genetic Testing. PG0336 Archived 06/01/2024. Maintain Prior Authorization per InterQual	Medical Policy PG0336 PTEN Genetic Testing is going to be archived. Procedures 81321-81323, require a prior authorizaiton for Commercial and Medicare plans. And procedure 0235U is noncovered for Commercial plans and requires a prior authorization for Medicare plans. These prior authorizations and noncoverage will be maintained. The
81322	PTEN (phosphatase and tensin homolog) (e.g., Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0336 PTEN Genetic Testing. PG0336 Archived 06/01/2024. Maintain Prior Authorization per InterQual	Medical Policy PG0336 PTEN Genetic Testing is going to be archived. Procedures 81321-81323, require a prior authorizaiton for Commercial and Medicare plans. And procedure 0235U is noncovered for Commercial plans and requires a prior authorization for Medicare plans. These prior authorizations and noncoverage will be maintained. The
81323	PTEN (phosphatase and tensin homolog) (e.g., Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0336 PTEN Genetic Testing. PG0336 Archived 06/01/2024. Maintain Prior Authorization per InterQual	Medical Policy PG0336 PTEN Genetic Testing is going to be archived. Procedures 81321-81323, require a prior authorizaiton for Commercial and Medicare plans. And procedure 0235U is noncovered for Commercial plans and requires a prior authorization for Medicare plans. These prior authorizations and noncoverage will be maintained. The

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81324	PMP22 (peripheral myelin protein 22) (e.g., Charcot- Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; duplication/deletion analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81325	PMP22 (peripheral myelin protein 22) (e.g., Charcot- Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; full sequence analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81326	PMP22 (peripheral myelin protein 22) (e.g., Charcot- Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; known familial variant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81327	SEPT9 (Septin9) (eg, colorectal cancer) methylation analysis	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0065 Colorectal Cancer Screening PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81328	SLCO1B1 (solute carrier organic anion transporter family, member 1B1) (eg, adverse drug reaction), gene analysis, common variant(s) (eg, *5)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81329	SMN1(survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; dosage/deletion analysis (eg, carrier testing), includes SMN2	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0398 Genetic Testing for Spinal Muscular Atrophy	Prior authorization is required for ALL genetic testing unless otherwise noted.
81330	SMPD1(sphingomyelin phosphodiesterase 1, acid lysosomal) (e.g., Niemann-Pick disease, Type A) gene analysis, common variants (e.g., R496L,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.
81331	SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (e.g., Prader-Willi syndrome and/or Angelman syndrome),	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81332	SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (e.g., alpha-1-antitrypsin deficiency), gene	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81333	TGFBI (transforming growth factor beta-induced) (eg, corneal dystrophy) gene analysis, common variants (eg, R124H, R124C, R124L, R555W, R555Q)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81334	RUNX1 (runt related transcription factor 1) (eg, acute myeloid leukemia, familial platelet disorder with associated myeloid malignancy), gene analysis,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81335	TPMT (thiopurine S-methyltransferase) (eg, drug metabolism), gene analysis, common variants (eg,*2, *3)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81336	SMN1(survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; full gene sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0398 Genetic Testing for Spinal Muscular Atrophy	Prior authorization is required for ALL genetic testing unless otherwise noted.
81337	SMN1(survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; known familial sequence variant(s)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0398 Genetic Testing for Spinal Muscular Atrophy	Prior authorization is required for ALL genetic testing unless otherwise noted.
81338	MPL (MPL proto-oncogene , thrombopoietin receptor) (eg, myeloproliferative disorder) gene	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81339	MPL (MPL proto-oncogene , thrombopoietin receptor) (eg, myeloproliferative disorder) gene	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81340	TRB@ (T cell antigen receptor, beta) (e.g., leukemia and lymphoma), gene rearrangement	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81341	TRB@ (T cell antigen receptor, beta) (e.g., leukemia and lymphoma), gene rearrangement	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81342	TRG@ (T cell antigen receptor, gamma) (e.g., leukemia and lymphoma), gene rearrangement	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81343	PPP2R2B (protein phosphatase 2 regulatory subunit Bbeta) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81344	TBP (TATA box binding protein) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81345	TERT (telomerase reverse transcriptase) (eg, thyroid carcinoma, glioblastoma multiforme) gene analysis, targeted sequence analysis (eg,	PRIOR AUTHORIZATION REQUIRED - iNTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81346	TYMS (thymidylate synthetase) (eg, 5-fluorouracil/5- FU drug metabolism), gene analysis, common variant(s) (eg,tandem repeat variant)	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Changed Commercial coverage from covered with a prior authorization to noncovered, effective 11/01/2024.
81347	SF3B1 (splicing factor [3b] subunit B1) (eg, myelodysplastic syndrome/acute myeloid leukemia)	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81348	SRSF2 (serine and arginine-rich splicing factor 2) (eg, myelodysplastic syndrome, acute	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81349	Cytogenomic constitutional (genome-wide) microarray analysis; Interrogation of genomic regions for copy number loss-of-heterozygosity variants, low-pass	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81350	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (e.g., irinotecan metabolism), gene analysis, common variants (e.g., *28, *36,	PRIOR AUTHORIZATION REQUIRED- INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing PG0391 UGT1A1 Targeted Mutation Analysis for Irinotecan Response	Effective 05/01/2024, procedure 81350, is covered with a prior authorization for all product lines. (Procedure 81350 went from noncovered to covered with a prior authorization)
81351	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; full gene sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81352	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; targeted sequence	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81353	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; known familial variant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81355	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (e.g., warfarin metabolism), gene analysis, common variant(s) (e.g., -1639G>A, c.173+1000C>T)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0390 Genetic Testing for Warfarin Dose Archived 09/01/24	Prior authorization is required for ALL genetic testing unless otherwise noted.
81357	U2AF1 (U2 small nuclear RNA auxiliary factor 1) (eg, myelodysplastic syndrome, acute	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81360	ZRSR2 (zinc finger CCCH-type, RNA binding motif and serine/arginine-rich 2) (eg,	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81361	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia hemoglobinopathy); common variant(s) (eg, HbS, HbC, HbE)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.
81362	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia hemoglobinopathy); known familial variant(s)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.
81363	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia hemoglobinopathy); duplication/deletion variant(s)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.
81364	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia hemoglobinopathy); full gene sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.
81370	HLA Class I and II typing, low resolution (e.g., antigen equivalents); HLA-A, -B, -C, -	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81371	HLA Class I and II typing, low resolution (e.g., antigen equivalents); HLA-A, -B, and -	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81372	HLA Class I typing, low resolution (e.g., antigen equivalents); complete (i.e., HLA-A, -B, and -C)	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81373	HLA Class I typing, low resolution (e.g., antigen equivalents); one locus (e.g., HLA-A, -B, or -C), each	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81374	HLA Class I typing, low resolution (e.g., antigen equivalents); one antigen equivalent (e.g., B*27),	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81375	HLA Class II typing, low resolution (e.g., antigen equivalents); HLA-DRB1/3/4/5 and -DQB1	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81376	HLA Class II typing, low resolution (e.g., antigen equivalents); one locus (e.g., HLA-DRB1/3/4/5, -	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81377	HLA Class II typing, low resolution (e.g., antigen equivalents); one antigen equivalent, each	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81378	HLA Class I typing, high resolution (i.e., alleles or allele groups); complete (i.e., HLA-A, -B, and -C)	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81379	HLA Class I typing, high resolution (i.e., alleles or allele groups); complete (i.e., HLA-A, -B, and -C)	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81380	HLA Class I typing, high resolution (i.e., alleles or allele groups); one locus (e.g., HLA-A, -B, or -C), each	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81381	HLA Class I typing, high resolution (i.e., alleles or allele groups); one allele or allele group (e.g., B*57:01P), each	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0437 HLA-B1502 & HLA-B5701 Pharmacogenetic Testing Archived 09/01/24	Prior authorization is required for ALL genetic testing unless otherwise noted.
81382	HLA Class II typing, high resolution (i.e., alleles or allele groups); one locus (e.g., HLA-DRB1, -DRB3, -	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81383	HLA Class II typing, high resolution (i.e., alleles or allele groups); one allele or allele group (e.g., HLA-	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81400	Molecular pathology procedure, Level 1 analysis)(e.g., identification of single germline variant [e.g., SNP] by techniques such as restriction enzyme	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0442 Carrier Screening for Genetic Diseases	Prior authorization is required for ALL genetic testing unless otherwise noted.
81401	Molecular pathology procedure, Level 2 (e.g., 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0119 Gene Expression Profiling of Melanomas- Archived 07/01/2024, PG0302 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81402	Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81403	Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes Archived 08/01/24, PG0442	Prior authorization is required for ALL genetic testing unless otherwise noted.
81404	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0442 Carrier Screening for Genetic Diseases, PG0467 Genetic Testing for Epilepsy	Prior authorization is required for ALL genetic testing unless otherwise noted.
81405	Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0412 Genetic Testing Age-Related Macular Degeneration	Prior authorization is required for ALL genetic testing unless otherwise noted.
81406	Molecular pathology procedure, Level 7 (e.g., analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndromes Archived 08/01/24, PG0442	Prior authorization is required for ALL genetic testing unless otherwise noted.
81407	Molecular pathology procedure Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0467 Genetic Testing for Epilepsy	Prior authorization is required for ALL genetic testing unless otherwise noted.
81408	Molecular pathology procedure, Level 9 (e.g., analysis of >50 exons in a single gene by DNA sequence analysis) FBN1 (fibrillin 1) (e.g., Marfan syndrome), full	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0411 Genetic Testing for Dystrophinopathies (Duchenne and Becker	Prior authorization is required for ALL genetic testing unless otherwise noted.
81410	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); duplication/deletion	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0453 Germline Multi-Gene Panel Testing-Archived 080124	Prior authorization is required for ALL genetic testing unless otherwise noted.
81411	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); duplication/deletion	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0453 Germline Multi-Gene Panel Testing-Archived 080124	Prior authorization is required for ALL genetic testing unless otherwise noted.
81412	Ashkenazi Jewish associated disorders (eg, Bloom syndrome, Canavan disease, cystic fibrosis, familial dysautonomia, Fanconi anemia group C, Gaucher disease,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0453 Germline Multi-Gene Panel Testing-Archived 080124, and PG0442 Carrier Screening	Prior authorization is required for ALL genetic testing unless otherwise noted.
81413	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); genomic	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0453 Germline Multi-Gene Panel Testing-Archived 080124, and PG0280 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81414	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia);	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0453 Germline Multi-Gene Panel Testing-Archived 080124, and PG0280 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81415	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0453 Germline Multi-Gene Panel Testing-Archived 080124, and PG0468 Whole Exome	Prior authorization is required for ALL genetic testing unless otherwise noted.
81416	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (eg, parents, siblings) (List separately	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0453 Germline Multi-Gene Panel Testing-Archived 080124, and PG0468 Whole Exome	Prior authorization is required for ALL genetic testing unless otherwise noted.
81417	Exome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained exome sequence (eg, updated knowledge	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0453 Germline Multi-Gene Panel Testing-Archived 080124, and PG0468 Whole Exome	Prior authorization is required for ALL genetic testing unless otherwise noted.
81418	Drug metabolism (eg, pharmacogenomics) genomic sequence analysis panel, must include testing of at least 6 genes, including CYP2C19, CYP2D6, and	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0453 Germline Multi-Gene Panel Testing-Archived 080124, and PG0368 Pharmacogenomic	Prior authorization is required for ALL genetic testing unless otherwise noted. Changed Commercial plans from noncovered to covered with a prior authorization-interqual, effective 11/01/2024
81419	Epilepsy genomic sequence analysis panel, must include analyses for ALDH7A1,CACNA1A, CDKL5, CHD2, GABRG2, GRIN2A, KCNQ2, MECP2,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0453 Germline Multi-Gene Panel Testing-Archived 080124, and PG0467 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81420	Fetal chromosomal aneuploidy (eg, trisomy 21, monosomy X) genomic sequence analysis panel,	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0041 Genetic Testing and PG0287 Non-Invasive Prenatal Screening	Prior authorization is required for ALL genetic testing unless otherwise noted.
81422	Fetal chromosomal microdeletion(s) genomic sequence analysis (eg. DiGeorge syndrome, Cri-du- chat syndrome), circulating cell-free fetal DNA in	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81425	Genome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	Prior authorization is required for ALL genetic testing unless otherwise noted.
81426	Genome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator genome (e.g., parents, siblings) (List separately	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	Prior authorization is required for ALL genetic testing unless otherwise noted.
81427	Genome (e.g., unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained genome sequence (e.g., updated	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	Prior authorization is required for ALL genetic testing unless otherwise noted.
81430	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); genomic sequence analysis panel, must include sequencing of at least 60	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0453 Germline Multi-Gene Panel Testing-Archived 080124	Prior authorization is required for ALL genetic testing unless otherwise noted.
81431	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); duplication/deletion analysis panel, must include copy number	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0453 Germline Multi-Gene Panel Testing-Archived 080124	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81432	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0067 Genetic Testing for Breast and Ovarian Cancers-Archived 090124, and PG0453 Germline	Prior authorization is required for ALL genetic testing unless otherwise noted.
81433	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); duplication/deletion analysis panel,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0067 Genetic Testing for Breast and Ovarian Cancers--Archived 090124, and PG0453 Germline	Prior authorization is required for ALL genetic testing unless otherwise noted.
81434	Hereditary retinal disorders (eg, retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy), genomic sequence analysis panel, must include	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0453 Germline Multi-Gene Panel Testing-Archived 080124	Prior authorization is required for ALL genetic testing unless otherwise noted.
81435	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis); genomic sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndrome Archived 08/01/24, and	Prior authorization is required for ALL genetic testing unless otherwise noted.
81436	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis); duplication/deletion	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0302 Genetic Testing for Lynch Syndrome and Polyposis Syndrome Archived 08/01/24, and	Prior authorization is required for ALL genetic testing unless otherwise noted.
81437	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma; genomic sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0453 Germline Multi-Gene Panel Testing-Archived 080124	Prior authorization is required for ALL genetic testing unless otherwise noted.
81438	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma;	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0453 Germline Multi-Gene Panel Testing-Archived 080124	Prior authorization is required for ALL genetic testing unless otherwise noted.
81439	Hereditary cardiomyopathy (eg, hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy), genomic	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0280 Genetic Testing for Cardiac Conditions, and PG0453 Germline Multi-Gene Panel Testing-	Prior authorization is required for ALL genetic testing unless otherwise noted.
81440	Nuclear encoded mitochondrial genes (eg, neurologic or myopathic phenotypes), genomic sequence panel, must include analysis of at least 100 genes,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0453 Germline Multi-Gene Panel Testing-Archived 080124	Prior authorization is required for ALL genetic testing unless otherwise noted.
81441	Inherited bone marrow failure syndromes (IBMFS) (eg, Fanconi anemia, dyskeratosis congenita, Diamond-Blackfan anemia, Shwachman-Diamond syndrome,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0453 Germline Multi-Gene Panel Testing-Archived 080124	Prior authorization is required for ALL genetic testing unless otherwise noted.
81442	Noonan spectrum disorders (eg, Noonan syndrome, cardio-facio-cutaneous syndrome, Costello syndrome, LEOPARD syndrome, Noonan-like syndrome), genomic	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0453 Germline Multi-Gene Panel Testing-Archived 080124	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81443	Genetic testing for severe inherited conditions (eg, cystic fibrosis, Ashkenazi Jewish-associated disorders [eg, Bloom syndrome, Canavan disease,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0453 Germline Multi-Gene Panel Testing-Archived 080124, PG0442 Carrier Screening for	Prior authorization is required for ALL genetic testing unless otherwise noted.
81445	Targeted genomic sequence analysis panel, solid organ neoplasm, DNA analysis, and RNA analysis when performed, 5-50 genes (eg, ALK, BRAF, CDKN2A,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0438 Molecular Profiling (Somatic Testing) Panels for Solid Cancer Tumors and Hematologic	Prior authorization is required for ALL genetic testing unless otherwise noted.
81448	Hereditary peripheral neuropathies (eg, Charcot- Marie-Tooth, spastic paraplegia), genomic sequence analysis panel, must include sequencing of at least 5 peripheral	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0453 Germline Multi-Gene Panel Testing-Archived 080124	Prior authorization is required for ALL genetic testing unless otherwise noted.
81449	Targeted genomic sequence analysis panel, solid organ neoplasm, 5-50 genes (eg, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, MET, NRAS,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0438 Molecular Profiling (Somatic Testing) Panels for Solid Cancer Tumors and Hematologic	Prior authorization is required for ALL genetic testing unless otherwise noted.
81450	Targeted genomic sequence analysis panel, hematolymphoid neoplasm or disorder, DNA analysis, and RNA analysis when performed, 5-50 genes (eg, BRAF,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0438 Molecular Profiling (Somatic Testing) Panels for Solid Cancer Tumors and Hematologic	Prior authorization is required for ALL genetic testing unless otherwise noted.
81451	Targeted genomic sequence analysis panel, hematolymphoid neoplasm or disorder, 5-50 genes (eg, BRAF, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0438 Molecular Profiling (Somatic Testing) Panels for Solid Cancer Tumors and Hematologic	Prior authorization is required for ALL genetic testing unless otherwise noted.
81455	Targeted genomic sequence analysis panel, solid organ or hematolymphoid neoplasm, DNA analysis, and RNA analysis when performed, 51 or greater genes	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0438 Molecular Profiling (Somatic Testing) Panels for Solid Cancer Tumors and Hematologic	Prior authorization is required for ALL genetic testing unless otherwise noted.
81456	Targeted genomic sequence analysis panel, solid organ or hematolymphoid neoplasm or disorder, 51 or greater genes (eg, ALK, BRAF, CDKN2A, CEBPA,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81457	Solid organ neoplasm, genomic sequence analusis panel, interrogation for sequence variants; DNA analysis, microsatellite instability	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81458	Solid organ neoplasm, genomic sequence analusis panel, interrogation for sequence variants; DNA analysis, copy number variants and microsatelite	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81459	Solid organ neoplasm, genomic sequence analusis panel, interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81460	Whole mitochondrial genome (eg, Leigh syndrome, mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes [MELAS], myoclonic epilepsy with	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81462	Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (eg, plasma), interrogation for sequence variants; DNA analysis or	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81463	Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (eg, plasma), interrogation for sequence variants; DNA analysis or	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81464	Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (eg, plasma), interrogation for sequence variants; DNA analysis or	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81465	Whole mitochondrial genome large deletion analysis panel (eg, Kearns-Sayre syndrome, chronic progressive external ophthalmoplegia), including	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0453 Germline Multi-Gene Panel Testing-Archived 080124	Prior authorization is required for ALL genetic testing unless otherwise noted.
81470	X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); genomic sequence analysis panel, must include sequencing of at least 60	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0453 Germline Multi-Gene Panel Testing-Archived 080124	Prior authorization is required for ALL genetic testing unless otherwise noted.
81471	X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); duplication/deletion gene analysis, must include analysis of at least 60	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0453 Germline Multi-Gene Panel Testing-Archived 080124	Prior authorization is required for ALL genetic testing unless otherwise noted.
81479	Unlisted molecular pathology procedure	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. **Percepta Genomic Sequencing Classifier (81479) is Non-Covered**
81490	Autoimmune (rheumatoid arthritis), analysis of 12 biomarkers using immunoassays, utilizing serum,	NON-COVERED	PRIOR AUTHORIZATION **NOT** REQUIRED	PG0041 Genetic Testing and PG0362 Vectra® DA; PG0043 Experimental	Prior authorization is required for ALL genetic testing unless otherwise noted.
81493	Coronary artery disease, mRNA, gene expression profiling by real-time RT-PCR of 23 genes, utilizing whole peripheral blood, algorithm reported as a risk score	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing AND PG0392 Cardiovascular Disease (CVD) Risk Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81500	Oncology (ovarian), biochemical assays of two proteins (CA-125 and HE-4), utilizing serum, with menopausal status, algorithm reported as a risk score	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81503	Oncology (ovarian), biochemical assays of five proteins (CA-125, apolipoprotein A1, beta-2 microglobulin, transferring, and pre-albumin), utilizing serum, algorithm	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81504	Oncology (tissue of origin), microarray gene expression profiling of > 2000 genes, utilizing	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing and PG0364 Gene Expression Profiling for	Prior authorization is required for ALL genetic testing unless otherwise noted.
81506	Endocrinology (type 2 diabetes), biochemical assays of seven analytes (glucose, HbA1c, insulin,	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81507	Fetal aneuploidy (trisomy 21, 18, and 13) DNA sequence analysis of selected regions using maternal	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and PG0287 Non-Invasive Prenatal Screening	Prior authorization is required for ALL genetic testing unless otherwise noted.
81508	Fetal congenital abnormalities, biochemical assays of two proteins (PAPP-A, hCG [any form]),	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81509	Fetal congenital abnormalities, biochemical assays of three proteins (PAPP-A, hCG [any form],	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81510	Fetal congenital abnormalities, biochemical assays of three analytes (AFP, uE3, hCG [any	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81511	Fetal congenital abnormalities, biochemical assays of four analytes (AFP, uE3, hCG [any	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81512	Fetal congenital abnormalities, biochemical assays of five analytes (AFP, uE3, total hCG,	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81518	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 11 genes (7 content and 4 housekeeping), utilizing formalin- fixed paraffin embedded	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0301 Genetic Expression Assays for Breast Cancer Prognosis-Archived 090124	Prior authorization is required for ALL genetic testing unless otherwise noted.
81519	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 21 genes, utilizing formalin- fixed paraffin embedded tissue, algorithm reported as	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0301 Genetic Expression Assays for Breast Cancer Prognosis-Archived 090125	Prior authorization is required for ALL genetic testing unless otherwise noted.
81520	Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin embedded	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0301 Genetic Expression Assays for Breast Cancer Prognosis-Archived 090126	Prior authorization is required for ALL genetic testing unless otherwise noted.
81521	Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and 465 housekeeping genes, utilizing fresh frozen or formalin-fixed	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0301 Genetic Expression Assays for Breast Cancer Prognosis-Archived 090127	Prior authorization is required for ALL genetic testing unless otherwise noted.
81522	Oncology (breast), mRNA, gene expression profiling by RT-PRC of 12 genes (8 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0301 Genetic Expression Assays for Breast Cancer Prognosis-Archived 090128	Prior authorization is required for ALL genetic testing unless otherwise noted.
81523	Oncology (breast), mRNA, next-generation sequencing gene expression profiling of 70 content genes and 31 housekeeping genes, utilizing formalin-fixed	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0301 Genetic Expression Assays for Breast Cancer Prognosis-Archived 090129	Prior authorization is required for ALL genetic testing unless otherwise noted.
81525	Oncology (colon), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing and PG0357 Gene Expression Profiling for	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
81528	Oncology (colorectal) screening, quantitative real- time target and signal amplification of 10 DNA	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing and PG0065 Colorectal Cancer Screening	
81529	Oncology (cutaneous melanoma), mRNA, gene expression profiling by real-time RT-PCR of 31 genes (28 content and 3 housekeeping), utilizing formalin-fixed paraffin	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0119 Gene Expression Profiling of Melanomas-Archived 07/01/2024	Prior authorization is required for ALL genetic testing unless otherwise noted.
81535	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and	NON-COVERED	NON-COVERED	PG0122 In Vitro Chemoresistance & Chemosensitivity Assays	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
81536	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and	NON-COVERED	NON-COVERED	PG0122 In Vitro Chemoresistance & Chemosensitivity Assays	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
81538	Oncology (lung), mass spectrometric 8-protein signature, including amyloid A, utilizing serum, prognostic and predictive algorithm reported as good versus	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0111 VeriStrat®	Prior authorization is required for ALL genetic testing unless otherwise noted.
81539	Oncology (high-grade prostate cancer), biochemical assay of four proteins (Total PSA, Free PSA,	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0041 Genetic Testing and PG0367 Genetic and Protein Biomarkers for	Prior authorization is required for ALL genetic testing unless otherwise noted.
81540	Oncology (tumor of unknown origin), mRNA, gene expression profiling by real-time RT-PCR of	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing and PG0364 Gene Expression Profiling for	Prior authorization is required for ALL genetic testing unless otherwise noted.
81541	Oncology (prostate), mRNA gene expression profiling by real-time RT-PCR of 46 genes (31 content and 15 housekeeping), utilizing formalin- fixed paraffin embedded	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate	Prior authorization is required for ALL genetic testing unless otherwise noted. 02/01/2024 Changed Commercial coverage from NonCovered to Covered with a PA-PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate Cancer
81542	Oncology (prostate), mRNA, microarray gene expression profiling of 22 content genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate	Prior authorization is required for ALL genetic testing unless otherwise noted.
81546	Oncology (thyroid), mRNA, gene expression analysis of 10,196 genes, utilizing fine	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing and PG0298 Molecular Markers in Fine Needle	Prior authorization is required for ALL genetic testing unless otherwise noted.
81551	Oncology (prostate), promoter methylation profiling by real-time PCR of 3 genes (GSTP1, APC, RASSF1), utilizing formalin-fixed paraffin embedded tissue,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate	Prior authorization is required for ALL genetic testing unless otherwise noted.
81552	needle aspirate, algorithm reported as a categorical result (eg, benign or suspicious) (Afirma Genomic Sequencing Classifier)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0119 Gene Expression Profiling of Melanomas-Archived 07/01/2024	Prior authorization is required for ALL genetic testing unless otherwise noted.
81554	Pulmonary disease (idiopathic pulmonary fibrosis [IPF]), mRNA, gene expression analysis of 190 genes, utilizing transbronchial biopsies, diagnostic algorithm	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81560	Transplantation medicine (allograft rejection, pediatric liver and small bowel), measurement of donor and	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81595	Cardiology (heart transplant), mRNA, gene expression profiling by real-time quantitative PCR of 20	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing and PG0525 Molecular Testing for Solid Organ	Prior authorization is required for ALL genetic testing unless otherwise noted.

