PARAMOUNT
Affiliate of ProMedica

PRIOR AUTHORIZATION LIST

Call Paramount's Provider Inquiry Department at 419-887-2564 or toll-free at 1-888-891-2564.

Electronic submission is preferred. Fax prior authorization request to the appropriate fax number or toll-free at 1-866-214-2024. Prior authorizations can be emailed to Paramount's Utilization Management staff at PHCReferralManagement@ProMedica.org.

Imaging procedures can be submitted through the web-based prior authorization submission tool (McKesson's Clear Coverage), via MyParamount.org as of 2/1/18.

Note: All products/benefit packages may not require prior authorization.

Providers: Please call Provider Inquiry at 419-887-2564 or toll-free at 1-888-891-2564.

Members: Please call Member Services at 419-887-2525 or toll-free 1-800-462-3589. TTY service for the hearing impaired is available at 419-887-2526 or toll-free at 1-888-740-5670. Hours of operation are Monday through Friday (excluding holidays) are: Commercial products 8am to 5pm; Paramount Advantage 7am-7pm; Paramount Elite 8am to 8pm.

NOTE: Prior Authorizations are required for payment for primary, secondary, or tertiary coverage. Retro-authorization reviews/provider appeals for denied claims for failure to follow precertification requirements will be considered for review for the following exception: the member represented as a self-pay. As a registered user to the Paramount Portal, you may also verify Paramount eligibility on MyParamount.org.

Call Paramount 's Utilization/ Case Management Department at 419-887-2520 or toll-free at 1-800-891-2520.

Updated 3/15/2018

PRIOR AUTHORIZATION REQUIRED = X

SERVICE/PROCEDURE	HMO/ Individual Marketplace	PPO	ELITE	ADVANTAGE	CODES	MEDICAL POLICY
ACTIGRAPHY	NON-COVERED	NON-COVERED	X	X	95803	PG0198 Actigraphy and Accelerometry
ACUPUNCTURE	NON-COVERED	NON-COVERED	NON-COVERED	Effective 10/01/17 X	97810-97814 Treatments beyond five (5) visits without proven success & treatments beyond twenty (30) visits per calendar year	PG0382 Acupuncture
ALL OUT OF NETWORK SERVICES (EXCEPT ER)	X	X	X	X		
AMBULATORY EEG MONITORING REQUIRES PRIOR AUTHORIZATION FOR >3DAYS	X	X	X	X	95950, 95951, 95953, 95956, 95957 requires prior authorization for > 3 days.	PG0333 Ambulatory EEG Monitoring
CHILDREN'S INTENSIVE BEHAVIORAL SERVICE & APPLIED BEHAVIORAL ANALYSIS (ABA)	X	X	NON-COVERED	NON-COVERED	96150-96155, 0359T-0374T	PG0335 Applied Behavioral Analysis (ABA)
ARTIFICIAL INTERVERTEBRAL DISC REPLACEMENT - CERVICAL ARTIFICIAL DISC REPLACEMENT AT MORE THAN ONE LEVEL	X	X	X	X	22858	PG0027 Artificial Intervertebral Disc Replacement
ARTIFICIAL INTERVERTEBRAL DISC REPLACEMENT - LUMBAR ARTIFICIAL DISC REPLACEMENT AT ONE LEVEL	X	X	X	NON-COVERED	22857	PG0027 Artificial Intervertebral Disc Replacement
AUTISM TREATMENT (MICHIGAN MEMBERS ONLY)	X	X	X	X		
AVISE PG	NON-COVERED	NON-COVERED	X	NON-COVERED	84999	PG0194 Avise PG
BINAURAL HEARING AIDS	NO	NO	NO	X	V5014, V5030, V5040, V5060, V5070, V5080, V5130, V5140, V5150, V5160, V5170, V5180, V5190, V5200, V5210, V5220, V5230, V5240, V5252, V5253, V5260, V5261, V5264, V5266, V5267, V5298	PG0141 Hearing Aids

