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
Mental Health, Chemical Dependency, and Partial Hospitalization Program (PHP)-567-661-0841
Home Health Care- 567-661-0843 Effective 08/01/2024 in-plan providers no longer require prior authorizations.
Imaging- 567-661-0844
Inpatient Acute Care- 567-661-0845
Med Surg/DME/Genetics- 567-661-0846
Out of Plan- 567-661-0847
SNF/Rehab/LTAC- 567-661-0848
Provider Clinical Appeals- 567-585-9500

Prior authorization is required for genetic testing unless otherwise noted in one of our policies. Refer to Medical Policy PG0041 Genetic Testing table for specific Coverage, Non-coverage, Medical Policy specifics, and Prior Authorization Requirements.

Inpatient rehabilitation admissions require a prior authorization.

Effective 04/01/2024: Court Ordered/Legally Mandated Treatment requires prior authorization for all product lines. Modifier H9.

Prior authorizations and supporting clinical documentation can be emailed to Paramount's Utilization Management staff at PHCUCMClerical@medmutual.com

Prior authorization is required for imaging procedures performed in an elective outpatient setting. Prior authorization is NOT required for imaging procedures performed in emergency department, facility

NOTE: All products/benefit packages may not require prior authorization. Prior authorizations are required for payment for primary, secondary, or tertiary coverage. Non-participating providers are required to obtain prior authorization for all nonemergent services before services are rendered. Paramount will not pay claims for services in which prior authorization is required, but not obtained by the provider. If an in-plan provider fails to obtain a prior authorization before rendering services claims will be denied with NO PATIENT LIABILITY. If you have registered as a Paramount Portal user, you may also verify Paramount eligibility on MyParamount.org. Paramount provides an easy hassle-free process to submit Prior Authorizations electronically. Please visit https://www.myparamount.org/. Call Paramount's Utilization Management Department at 419-887-2520 or toll-free at 1-800-891-2520

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 06/10/2025

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/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 Setting	Prior authorization is required for CPT codes 00170 and 41899, when related to dental procedures in the facility setting

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
10040	Acne surgery (e.g., marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PG0348 Acne Surgery, Dermabrasion and Chemical Peels	Covered for diagnosis L70.0-L70.9, L71.0-L71.9, L72.11-L72.12
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	**PG0105 Benign Skin Lesion Removal.- Archived 3/1/2025** PG0104 Cosmetic and Reconstructive Surgery	
11201	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	**PG0105 Benign Skin Lesion Removal.- Archived 3/1/2025** PG0104 Cosmetic and Reconstructive Surgery	
11920	Intradermal tattooing; 6sq cm or less	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY **(See Notes)**	PG0144 Breast Reconstruction Services. PG0104 Cosmetic and Reconstructive Surgery	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications.** Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery
11921	Intradermal tattooing; 6.1 to 20sq cm	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY **(See Notes)**	PG0144 Breast Reconstruction Services. PG0104 Cosmetic and Reconstructive Surgery	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications.** Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery
11922	Intradermal tattooing; each additional 20sq cm or part thereof	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY **(See Notes)**	PG0144 Breast Reconstruction Services. PG0104 Cosmetic and Reconstructive Surgery	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications.** Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery
11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0104 Cosmetic and Reconstructive Surgery	
11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0cc	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0104 Cosmetic and Reconstructive Surgery	
11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0cc	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0104 Cosmetic and Reconstructive Surgery	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0cc	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0104 Cosmetic and Reconstructive Surgery	
11970	Replacement of tissue expander with permanent prosthesis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY **(See Notes)**	PG0144 Breast Reconstruction Services. PG0104 Cosmetic and Reconstructive Surgery	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications.** Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery
11971	Removal of tissue expander(s) without insertion of prosthesis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY **(See Notes)**	PG0144 Breast Reconstruction Services. PG0104 Cosmetic and Reconstructive Surgery	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications.** Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery
11980	Subcutaneous hormone pellet implantation (implantation of Estradiol and/or testosterone pellets beneath the skin)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0225 Implantable Testosterone Pellets (Testopel®)	
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY **(See Notes)**	PG0144 Breast Reconstruction Services. PG0104 Cosmetic and Reconstructive Surgery	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications**. Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs, 50cc or less injectate	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY **(See Notes)**	PG0144 Breast Reconstruction Services. PG0104 Cosmetic and Reconstructive Surgery	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications**. Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate	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 indications support medical necessity. Cosmetic Services performed solely to improve one's appearance and/or self-esteem are considered not medically necessary and therefore not covered.
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)	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 indications support medical necessity. Cosmetic Services performed solely to improve one's appearance and/or self-esteem are considered not medically necessary and therefore not covered.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
15775	Punch graft for hair transplant; 1 to 15 punch grafts	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0104 Cosmetic and Reconstructive Surgery	
15776	Punch graft for hair transplant; more than 15 punch grafts	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0104 Cosmetic and Reconstructive Surgery	
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PG0348 Acne Surgery, Dermabrasion and Chemical Peels	Covered for diagnosis L57.0 & C44.01, C44.111 - C44.1192, C44.211 - C44.219, C44.310 - C44.319, C44.41, C44.510 - C44.519, C44.611 - C44.619, C44.711 - C44.719, C44.81, C44.91, L71.0, L71.1, L71.8
15781	Dermabrasion; segmental, face	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PG0348 Acne Surgery, Dermabrasion and Chemical Peels	Covered for diagnosis L57.0 & C44.01, C44.111 - C44.1192, C44.211 - C44.219, C44.310 - C44.319, C44.41, C44.510 - C44.519, C44.611 - C44.619, C44.711 - C44.719, C44.81, C44.91, L71.0, L71.1, L71.8
15782	Dermabrasion; regional, other than face	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PG0348 Acne Surgery, Dermabrasion and Chemical Peels	Covered for diagnosis L57.0 & C44.01, C44.111 - C44.1192, C44.211 - C44.219, C44.310 - C44.319, C44.41, C44.510 - C44.519, C44.611 - C44.619, C44.711 - C44.719, C44.81, C44.91, L71.0, L71.1, L71.8