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81596	Infectious disease, chronic hepatitis C virus (HCV) infection, six biochemical assays (ALT, A2-	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81599	Unlisted multianalyte assay with algorithmic analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0119 Gene Expression Profiling of Melanomas-Archived 07/01/2024, PG0298 Molecular Markers	Prior authorization is required for ALL genetic testing unless otherwise noted.
83700	Lipoprotein, blood; electrophoretic separation and quantitation	NON-COVERED	NON-COVERED	PG0392 Cardiovascular Disease (CVD) Risk Testing	
83701	Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (e.g., electrophoresis, ultracentrifugation)	NON-COVERED	NON-COVERED	PG0392 Cardiovascular Disease (CVD) Risk Testing	
83704	Lipoprotein, blood; quantitation of lipoprotein particle numbers and lipoprotein particle subclasses (e.g., by nuclear magnetic resonance spectroscopy)	NON-COVERED	NON-COVERED	PG0392 Cardiovascular Disease (CVD) Risk Testing	
83719	Lipoprotein, direct measurement; VLDL cholesterol	NON-COVERED	NON-COVERED	PG0392 Cardiovascular Disease (CVD) Risk Testing	
83722	Lipoprotein, direct measurement; small dense LDL cholesterol	NON-COVERED	NON-COVERED	PG0392 Cardiovascular Disease (CVD) Risk Testing	
83876	Myeloperoxidase (MPO)	NON-COVERED	NON-COVERED	PG0392 Cardiovascular Disease (CVD) Risk Testing	
83992	Phencyclidine (PCP)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
84431	Thromboxane metabolite(s), including thromboxane if performed, urine	NON-COVERED	NON-COVERED	PG0392 Cardiovascular Disease (CVD) Risk Testing	

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84999	Unlisted chemistry procedure	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0194 Avise MTX Test for Measuring Methotrexate Polyglutamate Levels in Rheumatoid Arthritis Therapy	7/1/2023 - Changed policy title from Avise PG to Avise MTX Test for Measuring Methotrexate Polyglutamate Levels in Rheumatoid Arthritis Therapy
86152	Cell enumeration using immunologic selection and identification in fluid specimen (eg,	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and PG0500 Liquid Biopsy	Prior authorization is required for ALL genetic testing unless otherwise noted.
86153	Cell enumeration using immunologic selection and identification in fluid specimen (eg,	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and PG0500 Liquid Biopsy	Prior authorization is required for ALL genetic testing unless otherwise noted.
87623	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), low-	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0369 Human Papillomavirus (HPV) Screening	87623, 87624, 87625, G0476 for ages under 21. AND 87623, 87624, 87625, G0476 for ages 21-29 and over age 65 only when the cervical cytology screening test results do not report as ASC-US or LSIL.
87624	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), high-	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0369 Human Papillomavirus (HPV) Screening	87623, 87624, 87625, G0476 for ages under 21. AND 87623, 87624, 87625, G0476 for ages 21-29 and over age 65 only when the cervical cytology screening test results do not report as ASC-US or LSIL.
87625	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV),	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0369 Human Papillomavirus (HPV) Screening	87623, 87624, 87625, G0476 for ages under 21. AND 87623, 87624, 87625, G0476 for ages 21-29 and over age 65 only when the cervical cytology screening test results do not report as ASC-US or LSIL.
87900	Infectious agent drug susceptibility phenotype prediction using regularly updated genotypic	NON-COVERED	NON-COVERED	PG0346 HIV Genotyping and Phenotyping Laboratory Testing;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
88230	Tissue culture for non-neoplastic disorders; lymphocyte	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, diagnosis C00-D49, D50-D77, R16.0, R16.1, R31.9, Z85.6, Z94.0-Z94.9
88233	Tissue culture for non-neoplastic disorders; skin or other solid tissue biopsy	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88235	Tissue culture for non-neoplastic disorders; amniotic fluid or chorionic villus cells	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88237	Tissue culture for neoplastic disorders; bone marrow, blood cells	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88239	Tissue culture for neoplastic disorders; solid tumor	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88240	Cryopreservation, freezing and storage of cells, each cell line	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88241	Thawing and expansion of frozen cells, each aliquot	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing

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88245	Chromosome analysis for breakage syndromes; baseline Sister Chromatid Exchange (SCE), 20-25 cells	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88248	Chromosome analysis for breakage syndromes; baseline breakage, score 50-100 cells, count 20 cells, 2 karyotypes (eg, for ataxia telangiectasia, Fanconi	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88249	Chromosome analysis for breakage syndromes; score 100 cells, clastogen stress (eg, diepoxybutane, mitomycin C, ionizing radiation, UV radiation)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88261	Chromosome analysis; count 5 cells, 1 karyotype, with banding	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88262	Chromosome analysis; count 15-20 cells, 2 karyotypes, with banding	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88263	Chromosome analysis; count 45 cells for mosaicism, 2 karyotypes, with banding	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88264	Chromosome analysis; analyze 20-25 cells	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88267	Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, 1 karyotype, with banding	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88269	Chromosome analysis, in situ for amniotic fluid cells, count cells from 6-12 colonies, 1 karyotype, with banding	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88271	Molecular cytogenetics; DNA probe, each (eg, FISH)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88272	Molecular cytogenetics; chromosomal in situ hybridization, analyze 3-5 cells (eg, for derivatives and markers)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88273	Molecular cytogenetics; chromosomal in situ hybridization, analyze 10-30 cells (eg, for microdeletions)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing

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88274	Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88275	Molecular cytogenetics; interphase in situ hybridization, analyze 100-300 cells	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88280	Chromosome analysis; additional karyotypes, each study	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88283	Chromosome analysis; additional specialized banding technique (eg, NOR, C-banding)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88285	Chromosome analysis; additional cells counted, each study	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88289	Chromosome analysis; additional high resolution study	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88291	Cytogenetics and molecular cytogenetics, interpretation and report	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, refer to medical policy PG0375 for diagnosis listing
88299	Unlisted cytogenetic study	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted. Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology
90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each [Synagis]	SEE NOTES	SEE NOTES	PG0528 Respiratory Syncytial Virus Infection Prophylaxis	•RSV Monoclonal Antibody Palivizumab (Synagis), medical benefit, is covered with a prior authorization when the coverage criteria below are met, through Magellan MRx @ https://www1.magellanrx.com/medical-rx-prior-authorization/
90626	Tick-borne encephalitis virus vaccine, inactivated; 0.25 mL dosage, for intramuscular use	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
90627	Tick-borne encephalitis virus vaccine, inactivated; 0.5 mL dosage, for intramuscular use	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
90649	HPV vaccine, types 6, 11, 16, 18 (quadrivalent), 3-dose schedule, for intramuscular use.	SEE NOTES	NON-COVERED	PG0092 HPV Vaccine Gardasil and Cervarix	Coverage ages 9-45 do not require a prior authorization. PRIOR AUTHORIZATION REQUIRED for age under 9 and over age 45.
90650	HPV vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use.	SEE NOTES	NON-COVERED	PG0092 HPV Vaccine Gardasil and Cervarix	Coverage ages 9-45 do not require a prior authorization. PRIOR AUTHORIZATION REQUIRED for age under 9 and over age 45.
90651	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 2 or 3 dose	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	NON-COVERED	PG0092 HPV Vaccine Gardasil and Cervarix	Coverage ages 9-45 do not require a prior authorization. PRIOR AUTHORIZATION REQUIRED for age under 9 and over age 45.
90791	Psychiatric diagnostic evaluation	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0530 Outpatient Psychiatry Diagnostic Evaluation Coverage and Limitations	Psychiatric diagnostic evaluation (90791) and Psychiatric diagnostic evaluation with medical services (90792) greater than once every 6 months per episode of illness, per billing provider, requires a prior authorization

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90792	Psychiatric diagnostic evaluation with medical services	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0530 Outpatient Psychiatry Diagnostic Evaluation Coverage and Limitations	Psychiatric diagnostic evaluation (90791) and Psychiatric diagnostic evaluation with medical services (90792) greater than once every 6 months per episode of illness, per billing provider, requires a prior authorization
90832	Psychotherapy, 30 minutes with patient	SEE NOTES	SEE NOTES	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)
90833	Psychotherapy, 30 minutes with patient when performed with and evaluation and management service	SEE NOTES	SEE NOTES	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)
90834	Psychotherapy, 45 minutes with patient	SEE NOTES	SEE NOTES	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)
90836	Psychotherapy, 45 minutes with patient when performed with and evaluation and management service	SEE NOTES	SEE NOTES	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)
90837	Psychotherapy, 60 minutes with patient	SEE NOTES	SEE NOTES	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)
90838	Psychotherapy, 60 minutes with patient when performed with and evaluation and management service	SEE NOTES	SEE NOTES	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)
90839	Pyschotherapy for crisis; first 60 minutes	SEE NOTES	SEE NOTES	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)
90840	each additional 30 minutes	SEE NOTES	SEE NOTES	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)
90845	Psychoanalysis	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)
90846	Family psychotherapy, without patient present; 50 minutes	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)
90847	Family psychotherapy, (conjoint psychotherapy) with patient present; 50 minutes	SEE NOTES	SEE NOTES	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)

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90849	Multiple-family group psychotherapy	SEE NOTES	SEE NOTES	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)
90853	Group psychotherapy (other than multiple-family group)	SEE NOTES	SEE NOTES	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)
90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	SEE NOTES	SEE NOTES	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)
90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes	SEE NOTES	SEE NOTES	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0294 Transcranial Magnetic Stimulation (TMS)and PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, when related to eye movement desensitization and reprocessing (EMDR) therapy prior authorization is required.
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0294 Transcranial Magnetic Stimulation (TMS)and PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, when related to eye movement desensitization and reprocessing (EMDR) therapy prior authorization is required.
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0294 Transcranial Magnetic Stimulation (TMS)and PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, when related to eye movement desensitization and reprocessing (EMDR) therapy prior authorization is required.
90870	Electroconvulsive therapy (includes necessary monitoring)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)
90870	Electroconvulsive therapy (includes necessary monitoring)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0485 Electroconvulsive Therapy (ECT)	
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)
90876	45 minutes	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)
90880	Hypnothrapy	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)
90882	Environmental intervention for medical management purposes on a psychiatri patient's behalf with	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing

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90885	Psychatric evaluation of hospital records, other psychiatic reports, psychometric and/or projective	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing
90887	Interpretation or explanation of results of psychiatric, other medical examinations and	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing
90899	Unlisted psychiatric services or procedures	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0464 Eye Movement Desensitization and Reprocessing (EMDR)	90832-90899 Psychotherapy, other psychotherapy, and other psychiatric services or procedures, ONLY require a prior authorization when related to eye movement desensitization and reprocessing (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD)
91110	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with interpretation and report	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0028 Wireless Capsule Endoscopy & Gastrointestinal Motility Monitoring System- archived 07/01/24	
91111	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus with interpretation and report	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0028 Wireless Capsule Endoscopy & Gastrointestinal Motility Monitoring System- archived 07/01/24	
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule,	NON-COVERED	NON-COVERED	PG0028 Wireless Capsule Endoscopy & Gastrointestinal Motility	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
91113	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), colon, with interpretation and report	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0028 Wireless Capsule Endoscopy & Gastrointestinal Motility Monitoring System- archived 07/01/24	
91132	Electrogastrography, diagnostic, transcutaneous	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
91133	Electrogastrography, diagnostic, transcutaneous; with provocative testing	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0318 Vision Therapy	
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with	NON-COVERED	NON-COVERED	PG0317 Corneal Hysteresis Determination by Air Impulse Stimulation;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
92512	Nasal function studies (e.g., rhinomanometry)	NON-COVERED	NON-COVERED	PG0045 Rhinomanometry & Acoustic – Optical Rhinometry; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
92517	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0323 Vestibular Function Testing; PG0043 Experimental	~~NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL~~ Effective 07/01/2024 procedures 92517, 92518, 92519 are covered without a prior authorization, when the coverage criteria are met.
92518	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; ocular	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0323 Vestibular Function Testing; PG0043 Experimental	~~NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL~~ Effective 07/01/2024 procedures 92517, 92518, 92519 are covered without a prior authorization, when the coverage criteria are met.
92519	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0323 Vestibular Function Testing; PG0043 Experimental	~~NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL~~ Effective 07/01/2024 procedures 92517, 92518, 92519 are covered without a prior authorization, when the coverage criteria are met.
92548	Computerized dynamic posturography	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0323 Vestibular Function Testing	

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92549	Computerized dynamic posturography with motor control test (MCT) and adaptation test (ADT)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0323 Vestibular Function Testing	
92972	Percutaneous transluminal coronary lithotripsy (list separately in addition to code for primary	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
93264	Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days, including at least	NON-COVERED	NON-COVERED	PG0377 Pulmonary Artery Pressure Monitoring (CardioMEMS); PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
93591	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
93592	Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
93668	Peripheral arterial disease (PAD) rehabilitation, per session	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0414 Peripheral Artery Disease (PAD) Rehabilitation	Effective 01/01/2024 covered for Paramount Commercial Insurance Plans - PROR AUTHORIZATION IS REQUIRED
93701	Bioimpedance-derived physiologic cardiovascular analysis	NON-COVERED	NON-COVERED	PG0282 Thoracic Electrical Bioimpedance for the Measurement of Cardiac	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
93702	Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s)	NON-COVERED	NON-COVERED	PG0295 Treatment of Lymphedema; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
~~95708~~	~~Electroencephalogram (EEG), without video, review of data, technical description by EEG~~	~~PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY~~	~~PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY~~	PG0333 Ambulatory EEG Monitoring	~~Effective 5/1/2021, Ambulatory EEG monitoring, with or without video, PRIOR AUTHORIZATION IS REQUIRED for > 84 hours. See highlighted coding scheme on policy. 95708 x 4, 95709 x 4, 95710 x~~
~~95709~~	~~Electroencephalogram (EEG), without video, review of data, technical description by EEG~~	~~PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY~~	~~PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY~~	PG0333 Ambulatory EEG Monitoring	~~Effective 5/1/2021, Ambulatory EEG monitoring, with or without video, PRIOR AUTHORIZATION IS REQUIRED for > 84 hours. See highlighted coding scheme on policy. 95708 x 4, 95709 x 4, 95710 x~~
~~95710~~	~~Electroencephalogram (EEG), without video, review of data, technical description by EEG~~	~~PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY~~	~~PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY~~	PG0333 Ambulatory EEG Monitoring	~~Effective 5/1/2021, Ambulatory EEG monitoring, with or without video, PRIOR AUTHORIZATION IS REQUIRED for > 84 hours. See highlighted coding scheme on policy. 95708 x 4, 95709 x 4, 95710 x~~
~~95714~~	~~Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored~~	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~	~~PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA~~	PG0333 Ambulatory EEG Monitoring	~~Effective 5/1/2021, Ambulatory EEG monitoring, with or without video, PRIOR AUTHORIZATION IS REQUIRED for > 84 hours. See highlighted coding scheme on policy. 95708 x 4, 95709 x 4, 95710 x 4, 95714 x 4, 95715 x 4, 95716 x 4, 95719 x 4, 95720 x 4, 95725, 95726. Effective 07/01/2024 no prior authorization required. Medical~~
~~95715~~	~~Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and~~	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~	~~PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA~~	PG0333 Ambulatory EEG Monitoring	~~Effective 5/1/2021, Ambulatory EEG monitoring, with or without video, PRIOR AUTHORIZATION IS REQUIRED for > 84 hours. See highlighted coding scheme on policy. 95708 x 4, 95709 x 4, 95710 x 4, 95714 x 4, 95715 x 4, 95716 x 4, 95719 x 4, 95720 x 4, 95725, 95726. Effective 07/01/2024 no prior authorization required. Medical~~
~~95716~~	~~Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time~~	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~	~~PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA~~	PG0333 Ambulatory EEG Monitoring	~~Effective 5/1/2021, Ambulatory EEG monitoring, with or without video, PRIOR AUTHORIZATION IS REQUIRED for > 84 hours. See highlighted coding scheme on policy. 95708 x 4, 95709 x 4, 95710 x 4, 95714 x 4, 95715 x 4, 95716 x 4, 95719 x 4, 95720 x 4, 95725, 95726. Effective 07/01/2024 no prior authorization required. Medical~~
~~95719~~	~~Electroencephalogram (EEG), continuous recording, physician or other qualified health care~~	~~PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY~~	~~PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY~~	PG0333 Ambulatory EEG Monitoring	~~Effective 5/1/2021, Ambulatory EEG monitoring, with or without video, PRIOR AUTHORIZATION IS REQUIRED for > 84 hours. See highlighted coding scheme on policy. 95708 x 4, 95709 x 4, 95710 x~~

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
~~95720~~	~~Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and~~	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~	~~PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA~~	PG0333 Ambulatory EEG Monitoring	~~Effective 5/1/2021, Ambulatory EEG monitoring, with or without video, PRIOR AUTHORIZATION IS REQUIRED for > 84 hours. See highlighted coding scheme on policy. 95708 x 4, 95709 x 4, 95710 x 4, 95714 x 4, 95715 x 4, 95716 x 4, 95719 x 4, 95720 x 4, 95725, 95726. Effective 07/01/2024 no prior authorization required. Medical~~
~~95725~~	~~Electroencephalogram (EEG), continuous recording, physician or other qualified health care~~	~~PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY~~	~~PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY~~	PG0333 Ambulatory EEG Monitoring	~~Effective 5/1/2021, Ambulatory EEG monitoring, with or without video, PRIOR AUTHORIZATION IS REQUIRED for > 84 hours. See highlighted coding scheme on policy. 95708 x 4, 95709 x 4, 95710 x~~
~~95726~~	~~Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and~~	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~	~~PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA~~	PG0333 Ambulatory EEG Monitoring	~~Effective 5/1/2021, Ambulatory EEG monitoring, with or without video, PRIOR AUTHORIZATION IS REQUIRED for > 84 hours. See highlighted coding scheme on policy. 95708 x 4, 95709 x 4, 95710 x 4, 95714 x 4, 95715 x 4, 95716 x 4, 95719 x 4, 95720 x 4, 95725, 95726. Effective 07/01/2024 no prior authorization required. Medical~~
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone), and sleep	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0207 Sleep Study Testing	Paramount supports the initial unattended (unsupervised) adult home sleep testing and one repeat unattended (unsupervised) adult home sleep testing without a prior authorization when the coverage criteria below is met. **Prior authorization is required for additional repeat unattended (unsupervised) adult home sleep study testing**
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (e.g., by airflow or peripheral arterial tone)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0207 Sleep Study Testing	Paramount supports the initial unattended (unsupervised) adult home sleep testing and one repeat unattended (unsupervised) adult home sleep testing without a prior authorization when the coverage criteria below is met. **Prior authorization is required for additional repeat unattended (unsupervised) adult home sleep study testing**
95803	Actigraphy, testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14	NON-COVERED	NON-COVERED	PG0198 Actigraphy and Accelerometry Sleep Diagnostics - Archived	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
95806	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0207 Sleep Study Testing	Paramount supports the initial unattended (unsupervised) adult home sleep testing and one repeat unattended (unsupervised) adult home sleep testing without a prior authorization when the coverage criteria below is met. **Prior authorization is required for additional repeat unattended (unsupervised) adult home sleep study testing**
95919	Quantitative pupillometry with physician or qualified health care professional interpretation and	NON-COVERED	NON-COVERED	PG0319 Quantitative Pupillometry/Pupillography; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (e.g., epileptic cerebral cortex localization)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0186 Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) - Archived 06/01/2024	Medical Policy PG0186 Magnetoencephalography (MEG) & Magnetic Source Imaging (MSI) is going to be archived. The procedure codes 95965, 95966, 95967 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel
95966	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (e.g., sensory, motor, language, or visual cortex localization)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0186 Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) - Archived 06/01/2024	Medical Policy PG0186 Magnetoencephalography (MEG) & Magnetic Source Imaging (MSI) is going to be archived. The procedure codes 95965, 95966, 95967 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel
95967	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (e.g., sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0186 Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0186 Magnetoencephalography (MEG) & Magnetic Source Imaging (MSI) is going to be archived. The procedure codes 95965, 95966, 95967 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel spreadsheet.
96040	Genetic counseling	SEE NOTES	SEE NOTES		Genetic Counseling (96040) provided by a trained genetic counselor does not require a prior authorization.
96931	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
96932	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
96933	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
96934	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
96935	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
96936	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
97151	Behavior identification assessment by qualified health care professional, each 15 minutes	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0335 Children's Adaptive Behavior Services. Archived	
97152	Behavior identification assessment by technician under direction of qualified health care professional,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0335 Children's Adaptive Behavior Services. Archived	
97153	Adaptive behavior treatment by protocol, administered by technician under direction of	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0335 Children's Adaptive Behavior Services. Archived	
97154	Adaptive behavior treatment by protocol, administered by technician under direction of	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0335 Children's Adaptive Behavior Services. Archived	
97155	Adaptive behavior treatment with protocol modification administered by qualified health care	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0335 Children's Adaptive Behavior Services. Archived	
97156	Family adaptive behavior treatment guidance by qualified health care professional (with or	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0335 Children's Adaptive Behavior Services. Archived	
97157	Family adaptive behavior treatment guidance by qualified health care professional without	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0335 Children's Adaptive Behavior Services. Archived	
97158	Group adaptive behavior treatment with protocol modification administered by qualified health	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0335 Children's Adaptive Behavior Services. Archived	
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	NON-COVERED (Refer to the members Benefits of Coverage for applicable terms, conditions, and limitations)	SEE NOTES	PG0382 Acupuncture	Effective 01/21/2020 acupuncture services are covered with chronic low back pain. Up to 12 visits in 90 days, no prior authorization is required. An additional 8 visits will be covered for those patients demonstrating an improvement, a PRIOR AUTHORIZATION IS REQUIRED, as of 5/1/2020 Total of 20 acupuncture treatments may
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-one contact with the patient, with re-insertion of needle(s) (List	NON-COVERED (Refer to the members Benefits of Coverage for applicable terms, conditions, and limitations)	SEE NOTES	PG0382 Acupuncture	Effective 01/21/2020 acupuncture services are covered with chronic low back pain. Up to 12 visits in 90 days, no prior authorization is required. An additional 8 visits will be covered for those patients demonstrating an improvement, a PRIOR AUTHORIZATION IS REQUIRED, as of 5/1/2020 Total of 20 acupuncture treatments may
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	NON-COVERED (Refer to the members Benefits of Coverage for applicable terms, conditions, and limitations)	SEE NOTES	PG0382 Acupuncture	Effective 01/21/2020 acupuncture services are covered with chronic low back pain. Up to 12 visits in 90 days, no prior authorization is required. An additional 8 visits will be covered for those patients demonstrating an improvement, a PRIOR AUTHORIZATION IS REQUIRED, as of 5/1/2020 Total of 20 acupuncture treatments may
97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-one contact with the patient, with re-insertion of needle(s) (List	NON-COVERED (Refer to the members Benefits of Coverage for applicable terms, conditions, and limitations)	SEE NOTES	PG0382 Acupuncture	Effective 01/21/2020 acupuncture services are covered with chronic low back pain. Up to 12 visits in 90 days, no prior authorization is required. An additional 8 visits will be covered for those patients demonstrating an improvement, a PRIOR AUTHORIZATION IS REQUIRED, as of 5/1/2020 Total of 20 acupuncture treatments may