BARIATRIC SURGERY; REMOVAL OF GASTRIC RESTRICTIVE DEVICE	X	X	X	X	43644, 43645, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43850, 43886, 43887, 43888, S2083	PG0163 Bariatric Services
BLEPHAROPLASTY	X	X	X	NON-COVERED	15820-15822	PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift
BLEPHAROPLASTY	X	X	X	X	15823	PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift
BROW PTOSIS, UPPER EYELID BLEPHAROPTOSIS REPAIR, LID RETRACTION	X	X	X	X	67900, 67901– 67909, 67911	PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift
BRONCHIAL THERMOPLASTY	NON-COVERED	NON-COVERED	NON-COVERED	X	31660, 31661	PG0316 Bronchial Thermoplasty
CANDELA LASER - PULSED DYE LASER (PDL) THERAPY FOR CUTANEOUS VASCULAR LESIONS	X	X	X	X	17106, 17107, 17108	PG0308 Pulsed Dye Laser Therapy for Cutaneous Vascular Lesions
CARTICEL - AUTOLOGOUS CHONDROCYTE TRANSPLANTATION (ACT)/AUTOLOGOUS CHONDROCYTE IMPLANTATION (ACI)	X	X	X	X	27412, J7330	PG0190 Chondrocyte Implantation of the Knee
CARTICEL - AUTOLOGOUS CHONDROCYTE TRANSPLANTATION (ACT)/AUTOLOGOUS CHONDROCYTE IMPLANTATION (ACI)	X	X	NON-COVERED	NON-COVERED	S2112	PG0190 Chondrocyte Implantation of the Knee
FETAL CHROMOSOMAL MICRODELETION	NON-COVERED	NON-COVERED	NON-COVERED	X	81422	PG0287 Cell-Free DNA Tests For Fetal Aneuploidy
CELL-FREE DNA TESTING (e.g., MaterniT21™, Verifi™, Harmony™, Panorama™)	X	X	X	X	81420	PG0287 Cell-Free DNA Tests For Fetal Aneuploidy
CHIROPRACTIC SERVICES & SPINAL MANIPULATION FOR CHILDREN 0-3 YEARS OF AGE	X	X	X	X	98940-98943	PG0150 Chiropractic Services & Spinal Manipulation
COCHLEAR (TRADITONAL) & AUDITORY BRAINSTEM IMPLANTS	X	X	X	X	69930, L8614, S2235	PG0281 Cochlear and Auditory Brainstem Implants
CONTINUOUS BLOOD GLUCOSE MONITORING SYSTEMS – LONG TERM	X	X	X	X	A9276, A9277, A9278, S1030, S1031	PG0177 Continuous Blood Glucose Monitoring Services
CONTINUOUS BLOOD GLUCOSE MONITORING SYSTEMS – LONG TERM	X	X	X	NON-COVERED	K0553, K0554	PG0177 Continuous Blood Glucose Monitoring Services
DRUG TESTING	X	X	X	X	Refer to PG0069 Urine Drug Testing for specifics: G0431, G0434, G0477-G0483, G6030-G6058, 80300-80307, 80320-80347, 80348, 80349-80374, 80375-80377, 83992	PG0069 Drug Testing
ELECTRICAL STIMULATION THERAPY (NMES, FES)	NON-COVERED	NON-COVERED	X	NON-COVERED	E0744, E0745, E0764, E0770, 64565	PG0228 Electrical Stimulation Therapy
ELECTRONIC BRACHYTHERAPY	NON-COVERED	NON-COVERED	X	NON-COVERED	0182T, 0394T, 0395T	PG0315 Electronic Brachytherapy
EXTERNAL COUNTERPULSATION THERAPY (ECP)	X	X	X	G0166 NON-COVERED	G0166, 92971	PG0209 External Counterpulsation
EXTRACORPOREAL SHOCK WAVE FOR PLANTAR FASCIITIS	X	X	X	X	28890	PG0004 Extracorporeal Shock Wave Therapy (ESWT)
FRENECTOMY OR FRENOTOMY OF THE LINGUAL FRENULUM FOR ANKYLOGLOSSIA FOR MEMBERS ≥1 YEAR OF AGE	X	X	X	X	41010, 41115, 41520	PG0407 Frenectomy or Frenotomy for Ankyloglossia
FRENECTOMY OR FRENOTOMY	NON-COVERED	NON-COVERED	NON-COVERED	X	40806, 40819	PG0407 Frenectomy or Frenotomy for Ankyloglossia
GASTRIC NEUROSTIMULATOR	X	X	X	X	43647, 43648, 43881, 43882, 64590, 64595, 95980, 95981, 95982, C1767, C1778, E0765, L8680, L8688	PG0235 Gastric Electrical Stimulation (GES)
GENDER REASSIGNMENT SURGERY	X	X	X	NON-COVERED	55970, 55980	PG0311 Gender Reassignment Surgery
HOME HEALTH CARE	X	X	X	X		