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
15783	Dermabrasion; superficial, any site (eg, tattoo removal)	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PG0348 Acne Surgery, Dermabrasion and Chemical Peels	Covered for diagnosis L57.0 & C44.01, C44.111 - C44.1192, C44.211 - C44.219, C44.310 - C44.319, C44.41, C44.510 - C44.519, C44.611 - C44.619, C44.711 - C44.719, C44.81, C44.91, L71.0, L71.1, L71.8
15786	Abrasion; single lesion (eg, keratosis, scar)	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
15788	Chemical peel, facial; epidermal	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PG0348 Acne Surgery, Dermabrasion and Chemical Peels	Covered for diagnosis L57.0
15789	Chemical peel, facial; dermal	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PG0348 Acne Surgery, Dermabrasion and Chemical Peels	Covered for diagnosis L57.0 & C44.01, C44.111 - C44.1192, C44.211 - C44.219, C44.310 - C44.319, C44.41, C44.510 - C44.519, C44.611 - C44.619, C44.711 - C44.719, C44.81, C44.91, L57.0

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
15792	Chemical peel, nonfacial; epidermal	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PG0348 Acne Surgery, Dermabrasion and Chemical Peels	Covered for diagnosis L57.0
15793	Chemical peel, nonfacial; dermal	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PG0348 Acne Surgery, Dermabrasion and Chemical Peels	Covered for diagnosis L57.0
15819	Cervicoplasty	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
15820	Blepharoplasty, lower eyelid	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 Authorization per InterQual Coverage Criteria	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift-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. Additional review : PG0104 Cosmetic and Reconstructive Surgery
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 Authorization per InterQual Coverage Criteria	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift-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. Additional review : PG0104 Cosmetic and Reconstructive Surgery
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 Authorization per InterQual Coverage Criteria	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift-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. Additional review : PG0104 Cosmetic and Reconstructive Surgery