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0150 Chiropractic Services & Spinal Manipulation	Coverage based on the member's benefit coverage for a specific product line or provider group. Chiropractic services & spinal manipulation (98940-98943) PRIOR AUTHORIZATION REQUIRED for children under 4 years of age. **Coverage per CMS criteria of subluxation (98940-98942)**
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0150 Chiropractic Services & Spinal Manipulation	Coverage based on the member's benefit coverage for a specific product line or provider group. Chiropractic services & spinal manipulation (98940-98943) PRIOR AUTHORIZATION REQUIRED for children under 4 years of age. **Coverage per CMS criteria of subluxation (98940-98942)**
98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0150 Chiropractic Services & Spinal Manipulation	Coverage based on the member's benefit coverage for a specific product line or provider group. Chiropractic services & spinal manipulation (98940-98943) PRIOR AUTHORIZATION REQUIRED for children under 4 years of age. **Coverage per CMS criteria of subluxation (98940-98942)**
98943	Chiropractic manipulative treatment (CMT); extraspinal, one or more regions	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0150 Chiropractic Services & Spinal Manipulation	Coverage based on the member's benefit coverage for a specific product line or provider group. Chiropractic services & spinal manipulation (98940-98943) PRIOR AUTHORIZATION REQUIRED for
0001U	Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0004M	Scoliosis, DNA analysis of 53 single nucleotide polymorphisms (SNPs), using saliva, prognostic	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0002U	Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid,	NON-COVERED	NON-COVERED	PG0065 Colorectal Cancer Screening PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0003U	Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0005U	Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3, and SPDEF), urine, algorithm reported as risk score	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of	Prior authorization is required for genetic testing unless otherwise noted in one of our policies. 02/01/2024 Changed Commercial coverage from NonCovered to Covered with a PA-PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate Cancer
0006M	Oncology (hepatic), mRNA expression levels of 161 genes, utilizing fresh hepatocellular	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	
0007M	Oncology (gastrointestinal neuroendocrine tumors), real-time PCR expression analysis of 51	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	
0007U	Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0009U	Oncology (breast cancer), ERBB2 (HER2) copy number by FISH, tumor cells from formalin fixed	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	
00104	Anesthesia for electroconvulsive therapy	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0485 Electroconvulsive Therapy (ECT)	
0011M	Oncology, prostate cancer, mRNA expression assay of 12 genes (10 content and 2 housekeeping), RT-	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate	
0011U	Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, using oral fluid, reported	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0012M	Oncology (urothelial), mRNA, gene expression profiling by real-hyphentime quantitative PCR of	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0013M	Oncology (urothelial), mRNA, gene expression profiling by real-hyphentime quantitative PCR of	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0014M	Liver disease, analysis of 3 biomarkers (hyaluronic acid [HA], procollagen III amino terminal	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0015M	Adrenal cortical tumor, biochemical assay of 25 steroid markers, utilizing 24-hour urine specimen	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0016M	Oncology (bladder), mRNA, microarray gene expression profiling of 209 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0016U	Oncology (hematolymphoid neoplasia), RNA, BCR/ABL1 major and minor breakpoint fusion	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0017M	Oncology (diffuse large B-cell lymphoma [DLBCL]), mRNA, gene expression profiling by fluorescent	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	
0017U	Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0018M	Transplantation medicine (allograft rejection, renal), measurement of donor and third party induced	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0018U	Oncology (thyroid), microRNA profiling by RT-PCR of 10 microRNA sequences, utilizing fine	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and PG0298 Molecular Markers in Fine Needle	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0019M	Cardiovascular disease, plasm, analysis of protein biomarkers by aptamer-based microarray and	NON-COVERED	NON-COVERED	PG0392 Cardiovascular Disease (CVD) Risk Testing	
0019U	Oncology, RNA, gene expression by whole transcriptome sequencing, formalin-fixed paraffin	NON-COVERED	NON-COVERED		
0021U	Oncology (prostate), detection of 8 autoantibodies (ARF 6, NKX3-1, 5GÇÖUTR-BMI1, CEP 164, 3GÇÖ-	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services and PG0367	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0022U	Targeted genomic sequence analysis panel, non-small cell lung neoplasia, DNA and RNA analysis, 23 genes, interrogation for sequence variants and	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0438 Molecular Profiling (Somatic Testing) Panels for Solid Cancer Tumors and Hematologic	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0023U	Oncology (acute myelogenous leukemia), DNA, genotyping of internal tandem duplication,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0024U	Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy,	NON-COVERED	NON-COVERED	PG0392 Cardiovascular Disease (CVD) Risk Testing; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0025U	Tenofovir, by liquid chromatography with tandem mass spectrometry (LC-MS/MS),	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0026U	Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0298 Molecular Markers in Fine Needle Aspirates of Thyroid Nodules-Archived	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0027U	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0029U	Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies. Changed 0029U from noncovered to covered with a prior authorization, InterQual, for Commercial, effective 11/01/2024.
0030U	Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823)	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0031U	CYP1A2 (cytochrome P450 family 1, subfamily A, member 2)(eg, drug metabolism) gene analysis, common variants (ie, *1F, *1K, *6, *7)	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0032U	COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G>A (rs4680) variant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies. Changed 0032U from noncovered to covered with a prior authorization, InterQual, for Commercial, effective 11/01/2024.
0033U	HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5-hydroxytryptamine receptor 2C) (eg, citalopram metabolism) gene analysis, common variants (ie	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies. Changed 0033U from noncovered to covered with a prior authorization, InterQual, for Commercial, effective 11/01/2024.
0034U	TPMT (thiopurine S-methyltransferase), NUDT15 (nudix hydroxylase 15)(eg, thiopurine metabolism), gene analysis, common variants (ie	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0036U	Exome (ie, somatic mutations), paired formalin-fixed paraffin-embedded tumor tissue and	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0037U	Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0438 Molecular Profiling (Somatic Testing) Panels for Solid Cancer Tumors and Hematologic	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0038U	Vitamin D, 25 hydroxy D2 and D3, by LCMS/MS, serum microsample, quantitative	NON-COVERED	NON-COVERED	PG0433 Vitamin D Testing; PG0043 Experimental Investigational Procedures	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0040U	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis, major breakpoint, quantitative	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0045U	Oncology (breast ductal carcinoma in situ), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0301 Genetic Expression Assays for Breast Cancer Prognosis-Archvied 090124	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0046U	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia) internal tandem duplication (ITD)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0047U	Oncology (prostate), mRNA, gene expression profiling by real-time RT- PCR of 17 genes (12 content and 5 housekeeping), utilizing formalin- fixed paraffin-embedded	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate	Prior authorization is required for genetic testing unless otherwise noted in one of our policies. 02/01/2024 Changed Commercial coverage from NonCovered to Covered with a PA-PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate Cancer
0048U	Oncology (solid organ neoplasia), DNA, targeted sequencing of protein- coding exons of 468 cancer-associated genes, including interrogation for somatic	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0049U	NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, quantitative	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0050U	Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants, copy number variants or	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0051U	Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, urine, 31 drug panel,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0052U	Lipoprotein, blood, high resolution fractionation and quantitation of lipoproteins, including all five major	NON-COVERED	NON-COVERED	PG0392 Cardiovascular Disease (CVD) Risk Testing; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0054T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure,	NON-COVERED	NON-COVERED	PG0128 Computer Assisted Surgery	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0054U	Prescription drug monitoring, 14 or more classes of drugs and substances, definitive tandem	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0055T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure,	NON-COVERED	NON-COVERED	PG0128 Computer Assisted Surgery	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0055U	Cardiology (heart transplant), cell-free DNA, PCR assay of 96 DNA target sequences (94 single	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0058U	Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0059U	Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus capsid	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0060U	Twin zygosity, genomic targeted sequence analysis of chromosome 2, using circulating cell-free fetal	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0061U	Transcutaneous measurement of five biomarkers (tissue oxygenation [StO2],	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0062U	Autoimmune (systemic lupus erythematosus), IgG and IgM analysis of 80 biomarkers, utilizing	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0064U	Antibody, Treponema pallidum, total and rapid plasma nswer (RPR), immunoassay, qualitative	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0066U	Placental alpha-micro globulin-1 (PAMG-1), immunoassay with direct optical observation, cervico-	NON-COVERED	NON-COVERED	PG0048 Tests for the Evaluation of Preterm Labor and	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0067U	Oncology (breast), immunohistochemistry, protein expression profiling of 4	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0069U	Oncology (colorectal), microRNA, RT-PCR expression profiling of miR-31-3p, formalin-fixed paraffin-	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0070U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, common and select rare variants (ie, *2, *3, *4, *4N, *5, *6, *7, *8	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0071T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata	NON-COVERED	NON-COVERED	PG0344 Uterine Fibroid Surgical Treatments	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0071U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, full gene sequence (List separately in addition to code for	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0072T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata	NON-COVERED	NON-COVERED	PG0344 Uterine Fibroid Surgical Treatments	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0072U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, CYP2D6-2D7 hybrid	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0073U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, CYP2D7-2D6 hybrid gene) (List	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0074U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, non-duplicated gene when	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0075U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, 5' gene duplication/multiplication)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0076U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, 3' gene duplication/multiplication)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0077U	Immunoglobulin paraprotein (Mprotein), qualitative, immunoprecipitation and mass	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0078U	Pain management (opioid-use disorder) genotyping panel, 16 common variants (ie, ABCB1, COMT, DAT1, DBH, DOR, DRD1, DRD2, DRD4, GABA, GAL	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0079U	Comparative DNA analysis using multiple selected single-nucleotide polymorphisms (SNPs), urine and buccal DNA, for	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0080U	Oncology (lung), mass spectrometric analysis of galectin-3-binding protein and scavenger	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0476 Proteomic Testing in the Management of Pulmonary Nodules	BDX-XL2 PRIOR AUTHORIZATION REQUIRED 0080U. All other Plasma-based proteomic testing in patients with undiagnosed pulmonary nodules detected by computed tomography is NON-
0082U	Drug test(s), definitive, 90 or more drugs or substances, definitive chromatography with mass	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0083U	Oncology, response to chemotherapy drugs using motility contrast tomography, fresh or	NON-COVERED	NON-COVERED	PG0122 In Vitro Chemoresistance & Chemosensitivity Assays;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0084U	Red blood cell antigen typing, DNA, genotyping of 10 blood groups with phenotype prediction of 37 red blood cell antigens	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0086U	Infectious disease (bacterial and fungal), organism identification, blood culture, using Rrna FISH, 6	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0087U	Cardiology (heart transplant), mRNA gene expression profiling by microarray	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0088U	Transplantation medicine (kidney allograft rejection), microarray gene expression profiling of 1494	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0089U	Oncology (melanoma), gene expression profiling by RTqPCR, PRAME and LINC00518, superficial collection using adhesive patch(es)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0119 Gene Expression Profiling of Melanomas-Archived 07/01/2024	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0090U	Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 23 genes (14 content and 9 housekeeping), utilizing formalin-fixed paraffin-	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0119 Gene Expression Profiling of Melanomas-Archived 07/01/2024	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0091U	Oncology (colorectal) screening, cell enumeration of circulating tumor cells, utilizing whole blood,	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0065 Colorectal Cancer Screening	
0092U	Oncology (lung), three protein biomarkers, immunoassay using magnetic nanosensor technology,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0093U	Prescription drug monitoring, evaluation of 65 common drugs by LC-MS/MS, urine, each drug	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0094U	Genome (e.g., unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0095T	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace,	NON-COVERED	NON-COVERED	PG0027 Artificial Intervertebral Disc Replacement	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0095U	Inflammation (eosinophilic esophagitis), ELISA analysis of eotaxin-3 (CCL26 [C-C motif	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0096U	Human papillomavirus (HPV), high-risk types (ie, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, 68),	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each	NON-COVERED	NON-COVERED	PG0027 Artificial Intervertebral Disc Replacement	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0100T	Placement of a subconjunctival retinal prosthesis receiver and pulse generator, and implantation	NON-COVERED	NON-COVERED	PG0418 Retinal Prosthesis	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0101T	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified, high	NON-COVERED	NON-COVERED	PG0004 Extracorporeal Shock Wave (ESWT)	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0101U	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), genomic sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0102T	Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than	NON-COVERED	NON-COVERED	PG0004 Extracorporeal Shock Wave (ESWT)	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0102U	Hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0103U	Hereditary ovarian cancer (eg, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0105U	Nephrology (chronic kidney disease), multiplex electrochemiluminescent	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0106T	Quantitative sensory testing (QST), testing and interpretation per extremity; using touch	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0106U	Gastric emptying, serial collection of 7 timed breath specimens, non-radioisotope carbon-13(13C)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0107T	Quantitative sensory testing (QST), testing and interpretation per extremity; using vibration	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0107U	Clostridium difficile toxin(s) antigen detection by immunoassay technique, stool, qualitative,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0108T	Quantitative sensory testing (QST), testing and interpretation per extremity; using cooling stimuli	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0108U	Gastroenterology (Barrett's esophagus), whole slide-digital imaging, including morphometric	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0109T	Quantitative sensory testing (QST), testing and interpretation per extremity; using heat-pain	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0110T	Quantitative sensory testing (QST), testing and interpretation per extremity; using other stimuli	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0110U	Prescription drug monitoring, one or more oral oncology drug(s) and substances, definitive tandem	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0111U	Oncology (colon cancer), targeted KRAS (codons 12, 13, and 61) and NRAS (codons 12, 13, and 61) gene analysis utilizing formalin-fixed paraffin-embedded tissue	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0112U	Infectious agent detection and identification, targeted sequence analysis (16S and 18S Rrna	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0113U	Oncology (prostate), measurement of PCA3 and TMPRSS2-ERG in urine and PSA in serum following prostatic massage, by RNA amplification and fluorescence-based detection, algorithm	NON-COVERED	NON-COVERED	Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate Cancer and PG0367 Genetic and Protein Biomarkers for	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0114U	Gastroenterology (Barrett's esophagus), VIM and CCNA1 methylation analysis, esophageal	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0115U	Respiratory infectious agent detection by nucleic acid (DNA and RNA), 18 viral types and subtypes	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0116U	Prescription drug monitoring, enzyme immunoassay of 35 or more drugs confirmed with LC-	NON-COVERED	NON-COVERED	PG0252 Noninvasive Tests for Hepatic Fibrosis; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0117U	Pain management, analysis of 11 endogenous analytes (methylmalonic acid, xanthurenic	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0118U	Transplantation medicine, quantification of donor-derived cell-free DNA using whole genome next-generation sequencing, plasma, reported as percentage of	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0525 Molecular Testing for Solid Organ Allograft Rejection	
0119U	Cardiology, ceramides by liquid chromatography-tandem mass spectrometry, plasma, quantitative	NON-COVERED	NON-COVERED	PG0392 Cardiovascular Disease (CVD) Risk Testing; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0120U	Oncology (B-cell lymphoma classification), mRNA, gene expression profiling by fluorescent	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0121U	Sickle cell disease, microfluidic flow adhesion (VCAM-1), whole blood	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0122U	Sickle cell disease, microfluidic flow adhesion (P-Selectin), whole blood	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0123U	Mechanical fragility, RBC, shear stress and spectral analysis profiling	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0129U	Hereditary breast cancer–related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis and	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0130U	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), targeted mRNA	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0131U	Hereditary breast cancer–related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0132U	Hereditary ovarian cancer–related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0133U	Hereditary prostate cancer–related disorders, targeted mRNA sequence analysis panel (11 genes)	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0134U	Hereditary pan cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0135U	Hereditary gynecological cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0136U	ATM (ataxia telangiectasia mutated) (eg, ataxia telangiectasia) mRNA sequence analysis	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0137U	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) mRNA sequence analysis	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0138U	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) mRNA sequence analysis	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0140U	Infectious disease (fungi), fungal pathogen identification, DNA (15 fungal targets), blood culture,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0141U	Infectious disease (bacteria and fungi), gram-positive organism identification and drug resistance	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0142U	Infectious disease (bacteria and fungi), gram-negative bacterial identification and drug resistance	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0143U	Drug assay, definitive, 120 or more drugs or metabolites, urine, quantitative liquid chromatography	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0144U	Drug assay, definitive, 160 or more drugs or metabolites, urine, quantitative liquid chromatography	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0145U	Drug assay, definitive, 65 or more drugs or metabolites, urine, quantitative liquid chromatography	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0146U	Drug assay, definitive, 80 or more drugs or metabolites, urine, by quantitative liquid chromatography	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0147U	Drug assay, definitive, 85 or more drugs or metabolites, urine, quantitative liquid chromatography	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0148U	Drug assay, definitive, 100 or more drugs or metabolites, urine, quantitative liquid chromatography	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0149U	Drug assay, definitive, 60 or more drugs or metabolites, urine, quantitative liquid chromatography	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0150U	Drug assay, definitive, 120 or more drugs or metabolites, urine, quantitative liquid chromatography	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0151U	Infectious disease (bacterial or viral respiratory tract infection), pathogen specific nucleic acid	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0152U	Infectious disease (bacteria, fungi, parasites, and DNA viruses), microbial cell-free DNS, plasma,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0153U	Oncology (breast), mRNA, gene expression profiling by next-generation sequencing of 101 genes, utilizing formalin-fixed paraffin-embedded tissue	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0154U	Oncology (urothelial cancer), RNA, analysis by real-time RT-PCR of the FGFR3 (fibroblast growth factor receptor 3) gene analysis (ie, p.R248C [c.742C>T]	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0155U	Oncology (breast cancer), DNA, PIK3CA (phosphatidylinositol-4,5-bisphosphate 3- kinase, catalytic subunit alpha) (eg, breast cancer) gene analysis (ie, p.C420R	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0156U	Copy number (eg, intellectual disability, dysmorphology), sequence analysis	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0157U	APC (APC regulator of WNT signaling pathway) (eg, familial adenomatosis polyposis [FAP]) mRNA sequence analysis	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0158U	MLH1 (mutL homolog 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0159U	MSH2 (mutS homolog 2) (eg, hereditary colon cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0160U	MSH6 (mutS homolog 6) (eg, hereditary colon cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0161U	PMS2 (PMS1 homolog 2, mismatch repair system component) (eg, hereditary nonpolyposis colorectal cancer, Lynch syndrome) mRNA sequence	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0162U	Hereditary colon cancer (Lynch syndrome), targeted mRNA sequence analysis panel (MLH1, MSH2, MSH6, PMS2) (List separately in addition to code	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0163T	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace	NON-COVERED	NON-COVERED	PG0027 Artificial Intervertebral Disc Replacement	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0163U	Oncology (colorectal) screening, biochemical enzyme-linked immunosorbent assay (ELISA) of 3	NON-COVERED	NON-COVERED	PG0065 Colorectal Cancer Screening; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0164T	Removal of total disc arthroplasty, (artificial disc), anterior approach, each additional interspace, lumbar	NON-COVERED	NON-COVERED	PG0027 Artificial Intervertebral Disc Replacement	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0164U	Gastroenterology (irritable bowel syndrome [IBS]), immunoassay for antiCdtB and anti-vinculin	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0165T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each	NON-COVERED	NON-COVERED	PG0027 Artificial Intervertebral Disc Replacement	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0165U	Peanut allergen-specific IgE and quantitative assessment of 64 epitopes using enzyme-linked	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0166U	Liver disease, 10 biochemical assays (α2-macroglobulin, haptoglobin, apolipoprotein A1,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0167U	Gonadotropin, chorionic (Hcg), immunoassay with direct optical observation, blood	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0169U	NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (eg, drug metabolism) gene analysis, common variants	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0170U	Neurology (autism spectrum disorder [ASD]), RNA, next-generation sequencing, saliva, algorithmic analysis, and results reported as predictive probability	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0171U	Targeted genomic sequence analysis panel, acute myeloid leukemia, myelodysplastic syndrome, and myeloproliferative neoplasms	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0172U	Oncology (solid tumor as indicated by the label), somatic mutation analysis of BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0171U	Targeted genomic sequence analysis panel, acute myeloid leukemia, myelodysplastic syndrome, and myeloproliferative neoplasms, SNA analysis, 23	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0172U	Oncology (solid tumor as indicated by the label), somatic mutation analysis of BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated)	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0173U	Psychiatry (ie, depression, anxiety), genomic analysis panel, includes variant analysis of 14 genes	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0174T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0174U	Oncology (solid tumor), mass spectrometric 30 protein targets, formalin-fixed paraffin-embedded	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0175T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0175U	Psychiatry (eg, depression, anxiety), genomic analysis panel, variant analysis of 15 genes	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies. Changed 0175U from noncovered to covered with a prior authorization, InterQual, for Elite, effective 11/01/2024.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0176U	Cytolethal distending toxin B (CdtB) and vinculin IgG antibodies by immunoassay (ie, ELISA)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0177U	Oncology (breast cancer), DNA, PIK3CA (phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0178U	Peanut allergen-specific quantitative assessment of multiple epitopes using enzyme-	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0179U	Oncology (non-small cell lung cancer), cell-free DNA, targeted sequence analysis of 23 genes (single nucleotide variations, insertions and deletions, fusions	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0500 Liquid Biopsy	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0180U	Red cell antigen (ABO blood group) genotyping (ABO), gene analysis Sanger/chain termination/conventional sequencing, ABO (ABO, alpha 1-3-	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0181U	Red cell antigen (Colton blood group) genotyping (CO), gene analysis, AQP1 (aquaporin 1 [Colton blood group]) exon 1	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0182U	Red cell antigen (Cromer blood group) genotyping (CROM), gene analysis, CD55 (CD55 molecule [Cromer blood group]) exons 1-10	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0183U	Red cell antigen (Diego blood group) genotyping (DI), gene analysis, SLC4A1 (solute carrier family 4 member 1 [Diego blood group]) exon 19	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0184U	Red cell antigen (Dombrock blood group) genotyping (DO), gene analysis, ART4 (ADP-ribosyltransferase 4 [Dombrock blood group]) exon 2	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0185U	Red cell antigen (H blood group) genotyping (FUT1), gene analysis, FUT1 (fucosyltransferase 1 [H blood group]) exon 4	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0186U	Red cell antigen (H blood group) genotyping (FUT2), gene analysis, FUT2 (fucosyltransferase 2) exon 2	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0187U	Red cell antigen (Duffy blood group) genotyping (FY), gene analysis, ACKR1 (atypical chemokine receptor 1 [Duffy blood group]) exons 1-2	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0188U	Red cell antigen (Gerbich blood group) genotyping (GE), gene analysis, GYPC (glycophorin C [Gerbich blood group]) exons 1-4	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0189U	Red cell antigen (MNS blood group) genotyping (GYPA), gene analysis, GYPA (glycophorin A [MNS blood group]) introns 1, 5, exon 2	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0190U	Red cell antigen (MNS blood group) genotyping (GYPB), gene analysis, GYPB (glycophorin B [MNS blood group]) introns 1, 5, pseudoexon 3	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0191U	Red cell antigen (Indian blood group) genotyping (IN), gene analysis, CD44 (CD44 molecule [Indian blood group]) exons 2, 3, 6	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0192U	Red cell antigen (Kidd blood group) genotyping (JK), gene analysis, SLC14A1 (solute carrier family 14 member 1 [Kidd blood group]) gene promoter, exon 9	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0193U	Red cell antigen (JR blood group) genotyping (JR), gene analysis, ABCG2 (ATP binding cassette subfamily G member 2 [Junior blood group]) exons 2-26	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0194U	Red cell antigen (Kell blood group) genotyping (KEL), gene analysis, KEL (Kell metallo-endopeptidase [Kell blood group]) exon 8	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0195U	KLF1 (Kruppel-like factor 1), targeted sequencing (ie, exon 13)	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0196U	Red cell antigen (Lutheran blood group) genotyping (LU), gene analysis, BCAM (basal cell adhesion molecule [Lutheran blood group]) exon 2	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0197U	Red cell antigen (Landsteiner-Wiener blood group) genotyping (LW), gene analysis, ICAM4 (intercellular adhesion molecule 4 [Landsteiner-Wiener blood group])	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0198T	Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services and PG0041	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0198U	Red cell antigen (RH blood group) genotyping (RHD and RHCE), gene analysis Sanger/chain termination/conventional sequencing, RHD (Rh blood group)	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0199U	Red cell antigen (Scianna blood group) genotyping (SC), gene analysis, ERMAP (erythroblast membrane associated protein [Scianna blood group]) exons 4, 12	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral	NON-COVERED	NON-COVERED	PG0038 Percutaneous Vertebroplasty, Kyphoplasty, and	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0200U	Red cell antigen (Kx blood group) genotyping (XK), gene analysis, XK (X-linked Kx blood group) exons 1-3	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or	NON-COVERED	NON-COVERED	PG0038 Percutaneous Vertebroplasty, Kyphoplasty, and	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0201U	Red cell antigen (Yt blood group) genotyping (YT), gene analysis, ACHE (acetylcholinesterase [Cartwright blood group]) exon 2	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0202T	Posterior vertebral joint(s) arthroplasty (e.g., facet joint[s] replacement) including	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0203U	Autoimmune (inflammatory bowel disease), mRNA, gene expression profiling by quantitative RT-PCR, 17 genes (15 target and 2 reference genes), whole blood	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0204U	Oncology (thyroid), mRNA, gene expression analysis of 593 genes (including BRAF, RAS, RET,	Non-Covered	Non-Covered	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0205U	Ophthalmology (age-related macular degeneration), analysis of 3 gene variants (2 CFH gene, 1 ARMS2 gene), using PCR and MALDI-TOF, buccal swab	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0412 Genetic Testing Age-Related Macular Degeneration	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0206U	Neurology (Alzheimer disease); cell aggregation using morphometric imaging and protein	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0207T	Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0207U	Neurology (Alzheimer disease); quantitative imaging of phosphorylated ERK1 and ERK2 in	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0208T	Pure tone audiometry (threshold), automated; air only	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0208U	Oncology (medullary thyroid carcinoma), mRNA, gene expression analysis of 108 genes,	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies. Deleted Code
0209T	Pure tone audiometry (threshold), automated; air and bone	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0209U	Cytogenomic constitutional (genome-wide) analysis, interrogation of genomic regions	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0468 Whole Exome Sequencing (WES) and Whole Genome	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0209U	Cytogenomic constitutional (genome-wide) analysis, interrogation of genomic regions for copy number, structural changes and areas of	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0210T	Speech audiometry threshold, automated;	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0210U	Syphilis test, non-treponemal antibody, immunoassay, quantitative (RPR)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0211T	Speech audiometry threshold, automated; with speech recognition	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0211U	Oncology (pan-tumor), DNA and RNA by next-generation sequencing, utilizing formalin-fixed	Non-Covered	Non-Covered	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0212T	Comprehensive audiometry threshold evaluation and speech recognition (0209T, 0211T	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0212U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small gene/gene changes	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0212U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0213T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or	NON-COVERED	NON-COVERED	PG0354 Facet Joint Injections	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0213U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE	PG0468 Whole Exome Sequencing (WES) and Whole Genome	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0213U	Rare diseases (constitutional/heritable disorders), whole genome and mitochodrial DNA sequence analysis, including small sequence changes,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0214T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or	NON-COVERED	NON-COVERED	PG0354 Facet Joint Injections	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0214U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes,	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0214U	Rare diseases (constitutional/heritable disorders), whole genome and mitochodrial DNA sequence analysis, including small sequence changes,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0215T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or	NON-COVERED	NON-COVERED	PG0354 Facet Joint Injections	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0215U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes,	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0215U	Rare diseases (constitutional/heritable disorders), whole genome and mitochodrial DNA sequence analysis, including small sequence changes,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0216T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or	NON-COVERED	NON-COVERED	PG0354 Facet Joint Injections	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0216U	Neurology (inherited ataxias), genomic DNA sequence analysis of 12 common genes including small sequence changes, deletions, duplications, short	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0217T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or	NON-COVERED	NON-COVERED	PG0354 Facet Joint Injections	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0217U	Neurology (inherited ataxias), genomic DNA sequence analysis of 51 genes including small sequence changes, deletions, duplications, short tandem repeat	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0218T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or	NON-COVERED	NON-COVERED	PG0354 Facet Joint Injections	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0218U	Neurology (muscular dystrophy), DMD gene sequence analysis, including small sequence changes, deletions, duplications, and variants in non-uniquely mappable	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0219T	Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0219U	Infectious agent (human immunodeficiency virus), targeted viral next-generation sequence	NON-COVERED	NON-COVERED	PG0346 HIV Genotyping and Phenotyping Laboratory Testing;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0220T	Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0220U	Oncology (breast cancer), image analysis with artificial intelligence assessment of 12 histologic and	Non-Covered	Non-Covered	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0221T	Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0221U	Red cell antigen (ABO blood group) genotyping (ABO), gene analysis, next-generation sequencing, ABO (ABO, alpha 1-3-N-acetylgalactosaminyltransferase	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0222T	Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0222U	Red cell antigen (RH blood group) genotyping (RHD and RHCE), gene analysis, next-generation sequencing, RH proximal promoter, exons 1-10, portions of	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0223U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0225U	Infectious disease (bacterial or viral respiratory tract infection) pathogen specific DNA and RNA,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0227U	Drug assay, presumptive, 30 or more drugs or metabolites, urine, liquid chromatography with tandem	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0228U	Oncology (prostate), multianalyte molecular profile by photometric detection of macromolecules	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services and PG0367	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0229U	BCAT1 (Branched chain amino acid transaminase 1) or IKZF1 (IKAROS family zinc finger 1) (eg,	PRIOR AUTHORIZATION REQUIRED - INTERQUA	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0230U	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation), full sequence analysis, including small sequence	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0231U	CACNA1A (calcium voltage-gated channel subunit alpha 1A) (eg, spinocerebellar ataxia), full gene analysis, including small sequence changes in exonic and intronic	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0232T	Injection(s), platelet rich plasma, any site, including image guidance, harvesting and	NON-COVERED	NON-COVERED	PG0293 Platelet Rich Plasma	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0232U	CSTB (cystatin B) (eg, progressive myoclonic epilepsy type 1A, Unverricht-Lundborg disease), full gene analysis, including small sequence changes in exonic and	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0467 Genetic Testing for Epilepsy, PG0041 Genetic Testing and Genetic Counseling	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0233U	FXN (frataxin) (eg, Friedreich ataxia), gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0533 Genetic Testing for Neurodegenerative Disorders	New Medical Policy, PG0533 genetic Testing for Neurodegenerative Disorders, procedure codes went from noncovered to covered effective 04/01/2024
0233U	FXN (frataxin)(eg, Friedreich ataxia), gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0533 Genetic Testing for Neurodegenerative Disorders	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0234T	Transluminal peripheral atherectomy, open or percutaneous, including	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0234U	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0235T	Transluminal peripheral atherectomy, open or percutaneous, including	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0235U	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome), full gene analysis, including small sequence changes	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0236T	Transluminal peripheral atherectomy, open or percutaneous, including	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0236U	SMN1 (survival of motor neuron 1, telomeric) and SMN2 (survival of motor neuron 2, centromeric) (eg, spinal muscular atrophy) full gene analysis, including small sequence	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0237T	Transluminal peripheral atherectomy, open or percutaneous, including	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0237U	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia), genomic	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0238T	Transluminal peripheral atherectomy, open or percutaneous, including	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0238U	Oncology (Lynch syndrome), genomic DNA sequence analysis of MLH1, MSH2, MSH6, PMS2, and EPCAM, including small sequence changes in exonic and	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0239U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free DNA, analysis of 311 or more genes, interrogation for sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0500 Liquid Biopsy	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0242U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 55-74 genes, interrogation for sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0500 Liquid Biopsy	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0239U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free DNA, analysis of 311 or more genes, interrogation for sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0242U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 55-74 genes, interrogation for sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0243U	Obstetrics (preeclampsia), biochemical assay of placental-growth factor, time-resolved	NON-COVERED	NON-COVERED	PG0048 Tests for the Evaluation of Preterm Labor and Premature	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0244U	Oncology (solid organ), DNA, comprehensive genomic profiling, 257 genes, interrogation for single-nucleotide variants, insertions/deletions, copy number	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0438 Molecular Profiling (Somatic Testing) Panels for Solid Cancer Tumors and Hematologic	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0245U	Oncology (thyroid), mutation analysis of 10 genes and 37 RNA fusions and expression of 4 Mrna markers using next-generation sequencing, fine needle aspirate,	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0246U	Red blood cell antigen typing, DNA, genotyping of at least 16 blood groups with phenotype prediction of at least 51 red blood cell antigens	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0500 Liquid Biopsy	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0247U	Obstetrics (preterm birth), insulin-like growth factor-binding protein 4 (IBP4), sex hormone-binding	NON-COVERED	NON-COVERED	PG0048 Tests for the Evaluation of Preterm Labor and Premature	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0248U	Oncology (brain), spheroid cell culture in a 3D microenvironment, 12 drug panel, tumor-response	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0249U	Oncology (breast), semiquantitative analysis of 32 phosphoproteins and protein	NON-COVERED	NON-COVERED	PG0301 Genetic Expression Assays for Breast Cancer Prognosis	
0250U	Oncology (solid organ neoplasm), targeted genomic sequence DNA analysis of 505 genes, interrogation for somatic alterations (SNVs [single	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0043 Experimental Investigational Procedures Services	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0251U	Hepcidin-25, enzyme-linked immunosorbent assay (ELISA), serum or plasma	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0252U	Fetal aneuploidy short (tandem–repeat comparative analysis, fetal DNA from products	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and PG0043 Experimental Investigational Procedures	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0253T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal	NON-COVERED	NON-COVERED	PG0327 Glaucoma Treatment with Aqueous Drainage Device	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0253U	Reproductive medicine (endometrial receptivity analysis), RNA gene expression profile, 238	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and PG0043 Experimental Investigational Procedures	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0254U	Reproductive medicine (preimplantation genetic assessment), analysis of 24	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and PG0043 Experimental Investigational Procedures	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0255U	Andrology (infertility), sperm-capacitation assessment of ganglioside GM1 distribution	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0256U	Trimethylamine/trimethylamine N-oxide (TMA/TMAO) profile, tandem mass spectrometry	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0257U	Very long chain acyl- coenzyme A (CoA) dehydrogenase (VLCAD), leukocyte enzyme activity, whole	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0258U	Autoimmune (psoriasis), Mrna, next-generation sequencing, gene expression profiling of 50-100 genes, skin- surface collection using adhesive patch, algorithm	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0043 Experimental Investigational Procedures Services	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0259U	Nephrology (chronic kidney disease), nuclear magnetic resonance spectroscopy	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0260U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations, and other structural	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0261U	Oncology (colorectal cancer), image analysis with artificial intelligence assessment of 4	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0262U	Oncology (solid tumor), gene expression profiling by real-time RT-PCR of 7 gene pathways (ER,	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and PG0043 Experimental Investigational Procedures	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0263T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells,	NON-COVERED	NON-COVERED	PG0400 Stem Cell Therapy for Orthopedic Applications	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0263U	Neurology (autism spectrum disorder [ASD]), quantitative measurements of 16 central	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0264T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells,	NON-COVERED	NON-COVERED	PG0400 Stem Cell Therapy for Orthopedic Applications	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0264U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations, and other structural	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0265T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells,	NON-COVERED	NON-COVERED	PG0400 Stem Cell Therapy for Orthopedic Applications	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0265U	Rare constitutional and other heritable disorders, whole genome and mitochondrial DNA sequence analysis, blood, frozen and formalin-fixed paraffin embedded	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0266T	Implantation or replacement of carotid sinus baroreflex activation device; total system (includes	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0266U	Unexplained constitutional or other heritable disorders or syndromes, tissue specific gene expression by whole transcriptome and next-generation sequencing, blood	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0267T	Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0267U	Rare constitutional and other heritable disorders, identification of copy number variations, inversions, insertions, translocations, and other structural	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0268U	Hematology (atypical hemolytic uremic syndrome [aHUS]), genomic sequence analysis of 15 genes, blood, buccal swab, or amniotic fluid	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0269T	Revision or removal of carotid sinus baroreflex activation device; total system (includes generator	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0269U	Hematology (autosomal dominant congenital thrombocytopenia), genomic sequence analysis of 14 genes, blood, buccal swab, or amniotic fluid	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0270T	Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0270U	Hematology (congenital coagulation disorders), genomic sequence analysis of 20 genes, blood, buccal swab, or amniotic fluid	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0271T	Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0271U	Hematology (congenital neutropenia), genomic sequence analysis of 23 genes, blood, buccal swab, or amniotic fluid	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0272T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0272U	Hematology (genetic bleeding disorders), genomic sequence analysis of 51 genes, blood, buccal swab, or amniotic fluid, comprehensive	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0273T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0273U	Hematology (genetic hyperfibrinolysis, delayed bleeding), genomic sequence analysis of 8 genes (F13A1, F13B, FGA, FGB, FGG, SERPINA1	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0274T	Percutaneous laminotomy/laminectomy (intralaminar approach) for	NON-COVERED	NON-COVERED	PG0026 Discogenic Pain Treatment; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0274U	Hematology (genetic platelet disorders), genomic sequence analysis of 43 genes, blood, buccal swab, or amniotic fluid	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for	NON-COVERED	NON-COVERED	PG0026 Discogenic Pain Treatment; PG0043 Experimental	Medicare Advantage Plans - 0275T is covered when part of a clinical trial, no prior authorization required
0276U	Hematology (inherited thrombocytopenia), genomic sequence analysis of 23 genes, blood, buccal swab, or amniotic fluid	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0277U	Hematology (genetic platelet function disorder), genomic sequence analysis of 31 genes, blood, buccal swab, or amniotic fluid	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0278T	Transcutaneous electrical modulation pain reprocessing (e.g., scrambler therapy), each	NON-COVERED	NON-COVERED	PG0244 Electrical Nerve Stimulators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0278U	Hematology (genetic thrombosis), genomic sequence analysis of 12 genes, blood, buccal swab, or amniotic fluid	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0282U	Red blood cell antigen typing, DNA, genotyping of 12 blood group system genes to predict 44 red blood cell antigen phenotypes	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0285U	Oncology, response to radiation, cell-free DNA, quantitative branched chain DNA amplification,	Non-Covered	Non-Covered	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0286U	CEP72 (centrosomal protein, 72-Kda), NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (eg, drug metabolism) gene analysis		PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0287U	Oncology (thyroid), DNA and mRNA, nextgeneration sequencing analysis of 112 genes, fine needle aspirate or formalin fixed paraffin-embedded (FFPE) tissue	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0287U	Oncology (thyroid), DNA and mRNA, next-generation sequencing analysis of 112 genes, fine needle aspirate or formalin-fixed paraffin-embedded (FFPE)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0288U	Oncology (lung), mRNA, quantitative PCR analysis of 11 genes (BAG1, BRCA1, CDC6, CDK2AP1, ERBB3, FUT3, IL11, LCK, RND3, SH3BGR, WNT3A)	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0289U	Neurology (Alzheimer disease), mRNA, gene expression profiling by RNA sequencing of 24 genes, whole blood, algorithm reported as predictive risk score	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0290U	Pain management, mRNA, gene expression profiling by RNA sequencing of 36 genes, whole blood, algorithm reported as predictive risk score	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0291U	Psychiatry (mood disorders), mRNA, gene expression profiling by RNA sequencing of 144 genes, whole blood, algorithm reported as predictive risk score	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0292U	Psychiatry (stress disorders), mRNA, gene expression profiling by RNA sequencing of 72 genes, whole blood, algorithm reported as predictive risk score	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0293U	Psychiatry (suicidal ideation), mRNA, gene expression profiling by RNA sequencing of 54 genes, whole blood, algorithm reported as predictive risk score	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0294U	Longevity and mortality risk, mRNA, gene expression profiling by RNA sequencing of 18 genes,	Non-Covered	Non-Covered	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0295U	Oncology (breast ductal carcinoma in situ), protein expression profiling by immunohistochemistry of 7	NON-COVERED	NON-COVERED	PG0301 Genetic Expression Assays for Breast Cancer Prognosis	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0296U	Oncology (oral and/or oropharyngeal cancer), gene expression profiling by RNA	Non-Covered	Non-Covered	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0297U	Oncology (pan tumor), whole genome sequencing of paired malignant and normal DNA specimens, fresh or formalin fixed paraffin embedded (FFPE) tissue	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0298U	Oncology (pan tumor), whole transcriptome sequencing of paired malignant and normal	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0468 Whole Exome Sequencing (WES) and Whole Genome	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0299U	Oncology (pan tumor), whole genome optical genome mapping of paired malignant and normal DNA specimens, fresh frozen tissue, blood, or bone	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0300U	Oncology (pan tumor), whole genome sequencing and optical genome mapping of paired malignant and normal DNA specimens, fresh tissue, blood, or	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0297U	oncology (pan tumor), whole genome sequencing of paired malignant and nomal DNA specimens, fresh or formalin-fixed paraffin-embedded (FFPE) tissue	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0298U	Oncology (pan tumor), whole transcriptome sequencing of paired malignant and normal RNA specimens, fresh or formalin-fixed paraffin-embedded (FFPE) tissue	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0299U	Oncology (pan tumor), whole genome optical genome mapping of paired malignant and normal DNA specimens, fresh frozen tissue, blood, or bone marrow	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0300U	Oncology (pan tumor), whole genome sequencing and optical genome mapping of paired malignant and normal DNA specimens, fresh tissue, blood, or	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0301U	Infectious agent detection by nucleic acid (DNA or RNA), Bartonella henselae and Bartonella	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0302U	Infectious agent detection by nucleic acid (DNA or RNA), Bartonella henselae and Bartonella	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0303U	Hematology, red blood cell (RBC) adhesion to endothelial/subendothelial	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0304U	Hematology, red blood cell (RBC) adhesion to endothelial/subendothelial	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0305U	Hematology, red blood cell (RBC) functionality and deformity as a function of shear stress, whole	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0306U	Oncology (minimal residual disease [MRD]), next-generation targeted sequencing analysis, cell-	Non-Covered	Non-Covered	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0307U	Oncology (minimal residual disease [MRD]), next-generation targeted sequencing analysis of a	Non-Covered	Non-Covered	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0308T	Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0351 The Implantable Miniature Telescope (IMT)	
0308U	Cardiology (coronary artery disease [CAD]), analysis of 3 proteins (high sensitivity [hs]	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0309U	Cardiology (cardiovascular disease), analysis of 4 proteins (NT-proBNP, osteopontin, tissue	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0310U	Pediatrics (vasculitis, Kawasaki disease [KD]), analysis of 3 biomarkers (NTproBNP, C-	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0311U	Infectious disease (bacterial), quantitative antimicrobial susceptibility reported as	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0312U	Autoimmune diseases (e.g., systemic lupus erythematosus [SLE]), analysis of 8 IgG	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0313U	Oncology (pancreas), DNA and mRNA next-generation sequencing analysis of 74 genes	Non-Covered	Non-Covered	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0314U	Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 35 genes (32 content and 3 housekeeping), utilizing formalin-fixed paraffin-	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0315U	Oncology (cutaneous squamous cell carcinoma), mRNA gene expression profiling by RT-PCR of	Non-Covered	Non-Covered	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0316U	Borrelia burgdorferi (Lyme disease), OspA protein evaluation, urine	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0317U	Oncology (lung cancer), four-probe FISH (3q29, 3p22.1, 10q22.3, 10cen) assay, whole blood,	Non-Covered	Non-Covered	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0318U	Pediatrics (congenital epigenetic disorders), whole genome methylation analysis by microarray for 50 or more genes, blood	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0319U	Nephrology (renal transplant), RNA expression by select transcriptome sequencing, using pretransplant	Non-Covered	Non-Covered	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0320U	Nephrology (renal transplant), RNA expression by select transcriptome sequencing, using post transplant	Non-Covered	Non-Covered	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0321U	Infectious agent detection by nucleic acid (DNA or RNA), genitourinary pathogens,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0322U	Neurology (autism spectrum disorder [ASD]), quantitative measurements of 14 acyl	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0324U	Oncology (ovarian), spheroid cell culture, 4-drug panel (carboplatin, doxorubicin, gemcitabine,	NON-COVERED	NON-COVERED	PG0122 In Vitro Chemoresistance & Chemosensitivity Assays;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0325U	Oncology (ovarian), spheroid cell culture, poly (ADP-ribose) polymerase (PARP) inhibitors	NON-COVERED	NON-COVERED	PG0122 In Vitro Chemoresistance & Chemosensitivity Assays;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0326U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 83 or more genes, interrogation for sequence	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0327U	Fetal aneuploidy (trisomy 13, 18, and 21), DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0236U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 83 or more genes, interrogation for sequence	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0327U	Fetal aneuploidy (trisome 13, 18, and 21), DNA sequence analysis of selected regions using maternal	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0329U	Oncology (neoplasia), exome and transcriptome sequence analysis for sequence variants, gene copy number amplifications and deletions, gene rearrangements	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0438 Molecular Profiling (Somatic Testing) Panels for Solid Cancer Tumors and Hematologic Malignancies Archived	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0329T	Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0330T	Tear film imaging, unilateral or bilateral, with interpretation and report	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0331U	Oncology (hematolymphoid neoplasia), optical genome mapping for copy number	NON-COVERED	NON-COVERED	PG0468 Whole Exome Sequencing (WES) and Whole Genome	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0332U	Oncology (pan-tumor), genetic profiling of 8 DNA-regulatory (epigenetic) markers by	Non-Covered	Non-Covered	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0333T	Visual evoked potential, screening of visual acuity, automated, with report	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0333U	Oncology (liver), surveillance for hepatocellular carcinoma (HCC) in high-risk patients, analysis of	Non-Covered	Non-Covered	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0334U	Oncology (solid organ), targeted genomic sequence analysis, formalin-fixed paraffinembedded (FFPE) tumor tissue, DNA analysis, 84 or more genes	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0438 Molecular Profiling (Somatic Testing) Panels for Solid Cancer Tumors and Hematologic	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0335T	Insertion of sinus tarsi implant	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0321 Subtalar Arthroeresis; PG0043 Experimental	NON-COVERED in Adults age ≥ 19 years of age. Prior Authorization required for ages 0-18.
0334U	Oncology (solid organ), targeted genomic sequence analysis, formalin-fixed paraffinembedded (FFPE) tumor tissue, DNA analysis, 84 or more genes	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0335U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis,	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and PG0468 Whole Exome Sequencing (WES) and	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0336U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis,	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and PG0468 Whole Exome Sequencing (WES) and	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0337U	Oncology (plasma cell disorders and myeloma), circulating plasma cell immunologic selection,	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0338T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0338U	Oncology (solid tumor), circulating tumor cell selection, identification, morphological characterization,	Non-Covered	Non-Covered	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0339T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0339U	Oncology (prostate), mRNA expression profiling of HOXC6 and DLX1, reverse transcription polymerase chain reaction (RT-PCR), first-void urine following	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0367 Genetic and Protein Biomarkers for Diagnosis	02/01/2024 ADDED Medicare and Commercial coverage with a PA-PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate Cancer
0340U	Oncology (pan-cancer), analysis of minimal residual disease (MRD) from plasma, with assays personalized to each patient based on prior next-generation	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0339U	Oncology (prostate), mRNA expression profiling of HOXC6 and DLX1, reverse transcription polymerase chain reaction (RT-PCR), first-void urine following	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0340U	Oncology (pan-cancer), analysis of minimal resifual disease (MRD) from plasma, with assays personalized to each patient bades on prior next-generation	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0341U	Fetal aneuploidy DNA sequencing comparative analysis, fetal DNA from products of conception,	Non-Covered	Non-Covered	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0342T	Therapeutic apheresis with selective HDL delipidation and plasma reinfusion	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0342U	Oncology (pancreatic cancer), multiplex immunoassay of C5, C4, cystatin C, factor B,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0343U	Oncology (prostate), exosome-based analysis of 442 small noncoding RNAs (sncRNAs) by	Non-Covered	Non-Covered	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0344U	Hepatology (nonalcoholic fatty liver disease [NAFLD]), semiquantitative evaluation of 28	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0345T	Transcatheter mitral valve repair percutaneous approach via the coronary sinus	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0345U	Psychiatry (eg, depression, anxiety, attention deficit hyperactivity disorder [ADHD]), genomic analysis panel, variant analysis of 15 genes, including	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies. Changed 0345U from noncovered to covered with a prior authorization, InterQual, for Commercial, effective 11/01/2024.
0346U	Beta amyloid, Aβ40 and Aβ42 by liquid chromatography with tandem mass spectrometry (LC-MS/MS),	NON-COVERED	NON-COVERED	PG0441 Genetic and Biomarker Testing for Alzheimer Disease;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0347T	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0347U	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 16 gene report, with variant analysis and reported phenotypes	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies. Changed 0347U from noncovered to covered with a prior authorization, InterQual, for Commercial, effective 11/01/2024
0348T	Radiologic examination, radiostereometric analysis (RSA); spine, (includes, cervical, thoracic	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0348U	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 25 gene report, with variant analysis and reported phenotypes	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 27 gene report, with variant analysis, including reported phenotypes and impacted gene-drug interactions
0349T	Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0349U	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 27 gene report, with variant analysis, including reported	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 27 gene report, with variant analysis, including reported phenotypes and impacted gene-drug interactions. Changed 0349U from noncovered to covered with a prior authorization, InterQual, for Commercial, effective 11/01/2024.
0350T	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0350U	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 27 gene report, with variant analysis and reported phenotypes	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies. Changed 0350U from noncovered to covered with a prior authorization, InterQual, for Commercial, effective 11/01/2024.
0351T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen;	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen;	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0353T	Optical coherence tomography of breast, surgical cavity; real time intraoperative	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0354T	Optical coherence tomography of breast, surgical cavity; interpretation and report, real time	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0355U	APOL1 (apolipoprotein L1) (eg, chronic kidney disease), risk variants (G1, G2)	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0356U	Oncology (oropharyngeal), evaluation of 17 DNA biomarkers using droplet digital PCR (ddPCR), cell-free DNA, algorithm reported as a prognostic risk score for	Non-Covered	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0358T	Bioelectrical impedance analysis whole body composition assessment, supine position, with	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0358U	Neurology (mild cognitive impairment), analysis of β-amyloid 1- 42 and 1-40,	NON-COVERED	NON-COVERED	PG0441 Genetic and Biomarker Testing for Alzheimer Disease;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0359U	Oncology (prostate cancer), analysis of all prostate-specific antigen (PSA) structural isoforms by phase separation and immunoassay, plasma, algorithm	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0367 Genetic and Protein Biomarkers for Diagnosis	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0360U	Oncology (lung), enzyme-linked immunosorbent assay (ELISA) of 7 autoantibodies (p53, NY-ESO-1,	NON-COVERED	NON-COVERED		NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0361U	Neurofilament light chain, digital immunoassay, plasma, quantitative (Effective 1/1/2023)	NON-COVERED	NON-COVERED	PG0441 Genetic and Biomarker Testing for Alzheimer Disease;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0362T	Exposure behavioral follow-up assessment, includes physician or other qualified health care	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0362U	Oncology (papillary thyroid cancer), gene-expression profiling via targeted hybrid	NON-COVERED	NON-COVERED	PG0041 Genetic Testing, PG0298 Molecular Markers in Fine Needle Aspirates of	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0363U	Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of 5 genes	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0364U	Oncology (hematolymphoid neoplasm), genomic sequence analysis using multiplex (PCR) and	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0368U	Oncology (colorectal cancer), evaluation for mutations of APC, BRAF,	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0373T	Exposure adaptive behavior treatment with protocol modification requiring two or more	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0335 Children's Adaptive Behavior Services- Arcived 07/01/2024;	
0376U	Oncology (prostate cancer), image analysis of at least 128 histologic features and clinical factors,	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and PG0367 Genetic and Protein Biomarkers for	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0377U	Cardiovascular disease, quantification of advanced serum or plasma lipoprotein profile, by	NON-COVERED	NON-COVERED	PG0392 Cardiovascular Disease (CVD) Risk Testing	
0378T	Visual field assessment, with concurrent real time data analysis and accessible data storage with	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0378U	RFC1 (replication factor C subunit 1), repeat expansion variant analysis by traditional and repeat-	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0379T	Visual field assessment, with concurrent real time data analysis and accessible data storage with	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0379U	Targeted genomic sequence analysis panel, solid organ neoplasm, DNA (523 genes) and RNA (55 genes) by next generation sequencing,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0438 Molecular Profiling (Somatic Testing) Panels for Solid Cancer Tumors and Hematologic	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0380U	Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis, 20 gene variants and CYP2D6 deletion or duplication analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0500 Liquid Biopsy	Prior authorization is required for genetic testing unless otherwise noted in one of our policies. Changed coverage from noncovered to covered with a PA for Commercial, effective 11/01/2024
0386U	Gastroenterology (Barrett's esophagus), P16, RUNX3, HPP1, and FBN1 methylation analysis,	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and PG0500 Liquid Biopsy	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0388U	Oncology (non-small cell lung cancer), next-generation sequencing with identification of single nucleotide variants, copy number variants, insertions and	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0500 Liquid Biopsy	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0388U	Oncology (non-small cell lung cancer), next-generation sequencing with identification of single nucleotide variants, copy number variants, insertions and	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0389U	Pediatric febrile illness (Kawasaki disease [KD]), interferon alphainducible protein 27 (IFI27) and mast cell-expressed membrane protein 1 (MCEMP1),	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0391U	Oncology (solid tumor), DNA and RNA by next-generation sequencing, utilizing formalin-fixed paraffin-embedded (FFPE) tissue, 437 genes, interpretive report for	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0438 Molecular Profiling (Somatic Testing) Panels for Solid Cancer Tumors and Hematologic	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0392U	Drug metabolism (depression, anxiety, attention deficit hyperactivity disorder [ADHD]), gene-drug interactions, variant analysis of 16 genes, including	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies. Changed 0392U from nonccovered to coveed with a prior authorization, InterQual, for Commercial, effective 11/01/2024.
0393U	Neurology (eg, Parkinson disease, dementia with Lewy bodies), cerebrospinal fluid (CSF),	NON-COVERED	NON-COVERED		