HPV VACCINES - PRIOR AUTHORIZATION FOR ONLY 27YO OR OLDER	X	X	NON-COVERED	X	90649, 90650, 90651 - If the HMO, PPO, Individual Marketplace, or Advantage member began the vaccine series before age 27, but the three part vaccine series is not completed by the time they reach age 27, the additional doses will be covered with prior authorization. This does not apply for the University of Toledo benefit contract.	PG0092 HPV Vaccine Gardasil and Cervarix
INJECTABLE BULKING AGENTS (SOLESTA) FOR TREATMENT OF FECAL INCONTINENCE	NON-COVERED	NON-COVERED	X	NON-COVERED	L8605, 0377T	PG0260 Injectable Bulking Agents for Fecal Incontinence
IMPLANTABLE MINIATURE TELESCOPE (IMT)	X	X	X	NON-COVERED	0308T	PG0351 The Implantable Miniature Telescope (IMT)
IMPLANTABLE TESTOSTERONE PELLETS (TESTOPEL)	X	X	X	X	S0189, 11980	PG0225 Implantable Testosterone Pellets
INPATIENT HOSPITAL ADMISSIONS	X	X	X	X		
INTENSIVE OUTPATIENT ADMISSIONS	X	X	X	X		
INTERACTIVE DIAGNOSTIC INTERVIEW/PSYCHOTHERAPY FOR MEMBERS 18 YRS AND OLDER	X	X	X	X		
INTERSPINOUS PROCESS DECOMPRESSION DEVICE (X-STOP)	NON-COVERED	NON-COVERED	X	X	22867-22870, C1821	PG0213 Interspinous Process Decompression Devices
INTRASTROMAL CORNEAL RING SEGMENTS (INTACS)	X	X	X	X	0099T, 65785	PG0174 Intrastromal Corneal Ring Segments (INTACS)
LEADLESS CARDIAC PACEMAKERS	NON-COVERED	NON-COVERED	X	NON-COVERED	0387T-0391T	PG0395 Leadless Cardiac Pacemakers
LIPECTOMY	NON-COVERED	NON-COVERED	NON-COVERED	X	15876, 15878, 15879	PG0104 Cosmetic and Reconstructive Surgery
LIPOSUCTION/ABDOMINAL SUCTION-ASSISTED LIPECTOMY	NON-COVERED	NON-COVERED	NON-COVERED	X	15877	PG0299 Abdominoplasty, Panniculectomy and Liposuction
MAGNETIC SOURCE IMAGING (MSI)	X	X	NON-COVERED	NON-COVERED	S8035	PG0186 Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)
MAGNETOENCEPHALOGRAPHY (MEG)	X	X	X	X	95965, 95966, 95967	PG0186 Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)
MAMMOPLASTY, REDUCTION	X	X	X	X	19318	PG0054 Reduction Mammoplasty
MANDIBULAR MAXILLARY OSTEOTOMY AND ADVANCEMENT AND/OR GENIGLOSSUS ADVANCEMENT WITH OR WITHOUT HYOID SUSPENSION	X	X	X	X	21141, 21145, 21196, 21199, 21685	PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)
MANUAL THERAPY	X	X	X	X	97140 - Prior authorization required for children 0-3 years of age for all product lines	PG0158 Physical Therapy (PT) and Occupational Therapy (OT)
MASTECTOMY FOR GYNECOMASTIA	X	X	X	X	19300	PG0221 Mastectomy for Gynecomastia
NEW TECHNOLOGY (MEDICAL & BEHAVIORAL HEALTH PROCEDURES, DIAGNOSTICS, DURABLE MEDICAL EQUIPMENT)	X	X	X	X		
OCCIPITAL NERVE BLOCK THERAPY	X	X	X	X	64405 - Prior authorization is required for seven (7) injections or more per calendar year	PG0389 Occipital Nerve Block Therapy for the Treatment of Headache and Occipital Neuralgia
ORAL APPLIANCES FOR OBSTRUCTIVE SLEEP APNEA – CUSTOM	X	X	X	X	E0486	PG0131 Custom Oral Appliance for OSA