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 Authorization per InterQual Coverage Criteria	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift-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. Additional review : PG0104 Cosmetic and Reconstructive Surgery
15824	Rhytidectomy; forehead	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0104 Cosmetic and Reconstructive Surgery	
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0104 Cosmetic and Reconstructive Surgery	
15826	Rhytidectomy; glabellar frown lines	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0104 Cosmetic and Reconstructive Surgery	
15828	Rhytidectomy; cheek, chin, neck	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0104 Cosmetic and Reconstructive Surgery	
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0104 Cosmetic and Reconstructive Surgery	
15830	Excision, excessive skin, and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0104 Cosmetic and Reconstructive Surgery. PG0299 Abdominoplasty, Panniculectomy and Liposuction-archived 120124	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm/hand	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0104 Cosmetic and Reconstructive Surgery; PG0299 Abdominoplasty, Panniculectomy and Liposuction-archived 120124	Note: dual diagnosis reporting is required to support the service as medically reasonable and necessary. ICD-10 diagnosis codes L98.7 or M79.3 should be reported as the primary diagnosis with ICD-10 codes E65, L30.4, R26.2, or Z74.09 reported as the secondary diagnosis. Per InterQual notes , "Medicare noncovered procedures: Cosmetic surgery or expenses incurred in connection with such surgery for the sole purpose of improving one's appearance is non-covered."

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 and a member's plan of benefits, then the provision of the benefits will govern and rule. Reconstructive Services are covered when medical indications support medical necessity. Cosmetic Services performed solely to improve one's appearance and/or self-esteem are considered not medically necessary and therefore not covered.
15877	Suction assisted lipectomy; trunk	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0104 Cosmetic and Reconstructive Surgery; PG0299 Abdominoplasty, Panniculectomy and Liposuction-archived 120124	Note: dual diagnosis reporting is required to support the service as medically reasonable and necessary. ICD-10 diagnosis codes L98.7 or M79.3 should be reported as the primary diagnosis with ICD-10 codes E65, L30.4, R26.2, or Z74.09 reported as the secondary diagnosis. Per InterQual notes , "Medicare noncovered procedures: Cosmetic surgery or expenses incurred in connection with such surgery for the sole purpose of improving one's appearance is non-covered."
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 and a member's plan of benefits, then the provision of the benefits will govern and rule. Reconstructive Services are covered when medical indications support medical necessity. Cosmetic Services performed solely to improve one's appearance and/or self-esteem are considered not medically necessary and therefore not covered.
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 indications support medical necessity. Cosmetic Services performed solely to improve one's appearance and/or self-esteem are considered not medically necessary and therefore not covered.
17110	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PG0348 Acne Surgery, Dermabrasion and Chemical Peels	Not Covered for acne treatment – diagnosis L70.0 - L70.9
17111	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PG0348 Acne Surgery, Dermabrasion and Chemical Peels	Not Covered for acne treatment – diagnosis L70.0 - L70.9

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
17340	Cryotherapy (CO , slush, liquid N) for acne	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PG0348 Acne Surgery, Dermabrasion and Chemical Peels	Covered for diagnosis L70.0
17360	Chemical exfoliation for acne (e.g., acne paste, acid)	NON-COVERED	NON-COVERED	PG0348 Acne Surgery, Dermabrasion and Chemical Peels	
17380	Electrolysis epilation, each 30 minutes	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services, PG0517 Cryoablation of Solid Tumors	
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 -archived. The coverage criteria will follow the InterQual criteria. Additional coverage reference at PG0104 Cosmetic and Reconstructive Surgery
19303	Simple complete mastectomy	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0251 Prophylactic Mastectomy-Archived. Prior Authorization-Experimental/Investigational-NonCovered excel spreadsheet	A Prior Authorization is requied for 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	A Prior Authorization is requied for 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. Procedure 19304 deleted 01/01/2020