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0394T	High dose rate electronic brachytherapy, skin surface application, per fraction, includes	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0315 Electronic Brachytherapy; PG0043 Experimental	
0395T	High dose rate electronic brachytherapy, interstitial or intracavitary treatment, per	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0315 Electronic Brachytherapy; PG0043 Experimental	
0396U	Obstetrics (pre-implantation genetic testing), evaluation of 300000 DNA single-nucleotide	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0397T	Endoscopic retrograde cholangiopancreatography (ERCP), with optical	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0397U	Oncology (non-small cell lung cancer), cell-free DNA from plasma, targeted sequence	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0398U	Gastroenterology (Barrett esophagus), P16, RUNX3, HPP1, and FBN1 DNA methylation	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0400U	Obstetrics (expanded carrier screening), 145 genes by nextgeneration sequencing, fragment analysis and multiplex ligation dependent probe	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0401U	Cardiology (coronary heart disease [CAD]), 9 genes (12 variants), targeted variant genotyping, blood, saliva, or buccal swab, algorithm reported as a genetic risk score for	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0403T	Preventive behavior change, intensive program of prevention of diabetes using a standardized	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0403U	Oncology (prostate), mRNA, gene expression profiling of 18 genes, first-catch postdigital rectal	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and PG0367 Genetic and Protein Biomarkers for	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0406U	Oncology (lung), flow cytometry, sputum, 5 markers (meso-tetra [4-carboxyphenyl] porphyrin [TCPP],	NON-COVERED	NON-COVERED	PG0476 Proteomic Testing in the Management of Pulmonary Nodules;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0408T	Insertion or replacement of permanent cardiac contractility modulation system, including	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0409T	Insertion or replacement of permanent cardiac contractility modulation system, including	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0410T	Insertion or replacement of permanent cardiac contractility modulation system, including	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0410U	Oncology (pancreatic), DNA, whole genome sequencing with 5-hydroxymethylcytosine	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0468 Whole Exome Sequencing (WES) and Whole Genome	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0410U	Oncology (pancreatic), DNA, whole genome sequencing with 5-hydroxymethylcytosine enrichment, whole blood or plasma, algorithm reported as	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0411T	Insertion or replacement of permanent cardiac contractility modulation system, including	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0411U	Psychiatry (eg, depression, anxiety, attention deficit hyperactivity disorder [ADHD]), genomic analysis panel, variant analysis of 15 genes, including	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		Added, effective 11/01/2024
0412T	Removal of permanent cardiac contractility modulation system; pulse generator only	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0412U	Beta amyloid, AB42/40 ratio, immunoprecipitation with quantitation by liquid	NON-COVERED	NON-COVERED		
0413T	Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization	NON-COVERED - EXPERIMENTNAL, INVESTIGATIONAL
0413U	Oncology (hematolymphoid neoplasm), optical genome mapping for copy number	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0468 Whole Exome Sequencing (WES) and Whole Genome	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0413U	Oncology (hematolymphoid neoplasm), optical genome mapping for copy number alterations, aneuploidy, and balanced/complex structural	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0414T	Removal and replacement of permanent cardiac contractility modulation system pulse generator	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0415T	Repositioning of previously implanted cardiac contractility modulation transvenous electrode,	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0415U	Cardiovascular disease (acute coronary syndrome [ACS]), IL-16, FAS, FASLigand, HGF, CTACK,	NON-COVERED	NON-COVERED	PG0392 Cardiovascular Disease (CVD) Risk Testing	
0416T	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0417T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0417U	Rare diseases (constitutional/heritable disorders), whole mitochondrial genome sequence with heteroplasmy detection and deletion analysis	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0417U	Rare diseases (constitutional/heriable disorders), whole mitochondrial genome sequence with heteroplasmy detection and deletion analysis	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0418T	Interrogation device evaluation (in person) with analysis, review and report, includes connection,	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0419T	Destruction neurofibromata, extensive, (cutaneous, dermal extending into subcutaneous);	NON-COVERED	NON-COVERED	PG0104 Cosmetic&Reconstructive Surgery; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0419U	Neuropsychiatry (eg, depression, anxiety), genomic sequence analysis panel, variant analysis of 13 genes, saliva or buccal swab, report of each gene phenotype	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0420T	Destruction neurofibromata, extensive, (cutaneous, dermal extending into subcutaneous);	NON-COVERED	NON-COVERED	PG0104 Cosmetic&Reconstructive Surgery; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0421T	Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0534 Fluid Jet System in the Treatment of Benign Prostatic Hyperplasia (BPH)	Effective 04/01/2024: Fluid jet system treatment of lower urinary tract symptoms attributable to benign prostatic hyperplasia (LUTS/BPH) is covered, with a prior authorization, when the coverage criteria indicated
0421U	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 8 RNA	NON-COVERED	NON-COVERED	PG0065 Colorectal Cancer Screening; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0422T	Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0423U	Psychiatry (eg, depression, anxiety), genomic analysis panel, including variant analysis of 26 genes, buccal swab, report including metabolizer status and	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		Added, effective 11/01/2024
0424T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea;	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0508 Phrenic Nerve Stimulation for Central Sleep Apnea (eg, remede	Prior authorization required effective August 1, 2022.
0424U	Oncology (prostate), exosome-based analysis of 53 small noncoding RNAs (sncRNAs) by	NON-COVERED	NON-COVERED	PG0468 Whole Exome Sequencing (WES) and Whole Genome	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0425T	Insertion or replacement of sensing lead only for treatment of central sleep apnea	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0508 Phrenic Nerve Stimulation for Central Sleep Apnea (eg, remede	Prior authorization required effective August 1, 2022.
0425U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis, each comparator genome (eg, parents, siblings)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0426T	Insertion or replacement of stimulation lead only for treatment of central sleep apnea	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0508 Phrenic Nerve Stimulation for Central Sleep Apnea (eg, remede	Prior authorization required effective August 1, 2022.
0426U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), ultra rapid sequence analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0427T	Insertion or replacement of pulse generator only for treatment of central sleep apnea	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0508 Phrenic Nerve Stimulation for Central Sleep Apnea (eg, remede	Prior authorization required effective August 1, 2022.
0431T	Removal and replacement of neurostimulator system for treatment of central sleep apnea,	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0508 Phrenic Nerve Stimulation for Central Sleep Apnea (eg, remede	Prior authorization required effective August 1, 2022.
0425U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis, each comparator genome (eg, parents, siblings)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0426U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), ultra-rapid	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0433U	Oncology (prostate), 5 DNA regulatory markers by quantitative PCR, whole blood, algorithm,	NON-COVERED	NON-COVERED	PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0434U	Drug metabolism (adverse drug reactions and drug response), genomic analysis panel, variant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED		Added, effective 11/01/2024
0437T	Implantation of non-biologic or synthetic implant (e.g., polypropylene) for fascial	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery; PG0043 Experimental	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0438U	Drug metabolism (adverse drug reactions and drug response), buccal specimen, gene-drug	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED		Added, effective 11/01/2024
0439T	Myocardial contrast perfusion echocardiography; at rest or with stress, for assessment of	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0443T	Real time spectral analysis of prostate tissue by fluorescence spectroscopy	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0444T	Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training,	NON-COVERED	NON-COVERED	PG0327 Glaucoma Treatment with Aqueous Drainage Device; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0445T	Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training,	NON-COVERED	NON-COVERED	PG0327 Glaucoma Treatment with Aqueous Drainage Device; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0446T	Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training	NON-COVERED	COVERED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0177 Continuous Blood Glucose Monitoring Services	
0447T	Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision	NON-COVERED	COVERED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0177 Continuous Blood Glucose Monitoring Services	
0448T	Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including	NON-COVERED	COVERED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0177 Continuous Blood Glucose Monitoring Services	
0456U	Autoimmune (rheumatoid arthritis), next-generation sequencing (NGS), gene expression testing of 19 genes, whole blood, with analysis of anti-cyclic citrullinated	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		Added, effective 11/01/2024
0459U	B-amyloid (Abeta42) and total tau (tTau), electrochemiluminescent immunoassay (ECLIA), cerebral	NON-COVERED	NON-COVERED		
0460U	Oncology, whole blood or buccal, DNA single-nucleotide polymorphism (SNP) genotyping by real-time PCR of 24 genes, with variant analysis and reported	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		Added, effective 11/01/2024
0461U	Oncology, pharmacogenomic analysis of single-nucleotide polymorphism (SNP) genotyping by real-time PCR of 24 genes, whole blood or buccal swab, with	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		Added, effective 11/01/2025
0464T	Visual evoked potential, testing for glaucoma, with interpretation and report	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0469T	Retinal polarization scan, ocular screening with on-site automated results, bilateral	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0470T	Optical coherence tomography (OCT) for microstructural and morphological imaging of skin,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0471T	Optical coherence tomography (OCT) for microstructural and morphological imaging of skin,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0472T	Device evaluation, interrogation, and initial programming of intra-ocular retinal electrode array (e.g.,	NON-COVERED	COVERED	PG0418 Retinal Prosthesis; PG0043 Experimental Investigational Procedures	
0473T	Device evaluation and interrogation of intra-ocular retinal electrode array (e.g., retinal	NON-COVERED	COVERED	PG0418 Retinal Prosthesis; PG0043 Experimental Investigational Procedures	
0474T	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space	NON-COVERED	COVERED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0327 Glaucoma Treatment with Aqueous Drainage Device; PG0043 Experimental Investigational Procedures	
0475T	Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0476T	Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording, data	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0477T	Recording of fetal magnetic cardiac signal using at least 3 channels; signal extraction,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0478T	Recording of fetal magnetic cardiac signal using at least 3 channels; review, interpretation,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0479T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement;	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0480T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement;	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0481T	Injection(s), autologous white blood cell concentrate (autologous protein solution), any site,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0483T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve;	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0484T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0485T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0486T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; bilateral	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0487T	Biomechanical mapping, transvaginal, with report	NON-COVERED	NON-COVERED	PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0488T	Preventive behavior change, online/electronic structured intensive program for prevention	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0489T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; adipose	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0490T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; multiple	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0491T	Ablative laser treatment, non-contact, full field and fractional ablation, open wound, per day,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0492T	Ablative laser treatment, non-contact, full field and fractional ablation, open wound, per day,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0493T	Near-infrared spectroscopy studies of lower extremity wounds (e.g., for oxyhemoglobin measurement)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0494T	Surgical preparation and cannulation of marginal (extended) cadaver donor lung(s) to ex vivo	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0495T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0496T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0497T	External patient-activated, physician- or other qualified health care professional-prescribed,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0498T	External patient-activated, physician- or other qualified health care professional-prescribed,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0499T	Cystourethroscopy, with mechanical dilation and urethral therapeutic drug delivery for	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0500T	Infectious agent detection by nucleic acid (DNA or RNA), human papillomavirus (HPV) for five or	NON-COVERED	NON-COVERED	PG0369 Human Papillomavirus (HPV) Screening; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0505T	Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0506T	Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0507T	Near-infrared dual imaging (i.e., simultaneous reflective and trans-illuminated light) of meibomian	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0508T	Pulse-echo ultrasound bone density measurement resulting in indicator of axial bone mineral	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0509T	Electroretinography (ERG) with interpretation and report, pattern (PERG)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0511T	Removal and reinsertion of sinus tarsi implant	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0321 Subtalar Arthroeresis; PG0043 Experimental	NON-COVERED in Adults age ≥ 19 years of age. Prior Authorization required for ages 0-18.
0512T	Extracorporeal shock wave for integumentary wound healing, including topical application and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0513T	Extracorporeal shock wave for integumentary wound healing, including topical application and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0514T	Intraoperative visual axis identification using patient fixation (List separately in addition to code	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0515T	Insertion of wireless cardiac stimulator for left ventricular pacing,	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0516T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0517T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0518T	Removal of only pulse generator component(s) (battery and/or transmitter) of wireless cardiac	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0519T	Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0520T	Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0521T	Interrogation device evaluation (in person) with analysis, review and report, includes connection,	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0522T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0523T	Intraprocedural coronary fractional flow reserve (FFR) with 3D functional mapping of color-coded	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0525T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the	NON-COVERED	NON-COVERED	PG0039 Ambulatory External and Implantable Electrocardiographic	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0526T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the	NON-COVERED	NON-COVERED	PG0039 Ambulatory External and Implantable Electrocardiographic	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0527T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the	NON-COVERED	NON-COVERED	PG0039 Ambulatory External and Implantable Electrocardiographic	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0528T	Programming device evaluation (in person) of intracardiac ischemia monitoring system with iterative	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0529T	Interrogation device evaluation (in person) of intracardiac ischemia monitoring system with analysis,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0530T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0531T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0532T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0533T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0534T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

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0535T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0536T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0537T	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T lymphocytes for	NON-COVERED	NON-COVERED	PG0460 Chimeric Antigen Receptor (CAR)-T Cell Therapy; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0538T	Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for	NON-COVERED	NON-COVERED	PG0460 Chimeric Antigen Receptor (CAR)-T Cell Therapy; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0539T	Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for	NON-COVERED	NON-COVERED	PG0460 Chimeric Antigen Receptor (CAR)-T Cell Therapy; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0540T	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous	NON-COVERED	NON-COVERED	PG0460 Chimeric Antigen Receptor (CAR)-T Cell Therapy; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0541T	Myocardial imaging by magnetocardiography (MCG) for detection of cardiac ischemia, by	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0542T	Myocardial imaging by magnetocardiography (MCG) for detection of cardiac ischemia, by	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0543T	Transapical mitral valve repair, including transthoracic echocardiography, when	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0544T	Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0545T	Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0546T	Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0547T	Bone-material quality testing by microindentation(s) of the tibia(s), with results reported as a score	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0553T	Percutaneous transcatheter placement of iliac arteriovenous anastomosis implant, inclusive of	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0554T	Bone strength and fracture risk using finite element analysis of functional data, and bonemineral	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0555T	Bone strength and fracture risk using finite element analysis of functional data, and bonemineral	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0556T	Bone strength and fracture risk using finite element analysis of functional data, and bonemineral	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0557T	Bone strength and fracture risk using finite element analysis of functional data, and bonemineral	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0559T	Anatomic model 3D-printed from image data set(s); first individually prepared and processed	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

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0560T	Anatomic model 3D-printed from image data set(s); first individually prepared and processed	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0561T	Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0562T	Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide; each	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0563T	Evacuation of Meibomian glands, using heat delivered through wearable, open-eye eyelid	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0564T	Oncology, chemotherapeutic drug cytotoxicity assay of cancer stem cells (CSCs), from cultured CSCs	NON-COVERED	NON-COVERED	PG0122 In Vitro Chemoresistance & Chemosensitivity Assays;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0565T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the	NON-COVERED	NON-COVERED	PG0400 Stem Cell Therapy for Orthopedic Applications; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0566T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the	NON-COVERED	NON-COVERED	PG0400 Stem Cell Therapy for Orthopedic Applications; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0567T	Permanent fallopian tube occlusion with degradable biopolymer implant, transcervical approach,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0568T	Introduction of mixture of saline and air for sonosalpingography to confirm occlusion of fallopian	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0569T	Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0570T	Transcatheter tricuspid valve repair, percutaneous approach; each additional prosthesis during	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0571T	Insertion or replacement of implantable cardioverter-defibrillator system with substernal	NON-COVERED	NON-COVERED	PG0224 Cardioverter Defibrillators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0572T	Insertion of substernal implantable defibrillator electrode	NON-COVERED	NON-COVERED	PG0224 Cardioverter Defibrillators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0573T	Removal of substernal implantable defibrillator electrode	NON-COVERED	NON-COVERED	PG0224 Cardioverter Defibrillators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0574T	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode	NON-COVERED	NON-COVERED	PG0224 Cardioverter Defibrillators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0575T	Programming device evaluation (in person) of implantable cardioverter-defibrillator system with substernal	NON-COVERED	NON-COVERED	PG0224 Cardioverter Defibrillators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0576T	Interrogation device evaluation (in person) of implantable cardioverter-defibrillator system with substernal	NON-COVERED	NON-COVERED	PG0224 Cardioverter Defibrillators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0577T	Electrophysiological evaluation of implantable cardioverter defibrillator system with substernal	NON-COVERED	NON-COVERED	PG0224 Cardioverter Defibrillators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0578T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-	NON-COVERED	NON-COVERED	PG0224 Cardioverter Defibrillators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0579T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-	NON-COVERED	NON-COVERED	PG0224 Cardioverter Defibrillators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