ORTHOGNATHIC/MAXILLOFACIAL SURGERY	X	X	X	X	21120-21123, 21125, 21127, 21141-21143, 21145-21147, 21150, 21151, 21154, 21155, 21159, 21160, 21181-21184, 21188, 21193-21196, 21198, 21199, 21206, 21208-21210, 21215, 21230, 21240, 21244-21249, 21255, 21270, 21275, 21295, 21296	PG0226 Orthognathic Surgery
OTOPLASTY	X	X	X	X	69300	PG0376 Otoplasty
PANCREATIC ISLET CELL TRANSPLANTATION	X	X	X	X	48160	PG0415 Pancreatic Islet Cell Transplantation
PANCREATIC ISLET CELL TRANSPLANTATION	NON-COVERED	NON-COVERED	X	NON-COVERED	S2102	PG0415 Pancreatic Islet Cell Transplantation
PANNICULECTOMY (15830) AND ABDOMINOPLASTY (15847)	X	X	X	X	15830, 15847	PG0299 Abdominoplasty, Panniculectomy and Liposuction
PARTIAL HOSPITALIZATION	X		X	X		
PEDIATRIC DENTAL GENERAL ANESTHESIA IN AN OUTPATIENT SETTING (OVER AGE 5)	X	X	X	X	41899	
PERCUTANEOUS & ENDOSCOPIC SPINAL SURGERY AND THERMAL INTRADISCAL PROCEDURES	NON-COVERED	NON-COVERED	NON-COVERED	X	22526, 22527, 62287	PG0026 Minimally Invasive Treatment of Back and Neck Pain
PERCUTANEOUS OR MINIMALLY INVASIVE SACROILIAC JOINT STABILIZATION FOR SACROILIAC JOINT FUSION	NON-COVERED	NON-COVERED	NON-COVERED	X	27279	PG0310 Sacroiliac Joint Fusion
PERIPHERAL ARTERY DISEASE (PAD)	NON-COVERED	NON-COVERED	X	NON-COVERED	93668	PG0414 Peripheral Artery Disease (PAD) Rehabilitation
POTENTIALLY COSMETIC SURGERY	X	X	X	X		
PROPHYLACTIC MASTECTOMY- RISK REDUCTION THERAPY (NO CANCER)	X	X	X	X	V50.41	PG0251 Prophylactic Mastectomy
RADIOFREQUENCY THERAPY FOR GERD (STRETTA SYSTEM)	NON-COVERED	NON-COVERED	NON-COVERED	X	43257, 43284, 43285	PG0166 Endoscopic Therapies for Gastroesophageal Reflux Disease (GERD)
RADIOREQUENCY VOLUMETRIC TISSUE REDUCTION (RFVTR) OF THE SOFT PALATE, UVULA, OR TONGUE BASE (e.g., Coblation®, Somnoplasty®)	NON-COVERED	NON-COVERED	NON-COVERED	X	41530	PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)
REHABILITATION ADMISSIONS	X	X	X	X		
RESPITE BEHAVIORAL HEALTH	NON-COVERED	NON-COVERED	NON-COVERED	X <21 YO	S5150, S5151 PER MEDICAID REQUIREMENTS	
RESPITE MEDICAL CARE	NON-COVERED	NON-COVERED	NON-COVERED	X <21 YO	S5150, S5151 PER MEDICAID REQUIREMENTS 5160-26-03	
REMOVAL OF MAMMARY IMPLANT	X	X	X	X	19328, 19330, 19370, 19371	PG0012 Breast Implant Removal
RHINOPLASTY	X	X	X	X	30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, 30465	PG0009 Rhinoplasty and Septoplasty
RHINOMANOMETRY AND ACOUSTIC/OPTICAL RHINOMETRY	NON-COVERED	NON-COVERED	NON-COVERED	X	92512	PG0045 Rhinomanometry and Acoustic - Optical Rhinometry
SKILLED NURSING FACILITY ADMISSIONS	X	X	X	X		
SPINAL CORD STIMULATION	X	X	X	X	63650, 63655, 63685	PG0253 Spinal Cord Stimulation
SUBTALAR ARTHROERESIS	X	X	X	X	S2117, 0335T	PG0321 Subtalar Arthroeresis
TEMPORAL BONE OSSEOINTEGRATED IMPLANTS (BAHA)	X	X	X	X	69710, 69711, 69714, 69715, 69717, 69718, L8690, L8691, L8692, L8693	PG0218 Bone-Anchored Hearing Aid (BAHA)
THERAPEUTIC CONTACT LENSES	X	X	X	X	V2520, V2521, V2522, V2523, V2530	PG0403 Therapeutic Contact Lenses
THERAPEUTIC CONTACT LENSES	X	X	NON-COVERED	NON-COVERED	S0515	PG0403 Therapeutic Contact Lenses