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
19316	Mastopexy	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA **(See Notes)**	PG0144 Breast Reconstruction Services	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications**. Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery
19318	Reduction mammoplasty	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA **(See Notes)**	PG0144 Breast Reconstruction Services; PG0054 Reduction Mammoplasty-Archived 06/01/2024.	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications**. Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery
19325	Breast augmentation with implant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA **(See Notes)**	PG0144 Breast Reconstruction Services	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications**. Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery
19328	Removal of intact mammary implant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA **(See Notes)**	PG0012 Breast Implant Removal and Reimplantation - Archived	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 the diagnosis must be in the first diagnosis position: C50.011, C50.012, C50.021, C50.022, C50.111, C50.112, C50.121, C50.122, C50.211, C50.212, C50.221, C50.222, C50.311, C50.312, C50.321, C50.322, C50.411, C50.412, C50.421, C50.422, C50.511,
19330	Removal of ruptured breast implant, including implant contents (e.g., saline, silicone gel)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA **(See Notes)**	PG0012 Breast Implant Removal and Reimplantation - Archived	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, the diagnosis must be in the first diagnosis position: C50.011, C50.012, C50.021, C50.022, C50.111, C50.112, C50.121, C50.122, C50.211, C50.212, C50.221, C50.222, C50.311, C50.312, C50.321, C50.322, C50.411, C50.412, C50.421, C50.422, C50.511,
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA **(See Notes)**	PG0012 Breast Implant Removal and Reimplantation - Archived	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, the diagnosis must be in the first diagnosis position: C50.011, C50.012, C50.021, C50.022, C50.111, C50.112, C50.121, C50.122, C50.211, C50.212, C50.221, C50.222, C50.311, C50.312, C50.321, C50.322, C50.411, C50.412, C50.421, C50.422, C50.511,
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy, or in reconstruction	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA **(See Notes)**	PG0012 Breast Implant Removal and Reimplantation - Archived	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, the diagnosis must be in the first diagnosis position: C50.011, C50.012, C50.021, C50.022, C50.111, C50.112, C50.121, C50.122, C50.211, C50.212, C50.221, C50.222, C50.311, C50.312, C50.321, C50.322, C50.411, C50.412, C50.421, C50.422, C50.511,

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
19350	Nipple/areola reconstruction	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA **(See Notes)**	PG0144 Breast Reconstruction Services	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications**. Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery
19355	Correction of inverted nipples	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA **(See Notes)**	PG0144 Breast Reconstruction Services	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications**. Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery
19357	Tissue expander placement in breast reconstruction, including subsequent expansions(s)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA **(See Notes)**	PG0144 Breast Reconstruction Services	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications**. Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery
19361	Breast reconstruction; with latissimus dorsi flap	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA **(See Notes)**	PG0144 Breast Reconstruction Services	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications**. Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery
19364	Breast reconstruction with free flap (e.g., fTRAM, DIEP, SIEA, GAP flap)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA **(See Notes)**	PG0144 Breast Reconstruction Services	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications**. Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery
19367	Breast reconstruction with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA **(See Notes)**	PG0144 Breast Reconstruction Services	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications**. Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery
19368	Breast reconstruction with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap, requiring separate microvascular anastomosis (supercharging)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA **(See Notes)**	PG0144 Breast Reconstruction Services	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications**. Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
19369	Breast reconstruction with bipedicled transverse rectus abdominis myocutaneous (TRM) flap	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA **(See Notes)**	PG0144 Breast Reconstruction Services	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications**. Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA **(See Notes)**	PG0012 Breast Implant Removal and Reimplantation - Archived	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, the diagnosis must be in the first diagnosis position: C50.011, C50.012, C50.021, C50.022, C50.111, C50.112, C50.121, C50.122, C50.211, C50.212, C50.221, C50.222, C50.311, C50.312, C50.321, C50.322, C50.411, C50.412, C50.421, C50.422, C50.511
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA **(See Notes)**	PG0012 Breast Implant Removal and Reimplantation - Archived	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, the diagnosis must be in the first diagnosis position: C50.011, C50.012, C50.021, C50.022, C50.111, C50.112, C50.121, C50.122, C50.211, C50.212, C50.221, C50.222, C50.311, C50.312, C50.321, C50.322, C50.411, C50.412, C50.421, C50.422, C50.511
19380	Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction).	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA **(See Notes)**	PG0144 Breast Reconstruction Services	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications**. Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery
19396	Preparation of moulage for custom breast implant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA **(See Notes)**	PG0144 Breast Reconstruction Services	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, the diagnosis must be in the first diagnosis position: C50.011, C50.012, C50.021, C50.022, C50.111, C50.112, C50.121, C50.122, C50.211, C50.212, C50.221, C50.222, C50.311, C50.312, C50.321, C50.322, C50.411, C50.412, C50.421, C50.422, C50.511, C50.512, C50.521, C50.522, C50.611, C50.612, C50.621, C50.622, C50.811, C50.812, C50.821, C50.822, C79.81, D05.01, D05.02**
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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 morphogenetic protein-2 and protein-7, see medical policy PG0365 Bone Graft Substitutes for coverage detail.
20931	Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)	PRIOR AUTHORIZATION REQUIRED -	PRIOR AUTHORIZATION REQUIRED	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 morphogenetic protein-2 and protein-7, see medical policy PG0365 Bone Graft Substitutes for coverage detail.
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures; image-less (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0128 Robotic & Computer Assisted Surgery/Navigation-archived-Medical Policy PG0128 Robotic & Computer Assisted Surgery/Navigation is being converted to Reimbursement Policy RM031	Effective 12/01/2024 procedure 20985 is considered experimental/investigational noncovered for all product lines
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 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 morphogenetic protein-2 and protein-7, see medical policy PG0365 Bone Graft Substitutes for coverage detail.
21073	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (i.e., general or monitored anesthesia care)	NON-COVERED	NON-COVERED	PG0422 Manipulation Under Anesthesia	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
21120	Genioplasty; Augmentation	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery	PG0104 Cosmetic and Reconstructive Surgery
21121	Genioplasty; Sliding Osteotomy	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery	PG0104 Cosmetic and Reconstructive Surgery
21122	Genioplasty; Sliding Osteotomies	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery	PG0104 Cosmetic and Reconstructive Surgery
21123	Genioplasty; Sliding Augmentation	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery	PG0104 Cosmetic and Reconstructive Surgery
21125	Augmentation Mandibular Body; Prosthetic Mat	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery	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	PG0104 Cosmetic and Reconstructive Surgery
21137	Reduction forehead; contouring only	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall	NON-COVERED	NON-COVERED	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)-Archived 120124	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)-Archived 120124	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)-Archived 120124	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)-Archived 120124	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)-Archived 120124	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)-Archived 120124	PG0104 Cosmetic and Reconstructive Surgery