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0580T	Removal of substernal implantable defibrillator pulse generator only	NON-COVERED	NON-COVERED	PG0224 Cardioverter Defibrillators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0581T	Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0582T	Transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy,	NON-COVERED	NON-COVERED	PG0534 Fluid Jet System in the Treatment of Benign Prostatic Hyperplasia	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0583T	Tympanostomy (requiring insertion of ventilating tube), using an automated tube delivery system,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0584T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including	NON-COVERED	NON-COVERED	PG0415 Pancreatic Islet Cell Transplantation; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0585T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including	NON-COVERED	NON-COVERED	PG0415 Pancreatic Islet Cell Transplantation; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0586T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including	NON-COVERED	NON-COVERED	PG0415 Pancreatic Islet Cell Transplantation; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0587T	Percutaneous implantation or replacement of integrated single device neurostimulation system	NON-COVERED	NON-COVERED	PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0588T	Revision or removal of integrated single device neurostimulation system including electrode array	NON-COVERED	NON-COVERED	PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0589T	Electronic analysis with simple programming of implanted integrated neurostimulation system	NON-COVERED	NON-COVERED	PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0590T	Electronic analysis with complex programming of implanted integrated neurostimulation system	NON-COVERED	NON-COVERED	PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0594T	Osteotomy, humerus, with insertion of an externally controlled intramedullary lengthening device,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0596T	Temporary female intraurethral valve-pump (i.e., voiding prosthesis); initial insertion,	NON-COVERED	NON-COVERED	PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0597T	Temporary female intraurethral valve-pump (i.e., voiding prosthesis); replacement	NON-COVERED	NON-COVERED	PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0598T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0599T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0600T	Ablation, irreversible electroporation; 1 or more tumors per organ, including imaging	NON-COVERED	NON-COVERED	PG0488 Irreversible Electroporation Ablation; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0601T	Ablation, irreversible electroporation; 1 or more tumors, including fluoroscopic and	NON-COVERED	NON-COVERED	PG0488 Irreversible Electroporation Ablation; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0602T	Glomerular filtration rate (GFR) measurement(s), transdermal, including sensor placement and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0603T	Glomerular filtration rate (GFR) monitoring, transdermal, including sensor placement and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

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0604T	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0605T	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0606T	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture, and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0607T	Remote monitoring of an external continuous pulmonary fluid monitoring system, including	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0608T	Remote monitoring of an external continuous pulmonary fluid monitoring system, including	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0609T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0610T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0611T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0612T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0613T	Percutaneous transcatheter implantation of interatrial septal shunt device, including right and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0614T	Removal and replacement of substernal implantable defibrillator pulse generator	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0615T	Eye-movement analysis without spatial calibration, with interpretation and report (i.e., the	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0616T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed;	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0617T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed;	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0618T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed;	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0619T	Cystourethroscopy with transurethral anterior prostate commissurotomy and drug	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0621T	Trabeculostomy ab interno by laser	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0623T	Automated quantification and characterization of coronary atherosclerotic plaque to assess	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0624T	Automated quantification and characterization of coronary atherosclerotic plaque to assess	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

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0625T	Automated quantification and characterization of coronary atherosclerotic plaque to assess	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0626T	Automated quantification and characterization of coronary atherosclerotic plaque to assess	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc,	NON-COVERED	NON-COVERED	PG0400 Stem Cell Therapy for Orthopedic Applications PG0026 Discogenic Pain	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc,	NON-COVERED	NON-COVERED	PG0400 Stem Cell Therapy for Orthopedic Applications PG0026 Discogenic Pain	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc,	NON-COVERED	NON-COVERED	PG0400 Stem Cell Therapy for Orthopedic Applications PG0026 Discogenic Pain	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0630T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc,	NON-COVERED	NON-COVERED	PG0400 Stem Cell Therapy for Orthopedic Applications PG0026 Discogenic Pain	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0631T	Transcutaneous visible light hyperspectral imaging measurement of oxyhemoglobin,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0632T	Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0633T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0634T	Computed tomography, breast, including 3D rendering, when performed, unilateral; with contrast	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0635T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0636T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0637T	Computed tomography, breast, including 3D rendering, when performed, bilateral; with contrast	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0638T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0639T	Wireless skin sensor thermal anisotropy measurement(s) and assessment of flow in	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0640T	Noncontact near-infrared spectroscopy studies of flap or wound (e.g., for measurement of	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0641T	Noncontact near-infrared spectroscopy studies of flap or wound (e.g., for measurement of	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0642T	Noncontact near-infrared spectroscopy studies of flap or wound (e.g., for measurement of	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0643T	Transcatheter left ventricular restoration device implantation including right and left heart	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0644T	Transcatheter removal or debulking of intracardiac mass (e.g., vegetations, thrombus) via	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

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0645T	Transcatheter implantation of coronary sinus reduction device including vascular access and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0646T	Transcatheter tricuspid valve implantation/replacement (TTVI) with prosthetic valve,	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0647T	Insertion of gastrostomy tube, percutaneous, with magnetic gastropexy, under ultrasound	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0648T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content),	NON-COVERED	NON-COVERED	PG0252 Noninvasive Tests for Hepatic Fibrosis; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0649T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content),	NON-COVERED	NON-COVERED	PG0252 Noninvasive Tests for Hepatic Fibrosis; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0651T	Magnetically controlled capsule endoscopy, esophagus through stomach, including intraprocedural	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0652T	Esophagogastroduodenoscopy, flexible, transnasal; diagnostic, including collection of specimen(s)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0653T	Esophagogastroduodenoscopy, flexible, transnasal; with biopsy, single or multiple	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0654T	Esophagogastroduodenoscopy, flexible, transnasal; with insertion of intraluminal tube or catheter	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0655T	Transperineal focal laser ablation of malignant prostate tissue, including transrectal imaging	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0656T	Vertebral body tethering, anterior; up to 7 vertebral segments	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0657T	Vertebral body tethering, anterior; 8 or more vertebral segments	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0658T	Electrical impedance spectroscopy of 1 or more skin lesions for automated melanoma risk score	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0659T	Transcatheter intracoronary infusion of supersaturated oxygen in conjunction with percutaneous	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0660T	Implantation of anterior segment intraocular nonbiodegradable drug-eluting system, internal approach	NON-COVERED	NON-COVERED	PG0327 Glaucoma Treatment with Aqueous Drainage Device; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0661T	Removal and reimplantation of anterior segment intraocular nonbiodegradable drug-eluting	NON-COVERED	NON-COVERED	PG0327 Glaucoma Treatment with Aqueous Drainage Device; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0662T	Scalp cooling, mechanical; initial measurement and calibration of cap	NON-COVERED	NON-COVERED	PG0535 Scalp cooling Devices to Prevent Hair Loss During	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0663T	Scalp cooling, mechanical; placement of device, monitoring, and removal of device (List	NON-COVERED	NON-COVERED	PG0535 Scalp cooling Devices to Prevent Hair Loss During	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0664T	Donor hysterectomy (including cold preservation); open, from cadaver donor	NON-COVERED	NON-COVERED	PG0461 Transplant Prior Authorization and Notification; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0665T	Donor hysterectomy (including cold preservation); open, from living donor	NON-COVERED	NON-COVERED	PG0461 Transplant Prior Authorization and Notification; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0666T	Donor hysterectomy (including cold preservation); laparoscopic or robotic, from living donor	NON-COVERED	NON-COVERED	PG0461 Transplant Prior Authorization and Notification; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0667T	Donor hysterectomy (including cold preservation); recipient uterus allograft transplantation from	NON-COVERED	NON-COVERED	PG0461 Transplant Prior Authorization and Notification; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0668T	Backbench standard preparation of cadaver or living donor uterine allograft prior to transplantation,	NON-COVERED	NON-COVERED	PG0461 Transplant Prior Authorization and Notification; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0669T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation;	NON-COVERED	NON-COVERED	PG0461 Transplant Prior Authorization and Notification; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0670T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation;	NON-COVERED	NON-COVERED	PG0461 Transplant Prior Authorization and Notification; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0672T	Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the tissues	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0673T	Ablation, benign thyroid nodule(s), percutaneous, laser, including imaging guidance	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0674T	Laparoscopic insertion of new or replacement of permanent implantable synchronized	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0675T	Laparoscopic insertion of new or replacement of diaphragmatic lead(s), permanent implantable	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0676T	Laparoscopic insertion of new or replacement of diaphragmatic lead(s), permanent implantable	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0677T	Laparoscopic repositioning of diaphragmatic lead(s), permanent implantable synchronized	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0678T	Laparoscopic repositioning of diaphragmatic lead(s), permanent implantable synchronized	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0679T	Laparoscopic removal of diaphragmatic lead(s), permanent implantable synchronized	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0680T	Insertion or replacement of pulse generator only, permanent implantable synchronized	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0681T	Relocation of pulse generator only, permanent implantable synchronized diaphragmatic	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0682T	Removal of pulse generator only, permanent implantable synchronized diaphragmatic	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0683T	Programming device evaluation (in-person) with iterative adjustment of the implantable device to test	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0684T	Peri-procedural device evaluation (in-person) and programming of device system parameters before	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0685T	Interrogation device evaluation (in-person) with analysis, review and report by a physician or other	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0686T	Histotripsy (i.e., non-thermal ablation via acoustic energy delivery) of malignant	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0687T	Treatment of amblyopia using an online digital program; device supply, educational set-up, and	NON-COVERED	NON-COVERED	PG0318 Vision Therapy; PG0043 Experimental Investigational Procedures	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0688T	Treatment of amblyopia using an online digital program; assessment of patient performance and	NON-COVERED	NON-COVERED	PG0318 Vision Therapy; PG0043 Experimental Investigational Procedures	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0689T	Quantitative ultrasound tissue characterization (nonelastography) including interpretation and report;	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0690T	Quantitative ultrasound tissue characterization (nonelastographic), including	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0691T	Automated analysis of an existing computed tomography study for vertebral fracture(s), including	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0692T	Therapeutic ultrafiltration	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0693T	Comprehensive full body computer-based markerless 3D kinematic and kinetic motion analysis and	NON-COVERED	NON-COVERED	PG0339 Gait Analysis; PG0043 Experimental Investigational Procedures	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0694T	3-dimensional volumetric imaging and reconstruction of breast or axillary lymph node tissue, each	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0695T	Body surface–activation mapping of pacemaker or pacing cardioverter-defibrillator lead(s) to	NON-COVERED	NON-COVERED	PG0224 Cardioverter Defibrillators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0696T	Body surface–activation mapping of pacemaker or pacing cardioverter-defibrillator lead(s) to	NON-COVERED	NON-COVERED	PG0224 Cardioverter Defibrillators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0697T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content),	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0698T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content),	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0700T	Molecular fluorescent imaging of suspicious nevus; first lesion	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0701T	Molecular fluorescent imaging of suspicious nevus; each additional lesion	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0702T	Remote therapeutic monitoring of a standardized online digital cognitive behavioral therapy	NON-COVERED	NON-COVERED	PG0402 Cognitive Rehabilitation; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0703T	Remote therapeutic monitoring of a standardized online digital cognitive behavioral therapy	NON-COVERED	NON-COVERED	PG0402 Cognitive Rehabilitation; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0704T	Remote treatment of amblyopia using an eye tracking device; device supply with initial setup and	NON-COVERED	NON-COVERED	PG0318 Vision Therapy; PG0043 Experimental Investigational Procedures	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0705T	Remote treatment of amblyopia using an eye tracking device; surveillance center technical	NON-COVERED	NON-COVERED	PG0318 Vision Therapy; PG0043 Experimental Investigational Procedures	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0706T	Remote treatment of amblyopia using an eye tracking device; interpretation and report by	NON-COVERED	NON-COVERED	PG0318 Vision Therapy; PG0043 Experimental Investigational Procedures	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0707T	Injection(s), bone-substitute material (e.g., calcium phosphate) into subchondral bone defect (i.e.,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0708T	Intradermal cancer immunotherapy; preparation and initial injection	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0709T	Intradermal cancer immunotherapy; each additional injection	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0710T	Noninvasive arterial plaque analysis using software processing of data from non-coronary	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0711T	Noninvasive arterial plaque analysis using software processing of data from non-coronary	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0712T	Noninvasive arterial plaque analysis using software processing of data from non-coronary	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0713T	Noninvasive arterial plaque analysis using software processing of data from non-coronary	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0714T	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance	NON-COVERED	NON-COVERED	PG0534 Fluid Jet Sytstem in the Treatment of Benign Prostatic Hyperplasia	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0715T	Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0716T	Cardiac acoustic waveform recording with automated analysis and generation of coronary artery	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0717T	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff	NON-COVERED	NON-COVERED	PG0400 Stem Cell Therapy of Orthopedic Applications	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0718T	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff	NON-COVERED	NON-COVERED	PG0400 Stem Cell Therapy of Orthopedic Applications	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0719T	Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0720T	Percutaneous electrical nerve field stimulation, cranial nerves, without implantation	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0721T	Quantitative computed tomography (CT) tissue characterization, including	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0722T	Quantitative computed tomography (CT) tissue characterization, including	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0723T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0724T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0725T	Vestibular device implantation, unilateral	NON-COVERED	NON-COVERED	PG0193 Treatment of Chronic Vertigo; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0726T	Removal of implanted vestibular device, unilateral	NON-COVERED	NON-COVERED	PG0193 Treatment of Chronic Vertigo; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0727T	Removal and replacement of implanted vestibular device, unilateral	NON-COVERED	NON-COVERED	PG0193 Treatment of Chronic Vertigo; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0728T	Diagnostic analysis of vestibular implant, unilateral; with initial programming	NON-COVERED	NON-COVERED	PG0193 Treatment of Chronic Vertigo; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0729T	Diagnostic analysis of vestibular implant, unilateral; with subsequent programming	NON-COVERED	NON-COVERED	PG0193 Treatment of Chronic Vertigo; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0730T	Trabeculotomy by laser, including optical coherence tomography (OCT) guidance	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0731T	Augmentative AI-based facial phenotype analysis with report	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0732T	Immunotherapy administration with electroporation, intramuscular	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0733T	Remote real-time, motion capture-based neurorehabilitative therapy ordered by a physician or other	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0734T	Remote real-time, motion capture-based neurorehabilitative therapy ordered by a physician or other	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0735T	Preparation of tumor cavity, with placement of a radiation therapy applicator for	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0736T	Colonic lavage, 35 or more liters of water, gravity-fed, with induced defecation, including insertion of	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0737T	Xenograft implantation into the articular surface	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0738T	Treatment planning for magnetic field induction ablation of malignant prostate tissue, using	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0739T	Ablation of malignant prostate tissue by magnetic field induction, including all	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0744T	Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound imaging	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0745T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; noninvasive arrhythmia localization	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0746T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; conversion of arrhythmia	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0747T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; delivery of radiation therapy,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0748T	Injections of stem cell product into perianal perifistular soft tissue, including fistula preparation (e.g.,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0751T	Digitization of glass microscope slides for level II, surgical pathology, gross and microscopic	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0752T	Digitization of glass microscope slides for level III, surgical pathology, gross and microscopic	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0753T	Digitization of glass microscope slides for level IV, surgical pathology, gross and microscopic	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0754T	Digitization of glass microscope slides for level V, surgical pathology, gross and microscopic	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0755T	Digitization of glass microscope slide for level VI, surgical pathology, gross and microscopic	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0756T	Digitization of glass microscope slides for special stain, including interpretation and report, group I,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0757T	Digitization of glass microscope slides for special stain, including interpretation and report, group II,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0758T	Digitization of glass microscope slides for special stain, including interpretation and report,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0759T	Digitization of glass microscope slides for special stain, including interpretation and report, group III,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0760T	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0761T	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0762T	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry per	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0763T	Digitization of glass microscope slides for morphometric analysis, tumor immunohistochemistry (e.g.,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0764T	Assistive algorithmic electrocardiogram risk-based assessment for cardiac	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0765T	related to previously performed electrocardiogram	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0766T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0767T	each additional nerve (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0768T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0769T	each additional nerve (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0775T	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0776T	Therapeutic induction of intra-brain hypothermia, including placement of a mechanical temperature-	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0777T	Real-time pressure-sensing epidural guidance system (List separately in addition to code for	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0778T	Surface mechanomyography (Smmg) with concurrent application of inertial measurement	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0779T	Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0781T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and	NON-COVERED	NON-COVERED	PG0316 Bronchial Thermoplasty; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0782T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and	NON-COVERED	NON-COVERED	PG0316 Bronchial Thermoplasty; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0783T	Transcutaneous auricular neurostimulation, set-up, calibration, and patient education	NON-COVERED	NON-COVERED	PG0244 Electrical Nerve Stimulators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0789T	Electronic analysis with complex programming of implanted integrated neurostimulation system	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0792T	Application of silver diamine fluoride 38%, by a physician or other qualified health care	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0793T	Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries,	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0795T	TRANSCATHETER INSERTION OF PERMANENT DUAL-CHAMBER LEADLESS PACEMAKER, INCLUDING IMAGING GUIDANCE (EG,	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is participating in an FDA approved post approval trial that is	PG0043 Experimental Investigational Procedures Services	Paramount Medicare Advantage Plans - Leadless Cardiac Pacemaker Systems (i.e., MicraTM Transcatheter Pacemaker System, Aveir VR Leadless System). Leadless cardiac pacemaker systems are miniaturized, full featured single or dual chamber pacemakers that are implanted directly in the right ventricle and right atrium in the case of
0796T	RIGHT ATRIAL PACEMAKER COMPONENT (WHEN AN EXISTING RIGHT VENTRICULAR	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is	PG0043 Experimental Investigational Procedures Services	Paramount Medicare Advantage Plans - Leadless Cardiac Pacemaker Systems (i.e., MicraTM Transcatheter Pacemaker System, Aveir VR Leadless System). Leadless cardiac pacemaker systems are
0797T	RIGHT VENTRICULAR PACEMAKER COMPONENT (WHEN PART OF A	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is	PG0043 Experimental Investigational Procedures Services	Paramount Medicare Advantage Plans - Leadless Cardiac Pacemaker Systems (i.e., MicraTM Transcatheter Pacemaker System, Aveir VR Leadless System). Leadless cardiac pacemaker systems are
0798T	TRANSCATHETER REMOVAL OF PERMANENT DUAL-CHAMBER LEADLESS	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is	PG0043 Experimental Investigational Procedures Services	Paramount Medicare Advantage Plans - Leadless Cardiac Pacemaker Systems (i.e., MicraTM Transcatheter Pacemaker System, Aveir VR Leadless System). Leadless cardiac pacemaker systems are
0799T	RIGHT ATRIAL PACEMAKER COMPONENT	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is	PG0043 Experimental Investigational Procedures Services	Paramount Medicare Advantage Plans - Leadless Cardiac Pacemaker Systems (i.e., MicraTM Transcatheter Pacemaker System, Aveir VR Leadless System). Leadless cardiac pacemaker systems are
0800T	RIGHT VENTRICULAR PACEMAKER COMPONENT (WHEN PART OF A	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is	PG0043 Experimental Investigational Procedures Services	Paramount Medicare Advantage Plans - Leadless Cardiac Pacemaker Systems (i.e., MicraTM Transcatheter Pacemaker System, Aveir VR Leadless System). Leadless cardiac pacemaker systems are
0801T	TRANSCATHETER REMOVAL AND REPLACEMENT OF PERMANENT DUAL-CHAMBER	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is	PG0043 Experimental Investigational Procedures Services	Paramount Medicare Advantage Plans - Leadless Cardiac Pacemaker Systems (i.e., MicraTM Transcatheter Pacemaker System, Aveir VR Leadless System). Leadless cardiac pacemaker systems are
0802T	RIGHT ATRIAL PACEMAKER COMPONENT	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is	PG0043 Experimental Investigational Procedures Services	Paramount Medicare Advantage Plans - Leadless Cardiac Pacemaker Systems (i.e., MicraTM Transcatheter Pacemaker System, Aveir VR Leadless System). Leadless cardiac pacemaker systems are
0803T	RIGHT VENTRICULAR PACEMAKER COMPONENT (WHEN PART OF A	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is	PG0043 Experimental Investigational Procedures Services	Paramount Medicare Advantage Plans - Leadless Cardiac Pacemaker Systems (i.e., MicraTM Transcatheter Pacemaker System, Aveir VR Leadless System). Leadless cardiac pacemaker systems are
0804T	PROGRAMMING DEVICE EVALUATION (IN PERSON) WITH ITERATIVE ADJUSTMENT	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is	PG0043 Experimental Investigational Procedures Services	Paramount Medicare Advantage Plans - Leadless Cardiac Pacemaker Systems (i.e., MicraTM Transcatheter Pacemaker System, Aveir VR Leadless System). Leadless cardiac pacemaker systems are
0805T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0806T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
0809T	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization),	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric	NON-COVERED	NON-COVERED	PG0163 Metabolic and Bariatric Surgery; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0814T	Percutaneous injection of calcium-based biodegradable osteoconductive material, proximal	NON-COVERED	NON-COVERED	PG0365 Bone Graft Substitutes; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0816T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0817T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0818T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0819T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0823T	Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial,	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is	PG0043 Experimental Investigational Procedures Services	Paramount Medicare Advantage Plans - Leadless Cardiac Pacemaker Systems (i.e., MicraTM Transcatheter Pacemaker System, Aveir VR Leadless System). Leadless cardiac pacemaker systems are
0824T	Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial,	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is	PG0043 Experimental Investigational Procedures Services	Paramount Medicare Advantage Plans - Leadless Cardiac Pacemaker Systems (i.e., MicraTM Transcatheter Pacemaker System, Aveir VR Leadless System). Leadless cardiac pacemaker systems are
0825T	Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is	PG0043 Experimental Investigational Procedures Services	Paramount Medicare Advantage Plans - Leadless Cardiac Pacemaker Systems (i.e., MicraTM Transcatheter Pacemaker System, Aveir VR Leadless System). Leadless cardiac pacemaker systems are
0826T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is	PG0043 Experimental Investigational Procedures Services	Paramount Medicare Advantage Plans - Leadless Cardiac Pacemaker Systems (i.e., MicraTM Transcatheter Pacemaker System, Aveir VR Leadless System). Leadless cardiac pacemaker systems are
0858T	Externally applied transcranial magnetic stimulation with concomitant measurement of	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0294 Transcranial Magnetic Stimulation (TMS)	Procedure 0858T went from noncoverage E/I to allowed coverage with a PA effective 06/01/2024
0861T	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; both	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	
0862T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	
0863T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	
0864T	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy Status	NON-COVERED	NON-COVERED	PG0004 Extracorporeal Shock Wave (ESWT)	New code effective 01/01/2024
A0140	Nonemergency transportation and air travel (private or commercial) intra-or interstate	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0455 Ambulance Transportation	Review medical policy for coverage/noncoverage details.
A0424	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0455 Ambulance Transportation	Review medical policy for coverage/noncoverage details. Requires medical review.
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0455 Ambulance Transportation	Review medical policy for coverage/noncoverage details.
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0455 Ambulance Transportation	Review medical policy for coverage/noncoverage details.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
A0435	Fixed wing air mileage, per statute mile	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0455 Ambulance Transportation	Review medical policy for coverage/noncoverage details.
A0436	Rotary wing air mileage, per statute mile	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0455 Ambulance Transportation	Review medical policy for coverage/noncoverage details.
A0888	Noncovered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0455 Ambulance Transportation	Review medical policy for coverage/noncoverage details.
A0999	Unlisted ambulance service [when specified as ambulance service, water transport]	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0455 Ambulance Transportation	Review medical policy for coverage/noncoverage details.
A4238	Supply allowance for adjunctive, nonimplanted continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0177 Continuous Blood Glucose Monitoring Systems & Insulin Pumps	Paramount Medicare Advantage Plans - no prior authorization required Coverage to follow CMS coverage guidelines.
A4239	Supply allowance for nonadjunctive, nonimplanted continuous glucose monitor	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION **NOT** REQUIRED	PG0177 Continuous Blood Glucose Monitoring Systems & Insulin Pumps	Paramount Medicare Advantage Plans - no prior authorization required Coverage to follow CMS coverage guidelines.
A4252	Blood ketone test or reagent strip, each	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0155 Glucose Testing Supplies	Effective 01/01/2023, Paramount Medicare Advantage Plans - No prior authorization required for Blood Glucose Monitors and Testing Supplies when utilization of a preferred product , medical policy PG0155 Glucose
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips (e.g., True Metrix, One Touch, FreeStyle, Accu-Chek, Contour)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0155 Glucose Testing Supplies	Effective 01/01/2023, Paramount Medicare Advantage Plans - No prior authorization required for Blood Glucose Monitors and Testing Supplies when utilization of a preferred product , medical policy PG0155 Glucose Testing Supplies
A4255	Platforms for home blood glucose monitor, 50 per box	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0155 Glucose Testing Supplies	Effective 01/01/2023, Paramount Medicare Advantage Plans - No prior authorization required for Blood Glucose Monitors and Testing Supplies when utilization of a preferred product , medical policy PG0155 Glucose Testing Supplies
A4256	Normal, low, and high calibrator solution/chips	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0155 Glucose Testing Supplies	Effective 01/01/2023, Paramount Medicare Advantage Plans - No prior authorization required for Blood Glucose Monitors and Testing Supplies when utilization of a preferred product , medical policy PG0155 Glucose Testing Supplies
A4257	Replacement lens shield cartridge for use with laser skin piercing device, each (Not Covered)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0155 Glucose Testing Supplies	Effective 01/01/2023, Paramount Medicare Advantage Plans - No prior authorization required for Blood Glucose Monitors and Testing Supplies when utilization of a preferred product , medical policy PG0155 Glucose Testing Supplies
A4258	Spring-powered device for lancet, each	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0155 Glucose Testing Supplies	Effective 01/01/2023, Paramount Medicare Advantage Plans - No prior authorization required for Blood Glucose Monitors and Testing Supplies when utilization of a preferred product , medical policy PG0155 Glucose Testing Supplies
A4259	Lancets, per box of 100	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0155 Glucose Testing Supplies	Effective 01/01/2023, Paramount Medicare Advantage Plans - No prior authorization required for Blood Glucose Monitors and Testing Supplies when utilization of a preferred product , medical policy PG0155 Glucose Testing Supplies
A4560	Neuromuscular electrical stimulator (NMES), disposable, replacement only	NON-COVERED	NON-COVERED	PG0228 Neuromuscular, Functional, & Therapeutic Electrical Stimulation Therapy, PG0043 Experimental Investigational Procedures Services	Effective 08/01/2024 procedures A4560, A4593, A4594 listed as non-covered