THERAPEUTIC CONTACT LENSES	X	X	X	NON-COVERED	V2531	PG0403 Therapeutic Contact Lenses
TOTAL ANKLE REPLACEMENT	X	X	X	X	27702, 27703	PG0151 Total Ankle Replacement
TONGUE BASE SUSPENSION	NON-COVERED	NON-COVERED	X	X	41512	PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)
TRANSCRANIAL MAGNETIC STIMULATION (TMS)	X	X	X	NON-COVERED	90867, 90868, 90869	PG0294 Transcranial Magnetic Stimulation (TMS)
TRANSPUPILLARY THERMOTHERAPY	X	X	X	X	67299	PG0149 Transpupillary Thermotherapy (TTT)
TRANSURETHRAL RADIOFREQUENCY	NON-COVERED	NON-COVERED	NON-COVERED	X	53860	PG0191 Transurethral & Transvaginal Radiofrequency for Urinary Incontinence
TREATMENT OF OPIOID DEPENDENCE	COVERED W/O PA	COVERED W/O PA	COVERED W/O PA	X	H0016	PG0313 Treatment of Opioid Dependence
TUMOR TREATMENT FIELD (TTF) THERAPY (i.e., OPTUNE)	X	X	X	X	E0766	PG0371 Tumor Treatment Field Therapy for Glioblastoma
VISION THERAPY	X	X	X	X	92065	PG0318 Vision Therapy
WIRELESS CAPSULE ENDOSCOPY (PILL CAM)	X	X	X	X	91110, 91111	PG0028 Wireless Capsule Endoscopy
WIRELESS GASTROINTESTINAL MOTILITY MONITORING SYSTEM (SMARTPILL)	X	X	X	X	91112	PG0394 Wireless Gastrointestinal Motility Monitoring System
GENETIC TESTING: Prior authorization is required for genetic testing unless otherwise noted in one of our policies.						
BRCA & BART TESTING FOR BREAST CANCER AND/OR OVARIAN CANCER	X	X	X	X	81162, 81211, 81212, 81213, 81214, 81215, 81216, 81217, 81432, 81445, 81455	PG0067 Genetic Testing for Breast and Ovarian Cancers
BRCA & BART TESTING FOR BREAST CANCER AND/OR OVARIAN CANCER	NON-COVERED	NON-COVERED	NON-COVERED	X	81433	PG0067 Genetic Testing for Breast and Ovarian Cancers
CARDIAC CONDITIONS GENETIC TESTING	X	X	X	X	81413, 81414, 81439, S3865, S3866	PG0280 Genetic Testing for Cardiac Conditions
COMPARATIVE GENOMIC HYBRIDIZATION (CGH) GENETIC TESTING	X	X	X	81228 & 81229 REQUIRES PA/ S3870 is NON-COVERED	81228, 81229, S3870	PG0296 Comparative Genomic Hybridization (CGH)
CORUS® CAD GENETIC TESTING	NON-COVERED	NON-COVERED	X	NON-COVERED	81493	PG0363 CORUS® CAD
DMD GENE MUTATIONS GENETIC TESTING	X	X	X	X	81161, 81408	PG0411 Genetic Testing for Duchenne and Becker Muscular Dystrophy
FAMILIAL ADENOMATOUS POLYPOSIS(FAP) GENETIC TESTING	X	X	X	X	81201, 81202, 81203	PG0302 Genetic Testing for Colorectal Cancer
FRAGILE X SYNDROME GENETIC TESTING	X	X	NON-COVERED	X	81243, 81244	PG0360 Genetic Testing for FMR1 Mutations Including Fragile X Syndrome
GENE EXPRESSION ANALYSIS FOR PROSTATE CANCER GENETIC TESTING	X	X	X	X	81313, 81479	PG0367 Gene Expression Analysis for Prostate Cancer
GENESIGHT® ASSAY FOR REFRACTORY DEPRESSION GENETIC TESTING	NON-COVERED	NON-COVERED	X	NON-COVERED	81479	PG0368 GeneSight® Assay for Refractory Depression