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
A4563	Rectal control system for vaginal insertion, for long term use, includes pump and all supplies and	NON-COVERED	NON-COVERED	PG0462 Rectal Control System for Fecal Incontinence (Eclipse);	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
A4575	Topical hyperbaric oxygen chamber, disposable	NON-COVERED	NON-COVERED	PG0205 Hyperbaric Oxygen Therapy (HBOT); PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
A4593	Neuromodulation stimulator system, adjunct to rehabilitation therapy regime, controlle	NON-COVERED	NON-COVERED	PG0228 Neuromuscular, Functional, & Therapeutic Electrical Stimulation	Effective 08/01/2024 procedures A4560, A4593, A4594 listed as non-covered
A4594	Neuromodulation stimulator system, adjunct to rehabilitation therapy regime, mouthpiece, each	NON-COVERED	NON-COVERED	PG0228 Neuromuscular, Functional, & Therapeutic Electrical Stimulation	Effective 08/01/2024 procedures A4560, A4593, A4594 listed as non-covered
A7020	Interface for cough stimulating device, includes all components, replacement only	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0227 Airway Clearance Devices	
A7025	High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0227 Airway Clearance Devices	
A7026	High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0227 Airway Clearance Devices	
A9274	External ambulatory insulin delivery system, disposable, each, includes all supplies and	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION **NOT** REQUIRED	PG0177 Continuous Blood Glucose Monitoring Systems & Insulin Pumps	Paramount Medicare Advantage Plans - no prior authorization required Coverage to follow CMS coverage guidelines.
A9276	Sensor; invasive (e.g., subcutaneous), disposable, for use with nondurable medical	NON-COVERED	PRIOR AUTHORIZATION **NOT** REQUIRED	PG0177 Continuous Blood Glucose Monitoring Systems & Insulin Pumps	Effective 01/01/2023 procedures A9278, A9277, and A9276 will be denied as noncovered. Paramount Medicare Advantage Plans - no prior authorization required
A9277	Transmitter; external, for use with nondurable medical equipment interstitial continuous glucose	NON-COVERED	PRIOR AUTHORIZATION **NOT** REQUIRED	PG0177 Continuous Blood Glucose Monitoring Systems & Insulin Pumps	Effective 01/01/2023 procedures A9278, A9277, and A9276 will be denied as noncovered. Paramount Medicare Advantage Plans - no prior authorization required
A9278	Receiver (monitor); external, for use with nondurable medical equipment interstitial continuous	NON-COVERED	PRIOR AUTHORIZATION **NOT** REQUIRED	PG0177 Continuous Blood Glucose Monitoring Systems & Insulin Pumps	Effective 01/01/2023 procedures A9278, A9277, and A9276 will be denied as noncovered. Paramount Medicare Advantage Plans - no prior authorization required
A9291	Prescription digital behavioral therapy, FDA cleared, per course of treatment	NON-COVERED	NON-COVERED	PG0318 Vision Therapy PG0506 Prescription Digital Therapeutics (PDTs)	
A9292	Prescription digital visual therapy, software-only, FDA cleared, per course of treatment	NON-COVERED	NON-COVERED	PG0318 Vision Therapy PG0506 Prescription Digital Therapeutics (PDTs)	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
A9513	Lutetium Lu 177, dotatate, therapeutic, 1 millicurie	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0494 Lutathera (Lutetium Lu 177 Dotatate)	
B4102	Enteral formula, for adults, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0114 Enteral and Parenteral Nutrition	Prior authorization required if NOT diagnosed with inborn errors of metabolism.
B4103	Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0114 Enteral and Parenteral Nutrition	Prior authorization required if NOT diagnosed with inborn errors of metabolism.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
B4104	Additive for enteral formula (e.g. fiber)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0114 Enteral and Parenteral Nutrition	Prior authorization required if NOT diagnosed with inborn errors of metabolism.
B4105	In-line cartridge containing digestive enzyme(s) for enteral feeding, each	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE	PG0114 Enteral and Parenteral Nutrition	Prior authorization required if NOT diagnosed with inborn errors of metabolism. Procedure B4105 coverage with a diagnosis of Exocrine Pancreatic Insufficiency (EPI), per CMS and ODM-appendix DD,
B4149	Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0114 Enteral and Parenteral Nutrition	Prior authorization required if NOT diagnosed with inborn errors of metabolism.
B4150	Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0114 Enteral and Parenteral Nutrition	Prior authorization required if NOT diagnosed with inborn errors of metabolism.
B4152	Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0114 Enteral and Parenteral Nutrition	Prior authorization required if NOT diagnosed with inborn errors of metabolism.
B4153	Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0114 Enteral and Parenteral Nutrition	Prior authorization required if NOT diagnosed with inborn errors of metabolism.
B4154	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0114 Enteral and Parenteral Nutrition	Prior authorization required if NOT diagnosed with inborn errors of metabolism.
B4155	Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g. glucose polymers), proteins/amino acids	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0114 Enteral and Parenteral Nutrition	Prior authorization required if NOT diagnosed with inborn errors of metabolism.
B4157	Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0114 Enteral and Parenteral Nutrition	Prior authorization required if NOT diagnosed with inborn errors of metabolism.
B4158	Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0114 Enteral and Parenteral Nutrition	Prior authorization required if NOT diagnosed with inborn errors of metabolism.
B4159	Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0114 Enteral and Parenteral Nutrition	Prior authorization required if NOT diagnosed with inborn errors of metabolism.
B4160	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0114 Enteral and Parenteral Nutrition	Prior authorization required if NOT diagnosed with inborn errors of metabolism.
B4161	Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0114 Enteral and Parenteral Nutrition	Prior authorization required if NOT diagnosed with inborn errors of metabolism.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
B4162	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0114 Enteral and Parenteral Nutrition	Prior authorization required if NOT diagnosed with inborn errors of metabolism.
C1052	Hemostatic agent, gastrointestinal, topical (Hemospray®)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C1761	Catheter, transluminal intravascular lithotripsy, coronary	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C1782	Morcellator	NON-COVERED	NON-COVERED	PG0344 Uterine Fibroid Surgical Treatments	
C1839	Iris prosthesis	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C1841	Retinal prosthesis, includes all internal and external components (Argus II Retinal Prosthesis	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C1842	Retinal prosthesis, includes all internal and external components; add-on to C1841 (Argus II Retinal	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C2624	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C9122	Mometasone furoate sinus implant, 10 micrograms (Sinuva)	NON-COVERED	NON-COVERED	PG0384 Drug Eluting Devices for Use Following Endoscopic Sinus Surgery;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C9399	Unclassified drugs or biologicals	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0460 Chimeric Antigen Receptor (CAR)-T Cell Therapy	Procedures Q2041, Q2042, Q2053, Q2054, Q2055, Q2056, S2107 may not be an all-inclusive listing, and C9399 when utilized for a CAR-T cell therapy. Prior Authorization review and approval is required for
C9759	Transcatheter intraoperative blood vessel microinfusion(s) (e.g., intraluminal, vascular wall and/or	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C9764	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C9765	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C9766	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C9767	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C9772	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C9773	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C9774	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C9775	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
C9777	Esophageal mucosal integrity testing by electrical impedance, transoral (list separately in addition	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C9781	Arthroscopy, shoulder, surgical; with implantation of subacromial spacer (e.g., balloon), includes	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
CLINICAL TRIALS	Clinical Trials prior authorization and notification	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0446 Clinical Trials	See details related to Clinical Trials Prior Authorization and Notification, Out-Patient services, procedures at Medical Policy PG0466. Effective 7/1/2022 no prior authorization/notification required
Court Ordered/Legally Mandated Tx	Court Ordered/Legally Mandated Treatment	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0532 Court-Ordered Services Legally Mandated Treatment	
COSMETIC SURGERY	Potentially cosmetic surgery	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0104 Cosmetic&Reconstructive Surgery	
E0194	Air-fluidized bed	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0352 Air Fluidized Bed	
E0277	Powered pressure-reducing air mattress	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0245 Hospital Beds and Accessories	
E0300	Pediatric crib, hospital grade, fully enclosed, with or without top enclosure	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0245 Hospital Beds and Accessories	
E0328	Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard, and side rails up to 24 inches above the spring, includes mattress	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0245 Hospital Beds and Accessories	
E0329	Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard, and side rails up to 24 inches above the spring, includes	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0245 Hospital Beds and Accessories	
E0470	Respiratory assist device, bi-level pressure capability, without back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0247 Management of Obstructive Sleep Apnea	Exception: Prior Notification see medical policy details.
E0471	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, eg, nasal or facial mask (intermittent assist device with	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0247 Management of Obstructive Sleep Apnea	Exception: Prior Notification see medical policy details.
E0472	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0247 Management of Obstructive Sleep Apnea	Exception: Prior Notification see medical policy details.
E0480	Percussor, electric or pneumatic, home model	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0227 Airway Clearance Devices	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
E0482	Cough stimulating device, alternating positive and negative airway pressure	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE	PG0227 Airway Clearance Devices	
E0483	High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0227 Airway Clearance Devices	
E0484	Oscillatory positive expiratory pressure device, non-electric, any type, each	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0227 Airway Clearance Devices	
E0486	Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, custom fabricated, includes fitting and adjustment	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0131 Custom Oral Appliance for OSA	
E0490	Power source and control electronics unit for oral device/appliance for	NON-COVERED	NON-COVERED	PG0247 Management of Obstructive Sleep Apnea; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
E0491	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle,	NON-COVERED	NON-COVERED	PG0247 Management of Obstructive Sleep Apnea; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
E0601	Continuous airway pressure (CPAP) device	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0247 Management of Obstructive Sleep Apnea	Exception: Prior Notification see medical policy details.
E0604	Breast pump, hospital grade, electric (AC and/or DC), any type	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0201 Breast Pump Equipment/Supplies and Counseling	E0604 - Prior authorization required if utilized for more that 6 months
E0607	Home blood glucose monitor	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0155 Glucose Testing Supplies	Effective 01/01/2023, Paramount Medicare Advantage Plans - No prior authorization required for Blood Glucose Monitors and Testing Supplies when utilization of a preferred product , medical policy PG0155 Glucose Testing Supplies
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0215 Pneumatic Compression Devices and Supplies-Archived	
E0677	Non-pneumatic sequential compression garment, trunk	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	
E0678	Non-pneumatic sequential compression garment, full leg	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	
E0679	E0679 Non-pneumatic sequential compression garment, half leg	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	
E0680	Non-pneumatic compression controller with sequential calibrated gradient pressure	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	
E0681	Non-pneumatic compression controller without calibrated gradient pressure	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	
E0682	Non-pneumatic sequential compression garment, full arm	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	
E0691	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0383 Home Phototherapy for Dermatologic Conditions	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
E0692	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; four foot panel	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0383 Home Phototherapy for Dermatologic Conditions	
E0693	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; six foot panel	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0383 Home Phototherapy for Dermatologic Conditions	
E0694	Ultraviolet multidirectional light therapy system in six foot cabinet, includes bulbs/lamps, timer, and	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0383 Home Phototherapy for Dermatologic Conditions	
E0740	Non-implanted pelvic floor electrical stimulator, complete system	NON-COVERED	NON-COVERED	PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
E0745	Neuromuscular stimulator, electronic shock unit (FES, NMES, TES)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0228 Neuromuscular, Functional, & Neuromuscular, Functional, & Therapeutic Electrical	
E0747	Osteogenesis stimulator, electrical, noninvasive, other than spinal applications	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0232 Bone Growth Stimulating Services-Devices (Osteogenic Stimulators)	
E0748	Osteogenesis stimulator, electrical, noninvasive, spinal applications	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0232 Bone Growth Stimulating Services-Devices (Osteogenic Stimulators)	
E0749	Osteogenesis stimulator, electrical, surgically implanted	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0232 Bone Growth Stimulating Services-Devices (Osteogenic	Code E0749 is non-covered for Medicare Advantage Plans
E0760	Osteogenesis stimulator, low intensity ultrasound, noninvasive	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0232 Bone Growth Stimulating Services-Devices (Osteogenic Stimulators)	
E0764	Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, used for walking	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0228 Neuromuscular, Functional, & Neuromuscular, Functional, & Therapeutic Electrical	
E0766	Electrical stimulation device used for cancer treatment, includes all accessories, any type	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE	PG0371 Electric Tumor Treatment Fields - Archived	
E0770	Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified (FES)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0228 Neuromuscular, Functional, & Neuromuscular, Functional, & Therapeutic Electrical	
E0784	External ambulatory infusion pump, insulin (should not be used for the Omnipod, there is no separate “pump” for Omnipod)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0177 Continuous Blood Glucose Monitoring Systems & Insulin Pumps	Paramount Medicare Advantage Plans - no prior authorization required Coverage to follow CMS coverage guidelines.
E0985	Wheelchair accessory, seat lift mechanism	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
E0986	Manual wheelchair accessory, push-rim activated power assist system	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
E1002	Wheelchair accessory, power seating system, tilt only	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
E1007	Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
E1008	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
E1010	Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rests, pair	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
E1030	Wheelchair accessory, ventilator tray, gimbaled	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
E1161	Manual adult size wheelchair, includes tilt in space	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
E1230	Power operated vehicle (3- or 4-wheel non-highway) specify brand name and model number	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
E1232	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
E1233	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
E1234	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
E1235	Wheelchair, pediatric size, rigid, adjustable, with seating system	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
E1236	Wheelchair, pediatric size, folding, adjustable, with seating system	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
E1238	Wheelchair, pediatric size, folding, adjustable, without seating system	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
E1239	Power wheelchair, pediatric size, not otherwise specified	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
E1392	Portable oxygen concentrator, rental	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0234 Home Oxygen Therapy	
E1399	Durable medical equipment, miscellaneous	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0227 Airway Clearance Devices	
E1902	Communication board, non-electronic augmentative or alternative communication device	NON-COVERED	NON-COVERED		
E2001	Suction pump, home model, portable or stationary, electric, any type, for use with external urine	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
E2100	Blood glucose monitor with integrated voice synthesizer	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0155 Glucose Testing Supplies	Effective 01/01/2023, Paramount Medicare Advantage Plans - No prior authorization required for Blood Glucose Monitors and Testing Supplies when utilization of a preferred product , medical policy PG0155 Glucose Testing Supplies
E2101	Blood glucose monitor with integrated lancing/blood sample	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0155 Glucose Testing Supplies	Effective 01/01/2023, Paramount Medicare Advantage Plans - No prior authorization required for Blood Glucose Monitors and Testing Supplies when utilization of a preferred product , medical policy PG0155 Glucose Testing Supplies
E2102	Adjunctive, nonimplantable continuous glucose monitor (CGM) or receiver (Effective 04/01/2022)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION NOT REQUIRED	PG0177 Continuous Blood Glucose Monitoring Systems & Insulin Pumps	Paramount Medicare Advantage Plans - no prior authorization required Coverage to follow CMS coverage guidelines.
E2103	Nonadjunctive, nonimplanted continuous glucose monitor (CGM) or receiver (Effective 01/01/2023)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION NOT REQUIRED	PG0177 Continuous Blood Glucose Monitoring Systems & Insulin Pumps	Paramount Medicare Advantage Plans - no prior authorization required Coverage to follow CMS coverage guidelines.
E2300	Wheelchair accessory, power seat elevation system, any type	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
E2310	Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
E2311	Power wheelchair accessory, electronic connection between wheelchair controller and 2 or more power seating system motors, including all related electronics, indicator feature	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
E2325	Power wheelchair accessory, sip, and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swing away mounting hardware	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
E2373	Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
E2500	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 min recording time	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0135 Speech Generating Devices, Archived 07/01/2024	
E2502	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 min recording time, but less than or equal to 20 min recording time	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0135 Speech Generating Devices, Archived 07/01/2024	
E2504	Speech generating device, digitized speech, using pre-recorded messages, greater than 20 min but less than or equal to 40 min recording time	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0135 Speech Generating Devices, Archived 07/01/2024	
E2506	Speech generating device, digitized speech, using pre-recorded messages greater than 40 min recording time	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0135 Speech Generating Devices, Archived 07/01/2024	
E2508	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0135 Speech Generating Devices, Archived 07/01/2024	
E2510	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0135 Speech Generating Devices, Archived 07/01/2024	
E2511	Speech generating software program, for personal computer or personal digital assistant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0135 Speech Generating Devices, Archived 07/01/2024	
E2512	Accessory for speech generating device, mounting system	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0135 Speech Generating Devices, Archived 07/01/2024	
E2599	Accessory for speech generating device, not otherwise classified	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0135 Speech Generating Devices, Archived 07/01/2024	
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		
G0155	Services of clinical social worker in the home health or hospice setting, each 15 minutes	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		
G0156	Services of home health/hospice aide in the home health or hospice setting, each 15 minutes	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		
G0235	PET imaging, any site, not otherwise specified	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0450 Positron Emission Tomography (PET) Oncology and Miscellaneous Applications	Effective 08/01/2021, an additional option for outpatient imaging prior authorization requests from Paramount participating in-plan providers; Paramount is recognizing the Protecting Access to Medicare Act (PAMA) scores greater than or equal to a score of 8, for administrative approvals across all product lines. The request form can be located at: https://www.paramounthealthcare.com/assets/documents/provider/Fax-Request-Form-imaging.pdf • 01/06/2024 - Medical Policy PG0450 Positron Emission Tomography (PET) Oncology and Miscellaneous Applications to be archived. The procedure codes 78608, 78609, 78811, 78812, 78813, 78814, 78815, 78816, G0235, G0252 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel spreadsheet. The procedure codes will align
G0252	PET imaging, full and partial-ring PET scanners only, for initial diagnosis of breast cancer and/ or surgical planning for breast cancer (e.g., initial staging of axillary lymph nodes)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0450 Positron Emission Tomography (PET) Oncology and Miscellaneous Applications	Effective 08/01/2021, an additional option for outpatient imaging prior authorization requests from Paramount participating in-plan providers; Paramount is recognizing the Protecting Access to Medicare Act (PAMA) scores greater than or equal to a score of 8, for administrative approvals across all product lines. The request form can be located at: https://www.paramounthealthcare.com/assets/documents/provider/Fax-Request-Form-imaging.pdf • 01/06/2024 - Medical Policy PG0450 Positron Emission Tomography (PET) Oncology and Miscellaneous Applications to be archived. The procedure codes 78608, 78609, 78811, 78812, 78813, 78814, 78815, 78816, G0235, G0252 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel spreadsheet. The procedure codes will align with the prior authorization excel spreadsheet and not the medical policy.
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each15 minutes	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		
G0300	Direct skilled nursing services of a licensed practical nurwse (LPN) in the home health or hospice setting, each15 minutes	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		
G0327	Colorectal cancer screening; blood-based biomarker	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0065 Colorectal Cancer Screening	
G0330	Facility services for dental rehabilitation procedure(s) performed on a patient who requires monitored anesthesia (e.g., general, intravenous	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0536 Anesthesia Services for Dental Procedures in the Facility Setting	Effective 10/01/2024 - Prior authorization is required for CPT code G0330

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
G0389	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0207 Sleep Study Testing	Paramount supports the initial unattended (unsupervised) adult home sleep testing and one repeat unattended (unsupervised) adult home sleep testing without a prior authorization when the coverage criteria
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	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0207 Sleep Study Testing	Paramount supports the initial unattended (unsupervised) adult home sleep testing and one repeat unattended (unsupervised) adult home sleep testing without a prior authorization when the coverage criteria below is met. **Prior authorization is required for additional repeat unattended (unsupervised) adult home sleep study testing**
G0400	Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0207 Sleep Study Testing	Paramount supports the initial unattended (unsupervised) adult home sleep testing and one repeat unattended (unsupervised) adult home sleep testing without a prior authorization when the coverage criteria below is met. **Prior authorization is required for additional repeat unattended (unsupervised) adult home sleep study testing**
G0452	Molecular pathology procedure; physician interpretation and report	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
G0460	Autologous platelet rich plasma for non-diabetic chronic wounds/ulcers, including	NON-COVERED	NON-COVERED	PG0293 Platelet Rich Plasma; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
G0465	Autologous platelet rich plasma (PRP) for diabetic chronic wounds/ulcers, using an FDA-cleared device (includes administration, dressing	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0293 Platelet Rich Plasma	
G0476	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), high-risk types (e.g.,16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0369 Human Papillomavirus (HPV) Screening	87623, 87624, 87625, G0476 for ages under 21. AND 87623, 87624, 87625, G0476 for ages 21-29 and over age 65 only when the cervical cytology screening test results do not report as ASC-US or LSIL.
G0480	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
G0481	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
G0482	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
G0483	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	
G2082	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0409 Ketamine and Esketamine for Treatment of Psychiatric Disorders and Pain Management	
G2083	Office or other outpatient visit for the evaluation and management of an established patient that	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0409 Ketamine and Esketamine for Treatment of Psychiatric Disorders	
G2171	Percutaneous arteriovenous fistula creation (avf), direct, any site, using magnetic-guided arterial and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
G9143	Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		Effective 06/01/2024 procedure G9143 covered with a prior authorization for Paramount Commercial Insurance Plans/per InterQual coverage criteria and is covered without a prior authorization for the Elite (Medicare Advantage) Plans

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
H0035	Mental Health Partial Hospitalization Treatment <24 Hours	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0531 Behavioral Health Partial Hospitalization Program	
H0039	Assertive community treatment, face-to-face, per 15 minutes	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0503 Assertive Community Therapy	
H0040	Assertive community treatment program, per diem	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0503 Assertive Community Therapy	
INPATIENT HOSPITAL ADMISSIONS	Inpatient admissions	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		
INTENSIVE OUTPATIENT ADMISSIONS	Outpatient admissions	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED		Effective 7/1/2021 Intensive Outpatient Admissions do not require a prior authorization
J1096	Dexamethasone, lacrimal ophthalmic insert, 0.1 mg (Dextenza)	SEE NOTES	SEE NOTES	PG0495 Intravitreal and Punctum Corticosteroid Implants	Effective 05/11/2022 Utilization of Corticosteroid Intravitreal Implants will be managed through MagellanRx Management by either post service claim editing or prior authorization.
J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	SEE NOTES	SEE NOTES	PG0520 Luxturna ((voretigene neparvovec-rzyl)	Code J3398 requires a prior authorization with Magellan MRx @ https://www1.magellanrx.com/medical-rx-prior-authorization/
J3398	Not otherwise classified, antineoplastic drugs [when specified as betibeglogene	SEE NOTES	SEE NOTES	PG0523 Zynteglo (betibeglogene autotemcel)	Code J3398 requires a prior authorization with Magellan MRx @ https://www1.magellanrx.com/medical-rx-prior-authorization/
J3399	Injection, Onasemnogene abeparvovec-xioi, per treatment, up to 5x1015 vector genomes	SEE NOTES	SEE NOTES	PG0522 Zolgensma (onasemnogene abeparvovec)	Code J3399 requires a prior authorization with Magellan MRx @ https://www1.magellanrx.com/medical-rx-prior-authorization/
J3490	Unclassified drugs	SEE NOTES	SEE NOTES	PG0225 Implantable Testosterone Pellets (Testopel®)	Unlisted code J3490 should be billed for Testopel® for Elite per CMS guidelines
J3490	Unclassified drugs [when specified as nadofaragene firadenovecvncg (Adstiladrin)]	SEE NOTES	SEE NOTES	PG0518 Adstiladrin (nadofaragene firadenovecvncg)	Codes J3490, J3590, J9999 [when specified as nadofaragene firadenovecvncg (Adstiladrin)] requires a prior authorization, via Magellan MRx @ https://www1.magellanrx.com/medical-rx-prior-
J3490	Unclassified drugs [when specified as etranacogene dezaparvovec-drlb (Hemgenix)]	SEE NOTES	SEE NOTES	PG0519 Hemgenix (etranacogene dezaparvovec)	Codes J3490, J3590, J9999 [when specified as etranacogene dezaparvovec-drlb (Hemgenix)] requires prior authorization, via Magellan MRx @ https://www1.magellanrx.com/medical-rx-prior-authorization/
J3490	Unclassified drugs [when specified as elivaldogene autotemcel (Skysona)]	SEE NOTES	SEE NOTES	PG0521 Skysona (elivaldogene autotemcel)	Code J3490, J3590, J9999 [when specified as elivaldogene autotemcel (Skysona)] requires a prior authorization with Magellan MRx @ https://www1.magellanrx.com/medical-rx-prior-authorization/
J3590	Unclassified biologics [when specified as nadofaragene firadenovecvncg (Adstiladrin)]	SEE NOTES	SEE NOTES	PG0518 Adstiladrin (nadofaragene firadenovecvncg)	Codes J3490, J3590, J9999 [when specified as nadofaragene firadenovecvncg (Adstiladrin)] requires a prior authorization, via Magellan MRx @ https://www1.magellanrx.com/medical-rx-prior-
J3590	Unclassified biologics [when specified as etranacogene dezaparvovec-drlb (Hemgenix)]	SEE NOTES	SEE NOTES	PG0519 Hemgenix (etranacogene dezaparvovec)	Codes J3490, J3590, J9999 [when specified as etranacogene dezaparvovec-drlb (Hemgenix)] requires prior authorization, via Magellan MRx @ https://www1.magellanrx.com/medical-rx-prior-authorization/
J3590	Unclassified biologics [when specified as elivaldogene autotemcel (Skysona)]	SEE NOTES	SEE NOTES	PG0521 Skysona (elivaldogene autotemcel)	Code J3490, J3590, J9999 [when specified as elivaldogene autotemcel (Skysona)] requires a prior authorization with Magellan MRx @ https://www1.magellanrx.com/medical-rx-prior-authorization/
J7311	Injection, fluocinolone acetonide, intravitreal implant (Restisert), 0.01 mg	SEE NOTES	SEE NOTES	PG0495 Intravitreal and Punctum Corticosteroid Implants	Effective 05/11/2022 Utilization of Corticosteroid Intravitreal Implants will be managed through MagellanRx Management by either post service claim editing or prior authorization.
J7312	Injection, dexamethasone, intravitreal implant, 0.1 mg (Ozurdex)	SEE NOTES	SEE NOTES	PG0495 Intravitreal and Punctum Corticosteroid Implants	Effective 05/11/2022 Utilization of Corticosteroid Intravitreal Implants will be managed through MagellanRx Management by either post service claim editing or prior authorization.
J7313	Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg	SEE NOTES	SEE NOTES	PG0495 Intravitreal and Punctum Corticosteroid Implants	Effective 05/11/2022 Utilization of Corticosteroid Intravitreal Implants will be managed through MagellanRx Management by either post service claim editing or prior authorization.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
J7314	Injection, fluocinolone acetonide, intravitreal implant (Yutiq), 0.01 mg	SEE NOTES	SEE NOTES	PG0495 Intravitreal and Punctum Corticosteroid Implants	Effective 05/11/2022 Utilization of Corticosteroid Intravitreal Implants will be managed through MagellanRx Management by either post service claim editing or prior authorization.
J7318	Hyaluronan or derivative, durolane, for intra-articular injection, 1 mg	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	PG0204 Viscosupplementation for Osteoarthritis -- Refer to the Magellan MRx Prescription Drug Benefits/Prior Authorizations. https://www.paramounthealthcare.com/services/providers/prior-
J7320	Hyaluronan or derivitive, genvisc 850, for intra-articular injection, 1 mg	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	PG0204 Viscosupplementation for Osteoarthritis -- Refer to the Magellan MRx Prescription Drug Benefits/Prior Authorizations. https://www.paramounthealthcare.com/services/providers/prior-
J7321	Hyaluronan or derivative, hyalgan, supartz or visco-3, for intra-articular injection, per dose	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	PG0204 Viscosupplementation for Osteoarthritis -- Refer to the Magellan MRx Prescription Drug Benefits/Prior Authorizations. https://www.paramounthealthcare.com/services/providers/prior-
J7322	Hyaluronan or derivative, hymovis, for intra-articular injection, 1 mg	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	PG0204 Viscosupplementation for Osteoarthritis -- Refer to the Magellan MRx Prescription Drug Benefits/Prior Authorizations. https://www.paramounthealthcare.com/services/providers/prior-
J7323	Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	PG0204 Viscosupplementation for Osteoarthritis -- Refer to the Magellan MRx Prescription Drug Benefits/Prior Authorizations. https://www.paramounthealthcare.com/services/providers/prior-
J7324	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	PG0204 Viscosupplementation for Osteoarthritis -- Refer to the Magellan MRx Prescription Drug Benefits/Prior Authorizations. https://www.paramounthealthcare.com/services/providers/prior-
J7325	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	PG0204 Viscosupplementation for Osteoarthritis -- Refer to the Magellan MRx Prescription Drug Benefits/Prior Authorizations. https://www.paramounthealthcare.com/services/providers/prior-
J7326	Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	PG0204 Viscosupplementation for Osteoarthritis -- Refer to the Magellan MRx Prescription Drug Benefits/Prior Authorizations. https://www.paramounthealthcare.com/services/providers/prior-
J7327	Hyaluronan or derivative, monovisc, for intra-articular injection, per dose	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	PG0204 Viscosupplementation for Osteoarthritis -- Refer to the Magellan MRx Prescription Drug Benefits/Prior Authorizations. https://www.paramounthealthcare.com/services/providers/prior-
J7328	Hyaluronan or derivative, Gel-Syn, for intra-articular injection, 0.1 mg	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	PG0204 Viscosupplementation for Osteoarthritis -- Refer to the Magellan MRx Prescription Drug Benefits/Prior Authorizations. https://www.paramounthealthcare.com/services/providers/prior-
J7329	Hyaluronan or derivative, trivisc, for intra-articular injection, 1 mg	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	PG0204 Viscosupplementation for Osteoarthritis -- Refer to the Magellan MRx Prescription Drug Benefits/Prior Authorizations. https://www.paramounthealthcare.com/services/providers/prior-
J7330	Autologous cultured chondrocytes, implant [except minced articular cartilage (whether synthetic, allograft or autograft)]	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0190 Focal Articular Cartilage of the Knee	
J7331	Hyaluronan or derivative, Synojoynt, for intra-articular injection, 1 mg	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	PG0204 Viscosupplementation for Osteoarthritis -- Refer to the Magellan MRx Prescription Drug Benefits/Prior Authorizations. https://www.paramounthealthcare.com/services/providers/prior-
J7332	Hyaluronan or derivative, Triluron, for intra-articular injection, 1 mg	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	PG0204 Viscosupplementation for Osteoarthritis -- Refer to the Magellan MRx Prescription Drug Benefits/Prior Authorizations. https://www.paramounthealthcare.com/services/providers/prior-
J7333	Hyaluronan or derivative, Visco-3, for intra-articular injection, per dose	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	PG0204 Viscosupplementation for Osteoarthritis -- Refer to the Magellan MRx Prescription Drug Benefits/Prior Authorizations. https://www.paramounthealthcare.com/services/providers/prior-
G9143	Warfarin responsiveness testing by genetic technique using any method, any number of	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	Covered with No Prior Authorization Required		
J7402	Mometasone furoate sinus implant, (sinuva), 10 micrograms	NON-COVERED	NON-COVERED	PG0384 Drug Eluting Devices for Use Following Endoscopic Sinus Surgery;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
J9999	Not otherwise classified, antineoplastic drugs [when specified as nadofaragene	SEE NOTES	SEE NOTES	PG0518 Adstiladrin (nadofaragene firadenovecvncg)	Codes J3490, J3590, J9999 [when specified as nadofaragene firadenovecvncg (Adstiladrin)] requires a prior authorization, via Magellan MRx @ https://www1.magellanrx.com/medical-rx-prior-