GENETIC EXPRESSION ASSAYS FOR BREAST CANCER PROGNOSIS: - ONCOTYPE DX BREAST CANCER ASSAY (81519) - MAMMAPRINT (81521) - PROSIGNA BREAST CANCER ASSAY (81520, 0008M) - BREAST CENCER INDEX (81479) - ENDOPREDICT (81479, S3854)	X	X	X (S3854 IS NON-COVERED)	X	81479, 81519, 81520, 81521, 0008M, S3854	PG0301 Genetic Expression Assays for Breast Cancer Prognosis
GENETIC EXPRESSION ASSAYS FOR BREAST CANCER PROGNOSIS: - HERMARK ASSAY (81479)	NON-COVERED	NON-COVERED	X	NON-COVERED	81479	PG0301 Genetic Expression Assays for Breast Cancer Prognosis
GENETIC TESTING	X	X	X	X	81105, 81106, 81107, 81108, 81109, 81110, 81111, 81112, 81120, 81121, 81162, 81175, 81176, 81201, 81202, 81203, 81211-81217, 81225, 81226, 81227, 81228, 81229, 81235, 81238, 81247, 81248, 81249, 81280-81282, 81283, 81287, 81288, 81292-81301, 81317-81319, 81321, 81322, 81323, 81332, 81334, 81335, 81346, 81400-81408, 81420, 81432, 81435, 81436, 81445, 81448, 81450, 81455, 81479, 81509, 81599	PG0041 Genetic Testing
GENETIC TESTING	NON-COVERED	NON-COVERED	NON-COVERED	X	81200, 81205, 81209, 81230, 81231, 81232, 81252, 81253, 81254, 81257, 81260, 81290, 81324, 81325, 81326, 81330, 81331, 81410, 81411, 81412, 81415, 81416, 81417, 81425, 81426, 81427, 81430, 81431, 81433, 81434, 81438, 81440, 81442, 81460, 81465, 81470, 81471, 81539	PG0041 Genetic Testing
GENETIC TESTING	X	X	X	NON-COVERED	81504	PG0041 Genetic Testing
GENETIC TESTING	X	X	NON-COVERED	X	81242, 81251, 81258, 81259, 81269, 81302, 81303, 81304, 81328, 81361, 81362, 81363, 81364	PG0041 Genetic Testing
HEREDITARY THROMBOPHILIA	X	X	X	X	81240, 81241	PG0355 Genetic Testing for Hereditary Thrombophilia
HEREDITARY THROMBOPHILIA	NON-COVERED	NON-COVERED	NON-COVERED	X	81291	PG0355 Genetic Testing for Hereditary Thrombophilia
LYNCH SYNDROME GENETIC TESTING	X	X	X	X	81292, 81293, 81294, 81295, 81296, 81297, 81298, 81299, 81300, 81301, 81317, 81318, 81319, 81403	PG0302 Genetic Testing for Colorectal Cancer
PTEN GENE TESTING	X	X	X	X	81321-81323, 81432, 81435, 81436, 81445, 81455	PG0336 PTEN Gene Testing

SPINAL MUSCULAR ATROPHY (SMA) GENETIC TESTING	X	X	X	X	81400, 81401, 81403, 81404, 81405, 81406, 81408, 81479	PG0398 Genetic Testing for Spinal Muscular Atrophy
VERISTRAT GENETIC TESTING	X	X	X	NON-COVERED	81538	PG0111 VeriStrat® Testing
IMAGING PROCEDURES:						
PRIOR AUTHORIZATION IS REQUIRED FOR IMAGING PROCEDURES PERFORMED IN AN ELECTIVE OUTPATIENT SETTING. PRIOR AUTHORIZATION IS NOT REQUIRED FOR IMAGING PROCEDURES PERFORMED IN THESE SETTINGS: • EMERGENCY DEPARTMENT • FACILITY OBSERVATION SETTING • INPATIENT SETTING						
COMPUTERIZED TOMOGRAPHY (CT) COMPUTERIZED TOMOGRAPHY ANGIOGRAPHY (CTA) OF THE CORONARY ARTERIES MAGNETIC RESONANCE IMAGING (MRI) MAGNETIC RESONANCE ANGIOGRAPHY (MRA)	X	X	X	X	70450, 70460, 70470, 70480, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 71250, 71260, 71270, 71550, 71551, 71552, 71555, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72192, 72193, 72194, 72195, 72196, 72197, 72198, 73200, 73201, 73202, 73218, 73219, 73220, 73221, 73222, 73223, 73225, 73700, 73701, 73702, 73718, 73719, 73720, 73721, 73722, 73723, 73725, 74150, 74160, 74170, 74176, 74177, 74178, 74181, 74182, 74183, 74185, 74261, 74262, 74263, 75557, 75559, 75561, 75563, 75571, 75572, 75573, 75574, 76380, 76497, 76498, 78599, C8900, C8901, C8902, C8903, C8904, C8905, C8910, C8911, C8912, C8913, C8914, C8918, C8919, C8920, C8931, C8932, C8933, C8934, C8935, C8936, S8037, S8042, S8080	
CT SCREENING FOR LUNG CANCER	X	X	X	X	G0296, G0297	PG0049 CT Screening for Lung Cancer in Heavy Smokers
CT VIRTUAL COLONSCOPY	X	X	X	X	74261-74263	PG0182 Virtual Colonoscopy
DURABLE MEDICAL EQUIPMENT:						
ALL DME THAT EXCEEDS BENEFIT LIMITS	X	X	X	X		
AIR FLUIDIZED BEDS	X	X	X	X	E0194	PG0352 Air Fluidized Bed
BONE GROWTH STIMULATORS	X	X	X	X	E0747, E0748, E0749, E0760	PG0232 Bone Growth Stimulating Services-Devices (Osteogenic Stimulators)
CRANIAL ORTHOTIC REMOLDING DEVICE	X	X	X	NON-COVERED	L0112, L0113	PG0120 Cranial Orthotic Devices

CRANIAL ORTHOTIC REMOLDING DEVICE	X	X	NON-COVERED	X	S1040	PG0120 Cranial Orthotic Devices
ENTERAL NUTRITION	X	X	X	X	B4102-B4155, B4158-B4161. B4157 & B4162 - Prior authorization required if NOT diagnosed with inborn errors of metabolism	PG0114 Enteral and Parenteral Nutrition
GLUCOSE TESTING SUPPLIES REQUIRE PRIOR AUTHORIZATION FOR COVERED CODES IF EXCEEDS BENEFIT LIMITS	X	X	X	X	A4252, A4253, A4255, A4256, A4257, A4258, A4259, E0607, E2100, E2101 S5560, S5561, S5565, S5566, S5570, S5571, S8490 - Prior authorization required for glucose testing supplies if benefit limits are exceeded	PG0155 Glucose Testing Supplies
HOME UVB PHOTOTHERAPY TREATMENT DEVICES	X	X	X	X	E0691-E0693	PG0383 Home Phototherapy for Dermatologic Conditions
HOSPITAL GRADE BREAST PUMP	X	X	X	X	E0604 - Prior authorization required if utilized for more that 6 months	PG0201 Breast Pump Equipment/Supplies and Counseling
POWER OPERATED VEHICLES, INCLUDING POWER OPERATED WHEELCHAIRS	X	X	X	X	E0985, E1230, E1239, K0010-K0014, K0800-K0802, K0806-K0808, K0812-K0816, K0820-K0831, K0835-K0843, K0848-K0864, K0868-K0871, K0877-K0880, K0884-K0886, K0890, K0891, K0898, K0899	PG0284 Power Mobility Devices
SPEECH GENERATING DEVICES	X	X	X	X	E2500, E2502, E2504, E2506, E2508, E2510, E2511, E2512, E2599	PG0135 Speech Generating Devices
WEARABLE CARDIOVERTER DEFIBRILLATORS	X	X	X	X	K0606	PG0224 Cardioverter Defibrillators
PROSTHETICS:						
ALL ORTHOTICS / PROSTHETICS THAT EXCEEDS BENEFIT LIMITS INITIAL PURCHASE ONLY			X			
INJECTABLES:						
SEE “SPECIALTY DRUG LIST” (UNDER PRESCRIPTION DRUG PROGRAM TAB/SPECIALTY DRUG PROGRAM TAB OF THIS SITE)						
DENTAL PROCEDURES:						
CLICK HERE FOR PARAMOUNT ADVANTAGE DENTAL PRIOR AUTH LIST						