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
J9999	Not otherwise classified, antineoplastic drugs [when specified as etranacogene	SEE NOTES	SEE NOTES	PG0519 Hemgenix (etranacogene dezaparvovec)	Codes J3490, J3590, J9999 [when specified as etranacogene dezaparvovec-drlb (Hemgenix)] requires prior authorization, via Magellan MRx @ https://www1.magellanrx.com/medical-rx-prior-authorization/
J9999	Not otherwise classified, antineoplastic drugs [when specified as elivaldogene	SEE NOTES	SEE NOTES	PG0521 Skysona (elivaldogene autotemcel)	Code J3490, J3590, J9999 [when specified as elivaldogene autotemcel (Skysona)] requires a prior authorization with Magellan MRx @ https://www1.magellanrx.com/medical-rx-prior-authorization/
K0005	Ultra-lightweight wheelchair	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0010	Standard-weight frame motorized/power wheelchair	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0011	Standard-weight frame motorized/power wheelchair with programmable control parameters	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0012	Lightweight portable motorized/power wheelchair	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0013	Custom motorized/power wheelchair base	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0014	Other motorized/power wheelchair base	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0108	Wheelchair component or accessory, not otherwise specified	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0224 Cardioverter Defibrillators	
K0800	Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0801	Power operated vehicle, group 1 heavy duty, patient weight capacity, 301 to 450 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0802	Power operated vehicle, group 1 very heavy duty, patient weight capacity 451 to 600 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0806	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0807	Power operated vehicle, group 2 heavy duty, patient weight capacity 301 to 450 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
K0808	Power operated vehicle group 2 very heavy duty, patient weight capacity 451 to 600 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0812	Power operated vehicle, not otherwise classified	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0813	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0814	Power wheelchair, group 1 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0815	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0816	Power wheelchair, group 1 standard, captain's chair, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0820	Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0821	Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0822	Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0823	Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0824	Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0825	Power wheelchair, group 2 heavy duty, captain's chair, patient weight capacity 301 to 450 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0826	Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
K0827	Power wheelchair, group 2 very heavy duty, captain's chair, patient weight capacity 451 to 600 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0828	Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0829	Power wheelchair, group 2 extra heavy duty, captain's chair, patient weight capacity 601 pounds or more	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0830	Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0831	Power wheelchair, group 2 standard, seat elevator, captain's chair, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0835	Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0836	Power wheelchair, group 2 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0837	Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0838	Power wheelchair, group 2 heavy duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0839	Power wheelchair, group 2 very heavy duty, single power option, sling/solid seat/back, patient	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0840	Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0841	Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0842	Power wheelchair, group 2 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
K0843	Power wheelchair, group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0848	Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0849	Power wheelchair, group 3 standard, captain's chair, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0850	Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0851	Power wheelchair, group 3 heavy duty, captain's chair, patient weight capacity 301 to 450 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0852	Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0853	Power wheelchair, group 3 very heavy duty, captain's chair, patient weight capacity 451 to 600 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0854	Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0855	Power wheelchair, group 3 extra heavy duty, captain's chair, patient weight capacity 601 pounds or more	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0856	Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0857	Power wheelchair, group 3 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0858	Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0859	Power wheelchair, group 3 heavy duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
K0860	Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0861	Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0862	Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0863	Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0864	Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0868	Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0869	Power wheelchair, group 4 standard, captain's chair, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0870	Power wheelchair, group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0871	Power wheelchair, group 4 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0877	Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0878	Power wheelchair, group 4 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0879	Power wheelchair, group 4 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0880	Power wheelchair, group 4 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
K0884	Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0885	Power wheelchair, group 4 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0886	Power wheelchair, group 4 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0890	Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0891	Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0898	Power wheelchair, not otherwise classified	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K0899	Power mobility device, not coded by DME PDAC or does not meet criteria	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	
K1002	Cranial electrotherapy stimulation (CES) system, includes all supplies and accessories, any type	NON-COVERED	NON-COVERED	PG0244 Electrical Nerve Stimulators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
K1004	Low frequency ultrasonic diathermy treatment device for home use, includes all	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
K1007	Bilateral hip, knee, ankle, foot device, powered, includes pelvic component, single or double	NON-COVERED	NON-COVERED	PG0425 Powered Robotic Lower Body Exoskeleton Devices; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
K1009	Speech volume modulation system, any type, including all components and accessories	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
K1016	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve (Monarch	NON-COVERED	NON-COVERED	PG0244 Electrical Nerve Stimulators PG0361 Alternative	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
K1017	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve (Monarch	NON-COVERED	NON-COVERED	PG0244 Electrical Nerve Stimulators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
K1018	External upper limb tremor stimulator of the peripheral nerves of the wrist (e.g., Cala Trio™)	NON-COVERED	NON-COVERED	PG0244 Electrical Nerve Stimulators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
K1019	Monthly supplies for use of device coded at K1018 (e.g., Cala Trio™)	NON-COVERED	NON-COVERED	PG0244 Electrical Nerve Stimulators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
K1023	Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm	NON-COVERED	NON-COVERED	PG0244 Electrical Nerve Stimulators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
K1026	Mechanical allergen particle barrier/inhalation filter, cream, nasal, topical (Alzair™).	NON-COVERED	NON-COVERED	PG0188 Allergy Testing and Treatments; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
K1027	Oral device/appliance used to reduce upper airway collapsibility, without fixed mechanical hinge,	NON-COVERED	NON-COVERED	PG0131 Custom Oral Appliances for Obstructive Sleep Apnea; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
K1030	External recharging system for battery (internal) for use with implanted cardiac contractility	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
K1036	Supplies and accessories (e.g., transducer) for low frequency ultrasonic diathermy treatment	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
L0112	Cranial cervical orthosis, congenital torticollis type, with or without soft interface material, adjustable range of motion joint, custom fabricated	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0120 Cranial Orthotic Devices and Protective Helmets	
L0113	Cranial cervical orthotic, torticollis type, with or without joint, with or without soft interface material, prefabricated, includes fitting and adjustment	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0120 Cranial Orthotic Devices and Protective Helmets	
L1810	Knee orthosis, elastic with joints, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
L1812	Knee orthosis, elastic with joints, prefabricated, off-the-shelf	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
L1820	Knee orthotic, elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
L1830	Knee orthosis, immobilizer, canvas longitudinal, prefabricated, off-the-shelf	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
L1831	Knee orthotic, locking knee joint(s), positional orthotic, prefabricated, includes fitting and adjustment	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
L1832	Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated item that has been trimmed, bent, molded	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
L1833	Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the shelf	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
L1834	Knee orthotic (KO), without knee joint, rigid, custom fabricated	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
L1836	Knee orthosis, rigid, without joint(s), includes soft interface material, prefabricated, off-the-shelf	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
L1840	Knee orthotic (KO), derotation, medial-lateral, anterior cruciate ligament, custom fabricated	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
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	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
L1844	Knee orthotic (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
L1845	Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
L1846	Knee orthotic, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
L1847	Knee orthosis, double upright with adjustable joint, with inflatable air support chamber(s), prefabricated	NON-COVERED	NON-COVERED	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
L1848	Knee orthosis, double upright with adjustable joint, with inflatable air support chamber(s), prefabricated,	NON-COVERED	NON-COVERED	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
L1850	Knee orthosis, Swedish type, prefabricated, off-the-shelf	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
L1851	Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
L1852	Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
L1860	Knee orthotic (KO), modification of supracondylar prosthetic socket, custom fabricated (SK)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0480 Knee Orthosis	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
~~L5301~~	Below knee, molded socket, shin, SACH foot, endoskeletal system	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL.~~ Prior authoriztion end-dated 07/01/2024	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~ Prior authoriztion end-dated 07/01/2024	PG0489 Lower Limb Prostheses. Prior Authorization end-dated 07/01/2024, Medical Policy Archived	
~~L5321~~	Above knee, molded socket, open end, SACH foot, endoskeletal system, single axis knee	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL.~~ Prior authoriztion end-dated 07/01/2024	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~ Prior authoriztion end-dated 07/01/2024	PG0489 Lower Limb Prostheses. Prior Authorization end-dated 07/01/2024, Medical Policy Archived	
~~L5647~~	Addition to lower extremity, below knee suction socket	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL.~~ Prior authoriztion end-dated 07/01/2024	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~ Prior authoriztion end-dated 07/01/2024	PG0489 Lower Limb Prostheses. Prior Authorization end-dated 07/01/2024, Medical Policy Archived	
~~L5649~~	Addition to lower extremity, ischial containment/narrow M-L socket	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL.~~ Prior authoriztion end-dated 07/01/2024	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~ Prior authoriztion end-dated 07/01/2024	PG0489 Lower Limb Prostheses. Prior Authorization end-dated	
~~L5651~~	Addition to lower extremity, above knee, flexible inner socket, external frame	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL.~~ Prior authoriztion end-dated 07/01/2024	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~ Prior authoriztion end-dated 07/01/2024	PG0489 Lower Limb Prostheses. Prior Authorization end-dated	
~~L5673~~	Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL.~~ Prior authoriztion end-dated 07/01/2024	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~ Prior authoriztion end-dated 07/01/2024	PG0489 Lower Limb Prostheses. Prior Authorization end-dated 07/01/2024, Medical Policy Archived	
~~L5700~~	Replacement, socket, below knee, molded to patient mode	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL.~~ Prior authoriztion end-dated 07/01/2024	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~ Prior authoriztion end-dated 07/01/2024	PG0489 Lower Limb Prostheses. Prior Authorization end-dated 07/01/2024, Medical Policy Archived	
~~L5950~~	Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL.~~ Prior authoriztion end-dated 07/01/2024	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~ Prior authoriztion end-dated 07/01/2024	PG0489 Lower Limb Prostheses. Prior Authorization end-dated 07/01/2024, Medical Policy Archived	
~~L5980~~	All lower extremity prostheses, flex foot system	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL.~~ Prior authoriztion end-dated 07/01/2024	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~ Prior authoriztion end-dated 07/01/2024	PG0489 Lower Limb Prostheses. Prior Authorization end-dated 07/01/2024, Medical Policy Archived	
~~L5981~~	All lower extremity prostheses, flex-walk system or equal	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL.~~ Prior authoriztion end-dated 07/01/2024	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~ Prior authoriztion end-dated 07/01/2024	PG0489 Lower Limb Prostheses. Prior Authorization end-dated 07/01/2024, Medical Policy Archived	
~~L5986~~	All lower extremity prostheses, multi-axial rotation unit ('MCP' or equal)	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL.~~ Prior authoriztion end-dated 07/01/2024	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~ Prior authoriztion end-dated 07/01/2024	PG0489 Lower Limb Prostheses. Prior Authorization end-dated 07/01/2024, Medical Policy Archived	
~~L5987~~	All lower extremity prosthesis, shank foot system with vertical loading pylon	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL.~~ Prior authoriztion end-dated 07/01/2024	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~ Prior authoriztion end-dated 07/01/2024	PG0489 Lower Limb Prostheses. Prior Authorization end-dated 07/01/2024, Medical Policy Archived	

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L6026	Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended,	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6611	Addition to upper extremity prosthesis, external powered, additional switch, any type	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6646	Upper extremity addition, shoulder joint, multipositional locking, flexion, adjustable abduction	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6648	Upper extremity addition, shoulder lock mechanism, external powered actuator	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6715	Terminal device, multiple articulating digits, includes motor (s), initial issue or replacement	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6880	Electric hand, switch, or myoelectric controlled, independently articulating digits, any grasp pattern or combination of grasp patterns, includes	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6881	Automatic grasp feature, addition to upper limb electric prosthetic terminal device	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6882	Microprocessor control feature, addition to upper limb prosthetic terminal device	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6920	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell,	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6925	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6930	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6935	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two batteries and one charger,	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6940	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6945	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm; Otto Bock or equal electrodes, cables, two	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6950	Above elbow, external power, molded inner socket, removable humeral shell, internal locking	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
L6955	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal electrodes, cables, two batteries	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6960	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6965	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6970	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6975	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L7007	Electric hand, switch or myoelectric controlled, adult	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L7008	Electric hand, switch or myoelectric controlled, pediatric	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L7009	Electric hook, switch or myoelectric controlled, adult	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L7040	Prehensile actuator, switch controlled	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L7045	Electric hook, switch or myoelectric controlled, pediatric	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L7170	Electronic elbow, Hosmer or equal, switch controlled	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L7180	Electronic elbow, microprocessor sequential control of elbow and terminal device	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L7181	Electronic elbow, microprocessor simultaneous control of elbow and terminal device	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L7185	Electronic elbow, adolescent, Variety Village or equal, switch controlled	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L7186	Electronic elbow, child, Variety Village or equal, switch controlled	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
L7190	Electronic elbow, adolescent, Variety Village or equal, myoelectronically controlled	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L7191	Electronic elbow, child, Variety Village or equal, myoelectronically controlled	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L7259	Electronic wrist rotator, any type	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L7400	Addition to upper extremity prosthesis, below elbow/wrist disarticulation, ultra-light material	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L7401	Addition to upper extremity prosthesis, above elbow disarticulation, ultra-light material (titanium, carbon fiber or equal)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L7402	Addition to upper extremity prosthesis, shoulder disarticulation/interscapular	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L7403	Addition to upper extremity prosthesis, below elbow/wrist disarticulation, acrylic material	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L7404	Addition to upper extremity prosthesis, above elbow disarticulation, acrylic material	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L7405	Addition to upper extremity prosthesis, shoulder disarticulation/interscapular	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L7499	Upper extremity prosthesis, not otherwise specified	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L8605	Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0260 Injectable Bulking Agents for Fecal Incontinence	
L8614	Cochlear device/system	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0281 Cochlear and Auditory Brainstem Implants - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0281 Cochlear and Auditory Brainstem Implants is going to be archived. The procedure codes 69930, L8614-L8624, L8627-L8629 and L8625 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel
L8615	Headset/headpiece for use with cochlear implant device, replacement	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0281 Cochlear and Auditory Brainstem Implants - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0281 Cochlear and Auditory Brainstem Implants is going to be archived. The procedure codes 69930, L8614-L8624, L8627-L8629 and L8625 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel
L8616	Microphone for use with cochlear implant device, replacement	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0281 Cochlear and Auditory Brainstem Implants - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0281 Cochlear and Auditory Brainstem Implants is going to be archived. The procedure codes 69930, L8614-L8624, L8627-L8629 and L8625 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
L8617	Transmitting coil for use with cochlear implant device, replacement	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0281 Cochlear and Auditory Brainstem Implants - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0281 Cochlear and Auditory Brainstem Implants is going to be archived. The procedure codes 69930, L8614-L8624, L8627-L8629 and L8625 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel
L8618	Transmitter cable for use with cochlear implant device or auditory osseointegrated device, replacement	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0281 Cochlear and Auditory Brainstem Implants - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0281 Cochlear and Auditory Brainstem Implants is going to be archived. The procedure codes 69930, L8614-L8624, L8627-L8629 and L8625 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel
L8619	Cochlear implant external speech processor, replacement	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0281 Cochlear and Auditory Brainstem Implants - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0281 Cochlear and Auditory Brainstem Implants is going to be archived. The procedure codes 69930, L8614-L8624, L8627-L8629 and L8625 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel
L8621	Zinc air battery for use with cochlear implant device and auditory osseointegrated sound processors, replacement, each	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0281 Cochlear and Auditory Brainstem Implants - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0281 Cochlear and Auditory Brainstem Implants is going to be archived. The procedure codes 69930, L8614-L8624, L8627-L8629 and L8625 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel
L8622	Alkaline battery for use with cochlear implant device, any size, replacement, each	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0281 Cochlear and Auditory Brainstem Implants - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0281 Cochlear and Auditory Brainstem Implants is going to be archived. The procedure codes 69930, L8614-L8624, L8627-L8629 and L8625 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel
L8623	Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0281 Cochlear and Auditory Brainstem Implants - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0281 Cochlear and Auditory Brainstem Implants is going to be archived. The procedure codes 69930, L8614-L8624, L8627-L8629 and L8625 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel
L8624	Lithium ion battery for use with cochlear implant or auditory osseointegrated device speech processor, ear level, replacement, each	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0281 Cochlear and Auditory Brainstem Implants - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0281 Cochlear and Auditory Brainstem Implants is going to be archived. The procedure codes 69930, L8614-L8624, L8627-L8629 and L8625 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel
L8625	External recharging system for battery use with cochlear implant or auditory osseointegrated device, replacement only, each	~~PRIOR AUTHORIZATION REQUIRED~~ Effective 08/12/2024 procedure L8625 does not require a prior authorizaton.	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0281 Cochlear and Auditory Brainstem Implants - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0281 Cochlear and Auditory Brainstem Implants is going to be archived. The procedure codes 69930, L8614-L8624, L8627-L8629 and L8625 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel
L8627	Cochlear implant, external speech processor, component, replacement	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0281 Cochlear and Auditory Brainstem Implants - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0281 Cochlear and Auditory Brainstem Implants is going to be archived. The procedure codes 69930, L8614-L8624, L8627-L8629 and L8625 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel
L8628	Cochlear implant, external controller component, replacement	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0281 Cochlear and Auditory Brainstem Implants - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0281 Cochlear and Auditory Brainstem Implants is going to be archived. The procedure codes 69930, L8614-L8624, L8627-L8629 and L8625 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel
L8629	Transmitting coil and cable, integrated, for use with cochlear implant device, replacement	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~ Effective 08/12/2024 procedure L8625 does not require a prior authorizaton.	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0281 Cochlear and Auditory Brainstem Implants - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	Medical Policy PG0281 Cochlear and Auditory Brainstem Implants is going to be archived. The procedure codes 69930, L8614-L8624, L8627-L8629 and L8625 require a prior authorization, and will maintain requiring a prior authorization. The coverage criteria will follow the InterQual criteria, as is indicated on the prior authorization excel
L8690	Auditory osseointegrated device, includes all internal and external components	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0218 Implantable Bone Conduction and Bone-Anchored Hearing Aids	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
L8691	Auditory osseointegrated device, external sound processor, replacement	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0218 Implantable Bone Conduction and Bone-Anchored Hearing Aids	
L8692	Auditory osseointegrated device, external sound processor, used without osseointegration, body worn – includes headband or other means of external attachment	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0218 Implantable Bone Conduction and Bone-Anchored Hearing Aids	
L8693	Auditory osseointegrated device abutment, any length, replacement only	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0218 Implantable Bone Conduction and Bone-Anchored Hearing Aids	
L8701	Powered upper extremity range of motion assist device, elbow, wrist, hand with single or double	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L8702	Powered upper extremity range of motion assist device, elbow, wrist, hand, finger with single or double	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
M0076	Prolotherapy	NON-COVERED	NON-COVERED	PG0170 Prolotherapy; PG0043 Experimental Investigational Procedures	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
NEW TECHNOLOGY	New technology (medical & behavioral health procedures, diagnostics, durable medical	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE		
NO SPECIFIC PROCEDURE CODES	Intradialytic Parenteral Nutrition (IDPN)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0501 Intradialytic Parenteral Nutrition (IDPN)	No specific procedure codes
NURSING FACILITY	Nursing facility intermediate level of care (ILOC)				Revenue Code 0191
OUT OF NETWORK SERVICES	All Out of Network Services (Except for ER)	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED		
P2031	Hair analysis (excluding arsenic)	NON-COVERED	NON-COVERED	PG0069 Drug Testing; PG0043 Experimental Investigational Procedures	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
PROSTHETICS	All orthotics/prosthetics that exceeds benefit limits initial purchase only	SEE NOTES	PRIOR AUTHORIZATION REQUIRED		Prior Authorization is required for services in a Medicare certified Religious Nonmedical Health Care Institutions (RNHCIs).
Q1004	New technology intraocular lens category 4 as defined in Federal Register notice	NON-COVERED	NON-COVERED	PG0063 Intraocular Lens Implant	
Q1005	New technology intraocular lens category 5 as defined in Federal Register notice	NON-COVERED	NON-COVERED	PG0063 Intraocular Lens Implant	
Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-CD19 CAR positive T cells, including	SEE NOTES	SEE NOTES	PG0460 Chimeric Antigen Receptor (CAR)-T Cell Therapy	Medical Policy PG0431 Yescarta™(axicabtagene ciloleucel) has been Retired from the Medical Policy Benefit coverage and relocated to the Pharmacy Benefits coverage. Please refer to Prescription Drug
Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-CD19 CAR positive T cells, including	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0460 Chimeric Antigen Receptor (CAR)-T Cell Therapy	Procedures Q2041, Q2042, Q2053, Q2054, Q2055, Q2056, S2107 may not be an all-inclusive listing, and C9399 when utilized for a CAR-T cell therapy. Prior Authorization review and approval is required for
Q2042	Tisagenlecleucel, up to 600 million CAR-positive viable T cells, including leukapheresis and dose	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0460 Chimeric Antigen Receptor (CAR)-T Cell Therapy	Procedures Q2041, Q2042, Q2053, Q2054, Q2055, Q2056, S2107 may not be an all-inclusive listing, and C9399 when utilized for a CAR-T cell therapy. Prior Authorization review and approval is required for
Q2053	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0460 Chimeric Antigen Receptor (CAR)-T Cell Therapy	Procedures Q2041, Q2042, Q2053, Q2054, Q2055, Q2056, S2107 may not be an all-inclusive listing, and C9399 when utilized for a CAR-T cell therapy. Prior Authorization review and approval is required for

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
Q2054	Lisocabtagene maraleucel, up to 110 million autologous anti-CD19 CAR-positive viable T cells,	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0460 Chimeric Antigen Receptor (CAR)-T Cell Therapy	Procedures Q2041, Q2042, Q2053, Q2054, Q2055, Q2056, S2107 may not be an all-inclusive listing, and C9399 when utilized for a CAR-T cell therapy. Prior Authorization review and approval is required for
Q2055	Idecabtagene vicleucel, up to 460 million autologous b-cell maturation antigen (bcma)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0460 Chimeric Antigen Receptor (CAR)-T Cell Therapy	Procedures Q2041, Q2042, Q2053, Q2054, Q2055, Q2056, S2107 may not be an all-inclusive listing, and C9399 when utilized for a CAR-T cell therapy. Prior Authorization review and approval is required for
Q2056	Ciltacabtagene autoleucel, up to 100 million autologous B-cell maturation antigen (BCMA)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0460 Chimeric Antigen Receptor (CAR)-T Cell Therapy	Procedures Q2041, Q2042, Q2053, Q2054, Q2055, Q2056, S2107 may not be an all-inclusive listing, and C9399 when utilized for a CAR-T cell therapy. Prior Authorization review and approval is required for
Q4100	Skin substitute, nos	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0203 Bioengineered Skin and Tissue Substitutes	
REHAB ADMISSIONS	Rehabilitation admissions	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED		
S-Codes	HCPCS S-Codes	Effective 04/01/2024, Paramount will no longer accept S-codes, for all product lines.	Effective 04/01/2024, Paramount will no longer accept S-codes, for all product lines.		
SKILLED NURSING FACILITY	Skilled nursing facility	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED		
T1000	Private duty/independent nursing service(s),licensed, up to 15 minutes	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED		
T1001	Nursing assessment, evaluation	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED		
TRANSPLANT	Transplant prior authorization and notification	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0461 Transplant Prior Authorization and Notification	Transplant procedures include: heart transplants, liver transplants, kidney transplants, corneal transplants, lung or double lung transplants, simultaneous pancreas and kidney transplants, intestine transplants
UNLISTED PROCEDURE CODES	Unlisted procedure codes	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0097 Unlisted/Non-specific HCPCS/CPT Codes	Unlisted or not otherwise classified (NOC) and miscellaneous codes do not provide clear information about the service or item being billed. Paramount requires that additional information accompany claims for
V2520	Contact lens, hydrophilic, spherical, per lens	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0403 Therapeutic Contact Lenses	
V2521	Contact lens, hydrophilic, toric, or prism ballast, per lens	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0403 Therapeutic Contact Lenses	
V2522	Contact lens, hydrophilic, bifocal, per lens	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0403 Therapeutic Contact Lenses	
V2523	Contact lens, hydrophilic, extended wear, per lens	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0403 Therapeutic Contact Lenses	
V2530	Contact lens, scleral, gas impermeable, per lens	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0403 Therapeutic Contact Lenses	

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
V2531	Contact lens, scleral, gas permeable, per lens	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0403 Therapeutic Contact Lenses	
V2787	Astigmatism correcting function of intraocular lens	NON-COVERED	NON-COVERED	PG0063 Intraocular Lens Implant	
V2788	Presbyopia correcting function of intraocular lens	NON-COVERED	NON-COVERED	PG0063 Intraocular Lens Implant	
V5130	In ear binaural hearing aid	SEE NOTES	SEE NOTES	PG0141 Hearing Aids	The hearing aid products, dispensing fees, and repairs are covered under the hearing aid rider benefit. These are covered based on the member's benefit coverage for a specific product line or provider group.
V5140	Behind ear binaur hearing aid	SEE NOTES	SEE NOTES	PG0141 Hearing Aids	The hearing aid products, dispensing fees, and repairs are covered under the hearing aid rider benefit. These are covered based on the member's benefit coverage for a specific product line or provider group.
V5150	Binaural, glasses	SEE NOTES	SEE NOTES	PG0141 Hearing Aids	The hearing aid products, dispensing fees, and repairs are covered under the hearing aid rider benefit. These are covered based on the member's benefit coverage for a specific product line or provider group.
V5160	Dispensing fee, binaural	SEE NOTES	SEE NOTES	PG0141 Hearing Aids	The hearing aid products, dispensing fees, and repairs are covered under the hearing aid rider benefit. These are covered based on the member's benefit coverage for a specific product line or provider group.
V5211	Hearing aid, contralateral routing system binaural, ITE/ITE	SEE NOTES	SEE NOTES	PG0141 Hearing Aids	The hearing aid products, dispensing fees, and repairs are covered under the hearing aid rider benefit. These are covered based on the member's benefit coverage for a specific product line or provider group.
V5212	Hearing aid, contralateral routing system binaural, ITE/ITC	SEE NOTES	SEE NOTES	PG0141 Hearing Aids	The hearing aid products, dispensing fees, and repairs are covered under the hearing aid rider benefit. These are covered based on the member's benefit coverage for a specific product line or provider group.
V5213	Hearing aid, contralateral routing system binaural, ITE/BTE	SEE NOTES	SEE NOTES	PG0141 Hearing Aids	The hearing aid products, dispensing fees, and repairs are covered under the hearing aid rider benefit. These are covered based on the member's benefit coverage for a specific product line or provider group.
V5214	Hearing aid, contralateral routing system binaural, ITC/ITC	SEE NOTES	SEE NOTES	PG0141 Hearing Aids	The hearing aid products, dispensing fees, and repairs are covered under the hearing aid rider benefit. These are covered based on the member's benefit coverage for a specific product line or provider group.
V5215	Hearing aid, contralateral routing system binaural, ITC/BTE	SEE NOTES	SEE NOTES	PG0141 Hearing Aids	The hearing aid products, dispensing fees, and repairs are covered under the hearing aid rider benefit. These are covered based on the member's benefit coverage for a specific product line or provider group.
V5221	Hearing aid, contralateral routing system binaural, BTE/BTE	SEE NOTES	SEE NOTES	PG0141 Hearing Aids	The hearing aid products, dispensing fees, and repairs are covered under the hearing aid rider benefit. These are covered based on the member's benefit coverage for a specific product line or provider group.
V5230	Hearing aid, BiCROS, glasses	SEE NOTES	SEE NOTES	PG0141 Hearing Aids	The hearing aid products, dispensing fees, and repairs are covered under the hearing aid rider benefit. These are covered based on the member's benefit coverage for a specific product line or provider group.
V5240	Dispensing fee, BICROS	SEE NOTES	SEE NOTES	PG0141 Hearing Aids	The hearing aid products, dispensing fees, and repairs are covered under the hearing aid rider benefit. These are covered based on the member's benefit coverage for a specific product line or provider group.
V5252	Hearing aid, prog, binaural, ITE	SEE NOTES	SEE NOTES	PG0141 Hearing Aids	The hearing aid products, dispensing fees, and repairs are covered under the hearing aid rider benefit. These are covered based on the member's benefit coverage for a specific product line or provider group.
V5253	Hearing aid, prog, binaural, BTE	SEE NOTES	SEE NOTES	PG0141 Hearing Aids	The hearing aid products, dispensing fees, and repairs are covered under the hearing aid rider benefit. These are covered based on the member's benefit coverage for a specific product line or provider group.
V5260	Hearing aid, digital, binaural, ITE	SEE NOTES	SEE NOTES	PG0141 Hearing Aids	The hearing aid products, dispensing fees, and repairs are covered under the hearing aid rider benefit. These are covered based on the member's benefit coverage for a specific product line or provider group.
V5261	Hearing aid, digital, binaural, BTE	SEE NOTES	SEE NOTES	PG0141 Hearing Aids	The hearing aid products, dispensing fees, and repairs are covered under the hearing aid rider benefit. These are covered based on the member's benefit coverage for a specific product line or provider group.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
V5273	Assistive listening device, for use with cochlear implant	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
V5298	Hearing aid, not otherwise classified	SEE NOTES	SEE NOTES	PG0141 Hearing Aids	The hearing aid products, dispensing fees, and repairs are covered under the hearing aid rider benefit. These are covered based on the member's benefit coverage for a specific product line or provider group.
Experimental/Investigational medical, surgical, diagnostic, psychiatric, substance use disorders treatment or other health care services, technologies, equipment, supplies, treatments, procedures, therapies, biologics, drugs, or device that may not have a CPT/HCPCS Code, not an all-inclusive listing					
	Abbott Vascular Absorb GT1 cardiac bio absorbable stent	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Avise PG and Avise MTX	NON-COVERED	NON-COVERED	PG0362 Biomarker and Disease Activity Testing for Rheumatoid Arthritis;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Amniotic Fluid and/or Placental Tissue Biological Injections Manipulated amniotic and/or	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Annulus fibrosus repair following spinal surgery	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Arup IBD	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Left Atrial Appendage (LAA) Closure devices: to Reduce the Risk of Stroke	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Autologous fat grafting for any foot or thyroid procedures	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Autologous fat transplant with the use of adipose-derived stems cell	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Bio-Engineered Skin and Soft Tissues Substitutes	SEE NOTES	SEE NOTES	PG0203 Bio-Engineered Skin and Soft Tissue Substitutes (Excluding Skin	Bio-Engineered Skin and Soft Tissues Substitutes, refer to PG0203 for list of those products that are covered or non-covered
	Bioimpedance spectroscopy (BIS)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Bone Marrow Aspiration and Platelet Rich Plasma with ankle joint procedures	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Bone Marrow Aspiration then injection of concentrate (BMAC)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Bronchial thermoplasty	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	C-11 Choline PET scan	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	CardioMEMS HF System	NON-COVERED	NON-COVERED	PG0377 Pulmonary Artery Pressure Monitoring (CardioMEMS); PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Cartiform	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
	Catheter, balloon dilatation, non-vascular [Relieva Stratus™ MicroFlow spacer]	NON-COVERED	NON-COVERED	PG0384 Drug Eluting Devices for Use Following Endoscopic Sinus Surgery;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Ceribell EEG System (Ceribell Inc.)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Chiropractic or diagnostic procedures oActive release technique	NON-COVERED	NON-COVERED	PG0150 Chiropractic Services & Spinal Manipulation; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	CyPass Micro-Stent (FDA removed from the market)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Dry Needling oTrigger Point Injections with the dry needling technique	NON-COVERED - see above 20560 & 20561	See above 20560 &20561	PG0465 Dry Needling-Archived (refer to PG0382); PG0382 Acupuncture;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Edison System for Histotripsy of Renal Tumors	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Electrical Nerve Stimulators – experimental/investigational, not an all-inclusive listing:	NON-COVERED	NON-COVERED	PG0244 Electrical Nerve Stimulators; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	dNerva Lung Denervation System	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	D-POEM	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	The Company has determined that the following peroral endoscopic myotomy (POEM) procedures are considered investigational and not eligible for reimbursement: • Diverticular peroral endoscopic myotomy
	Dual x-ray for preventive screen of vertebral fracture	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Extracorporeal Magnetic Stimulation for Treatment of Urinary Incontinence	NON-COVERED	NON-COVERED	PG0094 Biofeedback and Neurofeedback; PG0497 Urinary	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Eustachian tube dilation procedure oSinus stents or drug-eluting implants	NON-COVERED	NON-COVERED	PG0423 Eustachian Tube Dysfunction Treatment; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Fecal Analysis in the diagnosis of Intestinal Dysbiosis oFecal analysis of the following	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
	Gene/Protein expression profiling for Breast Cancer: the following are noncovered, not an all-inclusive listing: - BBDRisk Dx, BluePrint™ Molecular Subtyping Profile, Breast Cancer Gene Expression Ratio (also known as Theros H/I, BreastOncPX, BreastPRS, Combimatrix™ Breast Cancer Profile, DCISionRT, eXagen, Invasiveness Signature, Insight® DX Breast Cancer Profile, Mammostrat, MapQuant Dx, NexCourse® Breast IHC4, NuvoSelect™ eRx 200-Gene Assa, PAM50 Breast Cancer Intrinsic Classifier, PreludeDx™'s DCISionRT® Test, Randox Assay, Rotterdam Signature 76-Panel, SYMPHONY™ Genomic Breast Cancer Profile, TargetPrint	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and Genetic Counseling	
	Glenoid resurfacing	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Guardant Reveal	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	Circulating tumor DNA (ctDNA) (also referred to as a liquid biopsy) for - Minimal residual disease (MRD) assessment and monitoring (e.g., Guardant Reveal) in breast, colorectal, and lung cancers. Minimal
	Hearing In Noise Test – HINT, also known as Speech in Noise – SIN (QuickSIN) [92700]	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	HERmark Assay	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		
	High speed laryngoscopy	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Hummingbird Tympanostomy Tube System	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Icast stent	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Intraoperative Neurological Monitoring, noncovered, not an all-inclusive listing	See Notes	See Notes	Intraoperative Visual evoked potentials (VEP) and SEMG monitoring (eg, EPAD 2), Intraoperative monitoring of motor-evoked potentials, Intraoperative SEMG monitoring (eg, EPAD 2.0)	Intraoperative Visual evoked potentials (VEP) and SEMG monitoring (eg, EPAD 2) is NOT eligible under the Plan for intraoperative VEP monitoring for any indications. This is considered experimental/investigational as it is not identified as widely used and generally accepted for the proposed use as reported in nationally recognized peer-reviewed medical literature published in the English language. Intraoperative monitoring of motor-evoked potentials using transcranial magnetic stimulation is considered experimental/investigational and therefore, noncovered because the safety and/ or effectiveness of this service cannot be established by the available peer-reviewed literature. Intraoperative SEMG monitoring (eg, EPAD 2.0) is considered experimental/investigational as it is not identified as widely used and generally accepted.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
	Ketamine for Treatment of Psychiatric Disorders and Pain Management	NON-COVERED	NON-COVERED	PG0409 Ketamine for Treatment of Psychiatric Disorders and Pain	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	miraDry	NON-COVERED	NON-COVERED	PG0466 Hyperhidrosis Treatment (excluding botox); PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Ketostrips/Ketogenic diet	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Lenire Device (Neuromod Devices Ltd.) for Tinnitus	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Night Balance Sleep Position trainer (used with sleep Apnea)	NON-COVERED	NON-COVERED	PG0247 Management of Obstructive Sleep Apnea; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Non-Medical IV Hydration Therapy Services outside of Standard Medical Practice are non-Covered.	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	NTX100 Tonic Motor Activation (TOMAC) System	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Obstructive Sleep Apnea Devices: not all-inclusive oOral Pressure Therapy (OPT)	NON-COVERED	NON-COVERED	PG0247 Management of Obstructive Sleep Apnea; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Percutaneous discectomy and decompression procedures for treating discogenic pain	NON-COVERED	NON-COVERED	PG0026 Discogenic Pain Treatment; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Peripheral nerve stimulation using the ReActiv8 Implantable Neurostimulation System and the	NON-COVERED	NON-COVERED	PG0406 Implantable Peripheral Nerve Stimulation; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Peristeen Anal Irrigation System (A4459)	COVERED	NON-COVERED	PG0413 Peristeen Anal Irrigation System; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Permanently implantable aortic counter-pulsation ventricular assist systems	NON-COVERED	NON-COVERED	PG0070 Ventricular Assist Devices,Archived 07/01/24; PG0043 Experimental Investigational Procedures Service	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Prescription Digital Therapeutics (PDTs) Health Products	NON-COVERED	NON-COVERED	PG0506 Prescription Digital Therapeutics (PDTs) Health Products	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL. The following use of a digital health product in the treatment or prevention of any health condition is considered experimental/investigational/unproven, this is not an all-inclusive listing: BlueStar Rx, Canvas Dx, d-Nav, Endeavor Rx, Freespira, Halo AF
	Pro2cool	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Progenitor Cell Therapy for the Treatment of Damaged Myocardium (CardiAMP)	NON-COVERED	NON-COVERED	PG0513 Progenitor Cell Therapy for the Treatment of Damaged Myocardium;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Prometheus nswer ADA – Serum adalimumab levels and antibodies (Serum adalimumab (ADA) levels	NON-COVERED	NON-COVERED	PG0341 Measurement of Serum Antibodies to Infliximab, Adalimumab, &	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Prometheus nswer IFX – Serum infliximab levels and antibodies (Serum infliximab (IFX) levels and	NON-COVERED	NON-COVERED	PG0341 Measurement of Serum Antibodies to Infliximab, Adalimumab, &	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Prometheus nswer UST – Serum ustekinumab levels and antibodies (Serum ustekinumab (UST) and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Prometheus nswer VDZ – Serum vedolizumab levels and antibodies (Serum drug concentration and	NON-COVERED	NON-COVERED	PG0341 Measurement of Serum Antibodies to Infliximab, Adalimumab, &	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
	Pulse Radiofrequency Ablation oNoncovered – pulsed radiofrequency denervation, laser	NON-COVERED	NON-COVERED	PG0361 Alternative Radiofrequency Methods of Denervation; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	PrismRA oMolecular signature test to predict response to TNFi therapies	NON-COVERED	NON-COVERED	PG0362 Biomarker and Disease Activity Testing for Rheumatoid Arthritis;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Prometheus Celiac PLUS panel (serology plus genetics)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Prometheus FIBROSpect HCV is considered E/I for everything except Hepatitis C	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Prometheus IBD	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Prometheus Monitr Crohn's Disease	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Quantitative Pupillography	NON-COVERED	NON-COVERED	PG0319 Quantitative Pupillometry/Pupillography; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Radiofrequency ablation with genicular nerve block for pain – Coolief.	NON-COVERED	NON-COVERED	PG0361 Alternative Radiofrequency Methods of Denervation; PG0043	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Radiofrequency ablation of microcystic lymphatic malformation in the oral cavity	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Rebuilder Medical	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Scrambler therapy	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Serum antibodies to and measurement of serum levels using nswer™ or DoseAssure™	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Somatic therapy	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Spaceoar gel is considered experimental/investigational for everything except members	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Sphenopalatine Ganglion Block	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Spinal Lysis of Adhesion	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Subacromial Spacers – saline-filled balloon for the shoulder to treat irreparably torn rotator cuff	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Thread trigger finger release (TTFR)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Topaz Coblation	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Transanal radiofrequency therapy for the treatment of fecal incontinence (e.g., Secca	NON-COVERED	NON-COVERED	PG0057 Transanal Radiofrequency Therapy; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
	Transoral Incisionless Fundoplication (TIF) – EsophyX TIF 2.0 device	NON-COVERED	NON-COVERED	PG0166 Endoscopic Therapies for Gastroesophageal Reflux	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Transrectal Ultrasound is considered experimental when using for a screening test	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Tula Iontophoresis System	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	TYRX antibacterial envelope for neurological and cardiac implants	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Vasectomy •The following vasectomy and post-vasectomy procedures (not an all-	NON-COVERED	NON-COVERED	PG0288 Vasectomy Procedures; PG0043 Experimental	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Vertebral Axial Decompression Therapy o97039-Unlisted modality [when	NON-COVERED	NON-COVERED	PG0036 Vertebral Axial Decompression Therapy.Archived 080124;	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL. Vertebral axial decompression devices (e.g., VAX-D®, Accu-SPINA System, etc.) are computer-controlled tables that apply distractive tension along the
	Vestibular Autorotation Test (VAT)	NON-COVERED	NON-COVERED	PG0323 Vestibular Function Testing	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL - Vestibular autorotation test (VAT) is considered not medically necessary and experimental/investigational for the diagnosis of individuals with
	Vibrant Capsule System	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Virtual colonoscopy using MRI oParamount considers virtual colonoscopy using MRI (76498)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Woven EndoBridge (WEB) Aneurysm Embolization System	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Z-POEM	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	The Company has determined that the following peroral endoscopic myotomy (POEM) procedures are considered investigational and not eligible for reimbursement: • Diverticular peroral endoscopic myotomy
	Zoll Heart Failure Management System (HFMS)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Spreadsheet Change History (initiated 10/7/2020)

10/07/2020: Corrected/Updated HPV Vaccine Gardasil, to match the updated (11/25/2019) Medical Policy PG0092 - Coverage ages 9-45 do not require a prior authorization. Prior authorization required for age under 9 and over age 45.

10/19/2020: Add procedure code 64451 to Medical Policy PG0345 Interventional Pain Management Injections: Sacroiliac, Epidural Steroid, Facet and Trigger Point. Procedure 64451 does not require a prior authorization.

03/01/2021: Updated line 85, indicated that the dental treatment for a member over the age of 6, for medical anesthesia in the outpatient setting, requires a prior authorization. The CPT code requiring the Prior Authorization is the unlisted procedure 41899. Added new prior authorization requirement - Effective April 1st, 2021, Prior Authorization is required for the following procedure codes: L5301, L5321, L5647, L5649, L5651, L5673, L5700, L5950, L5980, L5981, L5986, and L5987. All product lines-PG0489 Lower Limb Prostheses

04/11/2021: Corrected/Updated procedure on line 153, from 51552 to 81552. Procedure 81210 does not require a prior authorization for all product lines=removed procedure 81210 from line 58 PG0298, line 129 PG0302 and line 138 PG0041.

5/25/2021 Added procedure A9513-PG0495 Lutathera (Lutetium Lu 177 Dotatate). Added procedures Ozurdex J7312, Retisert J7311, Yutiq J7314, Dextenza J1096, and Iluvien J7313-PG0495 Intravitreal and Punctum Corticosteroid Implants. Added procedures 22867, 22868, 22869, 22870, C1821 for PG0213 INTERSPINOUS and INTERLAMINAR STABILIZATION/DISTRACTION DEVICES (SPACERS) requiring prior authorization for all product lines.

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
6/3/2021 Added the active CPT procedure codes (removed the deleted CPT codes) for medical policy PG0333 Ambulatory Electroencephalography Monitoring (EEG).					
7/1/2021 Per Behavior Health review and determination, Effective 7/1/2021 Intensive Outpatient Admissions do not require a prior authorization. Also added to that procedures 21141, 21142, 21143, 21145, 21146, 21147, 21193, 21194, 21195, 21196, 21198, 21199, 21685 are addressed in MP PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA) along with MP PG0226 Orthognathic Surgery (line #82). Also PG0026 Change title name from Minimally Invasive Treatment of Back and Neck Pain to Discogenic Pain Treatment-addressed procedure codes on excel spreadsheet. And added PG0310 PERCUTANEOUS OR MINIMALLY					
7/6/2021 Clarified that Medical Policy PG0235 Gastric Electrical Stimulation (GES), that procedures 43647, 43648, 43881, 43882 require a prior authorization. The additional procedure codes that were listed (43647, 43648, 43881, 43882, 64590, 64595, 95980, 95981, 95982, C1767, C1778, E0765, L8680, L8688) were for reference only to the medical policy.					
7/20/2021 Medical Policy PG0191 Transurethral & Transvaginal Radiofrequency for Urinary Incontinence has been Archived. Documentation/criteria incorporated into a new medical policy PG0497 Urinary Incontinence/Voiding Dysfunction Treatments and Devices					
8/17/2021: Added Medical Policy PG0215 Pneumatic Compression Devices and Supplies, Effective 10/1/2021 procedure E0652 required PA for HMO, PPO, Individual Marketplace, Elite/ProMedica Medicare Plan. Additionally, changed MP PG0218 title from Bone-Anchored Hearing Aid (BAHA) to Implantable Bone Conduction and Bone-Anchored Hearing Aids. Also, added Medical Policy PG0428 Myoelectric Upper Extremity Prosthetic Devices, Effective 10/1/2021 procedures L6026, L6611, L6646, L6648, L6715, L6880, L6881, L6882, L6920, L6925, L6930, L6935, L6940, L6945, L6950, L6955, L6960, L6965, L6970, L6975, L7007,					
9/23/2021: Added Medical Policy PG0460 Chimeric Antigen Receptor (CAR)-T Cell Therapy, procedures Q2041, Q2053, Q2053, S2107, C9073, C9076, to the PA excel spreadsheet.					
9/27/2021: Corrected the code listing under Medical Policy PG0463, procedure 22630 listed twice and procedure 22633 missing.					
9/27/2021: Updated PG0482 and PG0487 with effective date 11/1/2021 prior authorizations changes					
10/05/2021: • Per the ODM mandate; "ODM fee-for-service does not have prior authorization requirements for oxygen DME items except for E0439 (liquid oxygen). Please be advised that, for ODM FFS, in emergency situations, providers can submit or retain the requisite medical necessity documentation to support post payment reviews after the fact. For members in ambulatory settings, prior authorization requirements for oxygen should be waived in accordance with the directive given in the attached memo. Removing administrative barriers is essential in the current state due to capacity constraints and COVID					
11/01/2021: Updated PA codes on Medical Policy PG0104-Cosmetic and Reconstructive Surgery for Prior Authorization coverage details. Advantage - Procedures 15773, 15774, 15876, 15878, & 15879, require a prior authorization. And Added BLOOD-BASED BIOMARKER TEST-COLORECTAL CANCER SCREENING, procedure G0327					
11/04/2021: Per request from Utilization only the CT (PG0482) and MRI (PG0487) codes that require a prior authorization as of 11/01/2021 are to be listed on the prior authorization excel spreadsheet					
11/09/2021: Corrected the updated prior authorization coverage for HPV screening, PG0369. 87623, 87624, 87625, G0476 for ages under 21. AND 87623, 87624, 87625, G0476 for ages 21-29 and over age 65 only when the cervical cytology screening test results do not report as ASC-US or LSIL.					
11/09/2021: Updated PG0395 Leadless Pacemaker medical policy procedure codes by removing the deleted codes and only allowing the codes that need prior authorized to remain. Additionally, added medical policy PG0460 Platelet Rich Plasma with the Elite prior authorization for procedure G0460.					
12/09/2021: Added newly created medical policy PG0500 Liquid Biopsy and the related codes that require a prior authorization 86152, 86153, 0091U, 0179U, 0229U, 0239U, 0242U					
12/12/2020: Updated PA Spreadsheet for medical policy PG0141 Hearing Aids with the codes that require a prior authorization for the Advantage product line, covered binaural hearing aids & related supplies require a prior authorization, updates Effective 7/1/2021. codes v5014, v5030, v5040, v5060, v5070, v5080, v5170, v5180, v5190, v5200, v5210, v5220, v5264, v5266, v5267 do not require a prior authorization. procedures v5130, v5140, v5150, v5160, v5211, v5212, v5213, v5214, v5215, v5221, v5230, v5240, v5252, v5253, v5260, v5261, v5298 require a prior authorization					
12/13/2021: Updated PA Spreadsheet to indicated medical policy PG0501 Intradialytic Parenteral Nutrition (IDPN) requires a pre-approval/prior authorization					
01/06/2022: Removed the unlisted procedure code E1399 for the procedure code listing under Airway Clearance Devices, per Utilization Brandon Urso direction. Added verbiage regarding the unlisted procedure code Medical Policy. Also, updated the Genetic codes under MP PG0041, listing only the codes that require a prior authorization (not the noncovered codes or the codes that do not require a prior authorization), and added any needed 2022 new codes.					
01/11/2022: Updated the PA spreadsheet to indicate the change in coverage of procedure 0037U from noncoverage for the HMO, PPO and Advantage products to now allowing coverage with a prior authorization. Medical Policies PG0438 Molecular Profiling (Somatic Testing) Panels for Solid Cancer Tumors and Hematologic Malignancies and PG0041 Genetic Testing. And clarified the coverage for procedures 0022U and 81455.					
01/19/2022: Added HIGH-INTENSITY FOCUSED ULTRASOUND (HIFU) requires a prior authorization for the Elite/ProMedica Medicare Plan. Added Assertive Community Therapy, H0039 & H0040 require a prior authorization for all product lines.					
02/04/2022: Added procedure S9432 as require a prior authorization effective 4/1/2022, for all product lines.					

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
02/11/2022:Effective 1/1/2022 ODM FFS Appendix DD supports coverage for the Advantage Product line, procedures 90867, 90868, 90869.					
03/14/2022: Added missing procedure E2373, PG0284.					
3/22/2022: Added genetic codes 0016M and 0244U to the prior authorization code listing. Added procedure 43497, Peroral endoscopic myotomy (POEM), to the PA requirement, effective 5/1/2022. Added PA requirement changes to the CAR-T Cell Therapy, updated to present active codes. Procedures Q2041, Q2042, Q2053, Q2054, Q2054, Q2055, S2107 may not be an all-inclusive listing, and C9399 when utilized for a CAR-T cell therapy					
05/17/2022: Documented the PA removal of MP PG0495 Intravitreal and Punctum Corticosteroid Implants in the medical process. Now the review process will be through Magellan-with pharmacy follow-through, effective 5/11/2022. Added end-date 12/31/2021 PA and coverage for procedure G0460 for the Elite/ProMedica Medicare Plan and added PA requirement for the new 2022 procedure G0465 effective 1/1/2022 for the Elite/ProMedica Medicare Plan. Added the Home Health codes requiring a prior authroization-G0151, G0152, G0153, G0155, G0156, G0299, G0300, T1000, T1001, and 0023 Rev Code. Effective 6/1/2022 No Prior					
05/23/2022: Added that Prior Authorization is required for services in a Medicare certified Religious Nonmedical Health Care Institutions (RNHCIs), PG0490					
6/14/2022: Effective 8/1/2022 procedure 28890 went from requiring a prior authorization for all product lines to only being covered for the Advantage product with a prior authorization. Effective 7/1/2021 ODM indicated that procedure 0275T is covered, per PG0026 prior authorization is required.					
6/21/2022: Effective 8/1/2022 procedures 0424T, 0425T, 0426T, 0427T, 0431T require a prior authorization					
7/14/2022: Added the Prior Authorization required for more than two Home Sleep Study tests, PG0207					
7/19/2022: Effective 7/1/2022 no prior authorization/notification required for Clinical Trials, PG0446					
08/08/2022: Added procedures 0326U, 0334U, 0340U -All product lines and 0345U-Elite/ProMedica Medicare Plan, to the Genetic Testing prior authorization required.					
09/15/2022. Added to the Acupuncture medical policy documentation, indicating to reference the medical policy for the diagnosis codes that support coverage.					
9/20/2022. Effective 10/1/2022 procedure 43210 will now not require a PA for the Elite/ProMedica Medicare Plan product lines and procedure 43210 will now be covered for the Commercial product lines without a PA.					
9/23/2022: Added Effective 12/01/2022 procedures A4238 and E2102 require a prior authorization, for the Commercial product lines.					
10/06/2022: Added Effective 11/01/2022 procedures 64628 & 64629 require a prior authorization. Coverage went from non-coverage to covered with a prior authorization, for all product lines.					
10/18/2022: Added that procedure 81539 is now covered with a prior authorization for the Commercial product line. Also added the documentation, 2/1/2022, when procedure 81539 was covered for the Elite/ProMedica Medicare Plan product lines					
01/01/2023: Removed deleted procedure 0099T, PG0174 Intrastromal Corneal Ring segments (INTACS) updated					
01/24/2023: Clarified Medicare Advantage Plans coverage for blood glucose monitors and testing supplies effective 01/01/2023, referring to Medical Policy PG0155					
01/25/2023: Added Effective 04/01/2023 procedures A4239 and E2103 require a prior authorization, for the Paramount Commercial product lines, PG0177. Removed the prior authorization indication for Partial Hospitalization for the HMO/Individual Marketplace, PPO/CDHP and Elite/ProMedica Medicare Plan product lines, per Behavioral Health dept.					
01/27/2023: Added procedure codes 69716, 69719, 69729 and 69730 to the prior authorization coverage for PG0218 Implantable Bone Conduction and Bone-Anchored Hearing Aids, and Effective 01/01/2023 CMS has indicated procedure 69710 as reimbursement Status N-noncovered					
01/31/2023: Added procedure codes 81418, 81441, 81449, 81451, 81456 to the Genetic Testing, PG0041 prior authorization list					

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
03/20/2023: Medical Policy PG0394 archived and combined with Medical Policy PG0028. New Medical Policy title - Wireless Capsule Endoscopy & Gastrointestinal Motility Monitoring System. Effective 5/1/2023 procedure 91112 is noncovered and procedure 91113 requires a prior authorization					
03/30/2023: Added documentation to the Prior Authorization indicated for medical policy PG0375 Molecular Cytogenetic Testing = "...except when used for Hematology/Oncology indications, see medical policy for diagnosis details."					
04/14/2023: Added the Gene Therapy Medial Policies PG00518, PG0519, PG0520, PG0521, PG0522, PG0523. Added Q2056 to PG0460 prior auth listing.					
4/19/2023: Medical Policy PG0481 has been archived.					
04/25/2023: Updated the PA request assistant information at the beginning/top for the excel spreadsheet					
04/28/2023: Updated the PA spreadsheet with the missing procedure codes from MP PG0284, E1161, E1232, E1233, E1234, E1235, E1236, E1238, K0005. Additionally, removed the DME line indicating that 'ALL DME THAT EXCEEDS BENEFIT LIMITS""PRIOR AUTHORIZATION REQUIRED", as directed by Utililzation					
05/02/2023: Added procedure code 0388U requiring a PA for all product lines and procedure code 0391U requiring a PA for Mediare Advantage Plans					
5/23/2023: Added codes L8615, L8616, L8617, L8618, L8619, L8621, L8622, L8623, L8624, L8627, L8628, L8629 require PA for all product line.					
06/06/2023: Removed code 0091U from the code listing for PG0041. It is listed under PG0500 Liquid Biopsy, requiring the PA.					
06/25/2023: Updated that Intrastromal Corneal Ring Segments (INTACS), Medical Policy PG0174 was added to Medical Policy PG0289. AND clarified the PA and Coverage for Medical Policy PG0299 Abdominoplasty, Panniculectomy and Liposuction. AND added procedure E2300 requires a prior authorization for the Medicare Advantage Plans-effective 08/01/2023. AND Added the prior authorization requirement for Katemine and Esketamine. PG0409 Katamine and Esketamine for Treatment of Psychiatric Disorders and Pain Management.					
7/31/2023: Effective 10/01/2023 procedure 0326U is noncovered for the Paramount Commercial Insurance plans.					
08/16/2023: Removed procedure 19301, 19302. 19305, 19306 and 19307 from the PA listing, the codes were removed from medical policies PG0251 and PG0104.					
08/24/2023: PG0204 Viscosupplementation for Osteoarthritis.Removed procedure C9465, not needed for this policy. Removed deleted procedure J7319. Updated PA Magellan coverage for procedure J7318, J7320, J7321, J7322, J7323, J7324, J7325, J7326, J7327, J7328, J7329, and added procedure ecodes J7331, J7332, J7333, for the Paramount Commercial Insurance Plans, effective 10/01/2023. And added procedure codes J7331, J7332, J7333 for the Medicare Advantage Plans for PA Magellan coverage.					
09/01/2023: Added Partial Hospitalization Program (PHP) 567-661-0841 fax number effective 10/1/2023.					
9/20/2023 Added the prior authorization requirement for Synagis, 90378, RSV Monoclonal Antibody Palivizumab (Synagis), medical benefit, is covered with a prior authorization through Magellan MRx @ https://www1.magellanrx.com/medical-rx-prior-authorization/					
10/06/2023 Add/Clarified for Genetic Testing to refer to medical policy PG0041 Genetic Testing for details.					
10/16/2023 Added procedured 90791, 90792 per PG0530, effective 12/01/2023					
11/07/2023 Added procedure code 81554 refer to medical policy PG0041 Genetic Testing for details					
1**1/13/2023 Effective 5/17/2023, code 33289 non-covered for Medicare Advantage Plans**					

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
12/12/2023 Added codes H0035 and S0201 requires prior authorization, PG0531. Added that as of 01/01/2024 procedures 70460, 70470, 70487, 70496, 72125, 72128, 72192, 72193, 73701, 74150 and 74176 will no longer require a prior authorization. Added that as of 01/01/2024 procedures 78451, 78452, 78453 and 78454 will no longer require a prior authorization.					
12/20/2023 Effective 01/01/2024 procedure 93668 is covered for Paramount Commercial Insurance Plans - PROR AUTHORIZATION IS REQUIRED					
01/22/2024. Effective 02/01/2024 changed procedure 0047U, 81541, 81551, 0005U Commercial coverage from NonCovered to Covered with a PA. Effective 02/01/2024 changed procedure 0339U covered from NonCovered to Covered for all product lines.					
02/13/2024 Added: Effective 04/01/2024: Court Ordered/Legally Mandated Treatment requires prior authorization for all product lines. Modifier H9. Also added: Effective 02/01/2024 the prior authorization requirement has been removed from procedures 22633, 29870, 29871, 29873, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886, 29887, C1821, effective 02/01/2024, for all Product Line. Added covered procedure codes 81271, 81274, 0233U, with a PA, medical policy PG0533 Genetic Testing for Neurodegenerative Disorders. Added procedure 0421T to require a prior authorization for all					
03/18/2024 updated documentation related to medical policy PG0456 Recombiant Human Bone Morphogenetic Protein. PG0456 has been archived and added to medical policy PG0365 Bone Graft Substitutes.					
03/27/2024 Corrected procedure codes 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T and 0373T to indicated prior authorization required (was incorrectly indicating NonCovered) for the Elite (Medicare Advantage) Plan. Medical Policy PG0335 Adaptive Behavior Services for Autism Spectrum Disorders					
3/28/2024 updated coverage for procedure 0080U. Procedure 0080U was listed twice on the spreadsheet, with the commercial coverage indicating covered with a prior authorization on one line and noncovered on another line. Per medical policy PG0476 procedure 0080U is noncovered for the Paramoutn Commercial Insurance Plans.					
04/08/2024-Added Effective 04/01/2024 PRIOR AUTHORIZATION REQUIRED for the following procedure codes 81415, 81416, 81417 for the Medicare Advantage Plans, and 81425, 81426, 81427, 0094U, 0209U, 0212U, 0213U, 0214U, 0215U, 0287U, 0298U, 0299U, 0300U, 0410U, 0413U, 0417U, 0425U, 0426U for all product lines.					
06/01/2024 - Added Interqual Criteria for Medicare and Commercial plans. Added experimental/investigational code listing, from PG0043 and Genetic Services code listing, to the spreadsheet. Changed the spreadsheet title name from Prior Authorization to PRIOR AUTHORIZATION-EXPERIMENTAL/INVESTIGATIONAL-NONCOVERED SERVICES					
6/11/2024 Add procedure 75571 to allow coverage with a prior authorization, InterQual criteria, for all product lines. This procedure went from noncovered to coverered with a PA. Added noncovered procedure codes 80145, 80230, 80280. Added procedure codes 81457, 81458, 81459 all to allow coverage with a prior authorization, InterQual criteria, for all product lines. Added procedures 81462, 81463, 81464 all to allow coverage with a prior authorization, InterQual critria, for the Medicare product lines and to deny as noncovered for the Commercial product lines, per InterQual.					
06/17/2024 - Updated PG0335 codes 97151-97158 and 0373T Require a prior auth through Interqual. Updated PG0206 Laser Interstitial Theramal Therapy (LITT) codes 61736 and 61737 to require a prior auth. Add procedures A4560, A4593, A4594 as noncovered effective 08/01/2024, for all product lines.					
07/08/2024 Added Effective 08/01/2024 in-plan providers no longer require prior authorizations for home health services. Added non-covered codes Q1004, Q1005, V2787, V2788, PG0063 Intraocular Lens Implant, for all product lines. Added non-covered code E1902, for all product lines. End-dated the prior authorization requirement for procedures L5301, L5321, L5647, L5649, L5651, L5673, L5700, L5950, L5980, L5981, L5986, and L5987. Removed deleted codes 0312T, 0313T, 0314T, 0315T, 0316T, 0317T . Added Effective 07/01/2024 procedures 61736 and 61737, and unlisted procedures used to report laser interstitial thermal therapy, to require a prior authorization. Added non-covered codes 0717T and 0718T.					
07/11/2024 - added documentaion to procedures 97810-97814 to (Refer to the members Benefits of Coverage for applicable terms, conditions, and limitations) for an Commercial exceptions to coverage.					
7/18/2024 -Added documentation that procedure 43497 requires a prior authorizaiton per InterQual coverage criteria (instead of per medical policy PG0379 which is being archived). Added the noncovered Intraoperative monitoring, not an all-inclusive listing. Added documenttation that procedure E0652 requires a prior authorization per InterQual coverage criteria (insead of per medical policy PG0215).Added noncovered procedures E0677-E0682. Added procedures 20560 & 20561 and addressed Dry Needling to refer to procedures 20560 & 20561. Added documentation that procedures 22867-22870 require a prior authorizaiton per InterQual coverage criteria (instead of per medical policy PG0213 which is being archived). Added documentation for Medicare plans coverage for procedures 33274 and 33275 r/t to medical policy PG0395 Leadless Cardiac Pacemakers being Archived. Added noncovered procedures 0793T, 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, 0804T, 0823T, 0824T, 0825T, and 0826T and					
8/1/2024 Corrected procedure 81402 coverage determination, changed from InterQual coverage to Medical Policy.					
8/2/2024- Changed coverage of procedure 81418 from non-covered to covered with a prior authorization, following InterQual criteria, for the Commercial Plans effective 11/01/2024. Changed 0175U from noncovered to covered with a prior authorization, InterQual, for Elite, effective 11/01/2024. Changed 0029U, 0032U, 0033U, 0345U, 0347U, 0349U, 0350U, from noncovered to covered with a prior authorization, InterQual, for Commercial, effective 11/01/2024. Added procedure 0434U, 0460U, 0461U, 0411U, 0423U, 0438U, 0456U, 0461U effective 11/01/2024. 81283, 81346, 0380U, changed Commercial plans from covered					
08/12/2024 Removed deleted codes 0501T-0504T, effective 12/31/2023. Added code 0864T as non-covered. Added noncovered code C1782. Added noncovered codes 0461T 0862T 0863T K1030. Removed codes 22505 23700 24300 25259 26340 27570 and 27860. Add noncovered codes 21073 27275. Added noncovered codes 0393U 0412U and 0459U. Effective 08/12/2024 procedure L8625 and L8629 does not require a prior authorizaton. Added noncovered D-POEM, Z-POEM.					

Codes	Code Description	Paramount Commercial Insurance Plans	Elite (Medicare Advantage) Plans	Medical Policy	Special Instructions - Notes
08/15/2024 Changed Column D Elite (Medicare Advantage)Plans when Prior Authorization Required - Interqual to Prior Authorization Required - Follow Medicare Coverage Criteria					