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
21150	Lefort II Recon; anterior intrustion	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery	PG0104 Cosmetic and Reconstructive Surgery
21151	Lefort II Recon; any direction with grafts	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery	PG0104 Cosmetic and Reconstructive Surgery
21154	Lefort III Recon; with bone grafts without Lefort I	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery	PG0104 Cosmetic and Reconstructive Surgery
21155	Lefort III Recon; with bone grafts with Lefort I	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery	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	PG0104 Cosmetic and Reconstructive Surgery
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	NON-COVERED	NON-COVERED	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	PG0104 Cosmetic and Reconstructive Surgery
21182	Recon orbital rims/forehead/with grafts less 40 cm	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery	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	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	PG0104 Cosmetic and Reconstructive Surgery

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
21188	Recon midface osteotomies and bone grafts	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery	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)-Archived 120124	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)-Archived 120124	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)-Archived 120124	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)-Archived 120124	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)-Archived 120124	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)-Archived 120124	PG0104 Cosmetic and Reconstructive Surgery

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
21206	Segmental Osteotomy	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery	PG0104 Cosmetic and Reconstructive Surgery
21208	Facial Osteoplasty	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery	PG0104 Cosmetic and Reconstructive Surgery
21209	Facial Osteoplasty reduction	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery	PG0104 Cosmetic and Reconstructive Surgery
21210	Nasal bone graft	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery	PG0104 Cosmetic and Reconstructive Surgery
21215	Nasal bone graft	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery	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	PG0104 Cosmetic and Reconstructive Surgery
21240	Arthroplasty, temporomandibular joint	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery	PG0104 Cosmetic and Reconstructive Surgery

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
21244	Reconstruction of mandible extraoral	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery	PG0104 Cosmetic and Reconstructive Surgery
21245	Reconstruction of mandible partial	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery	PG0104 Cosmetic and Reconstructive Surgery
21246	Reconstruction of mandible complete	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery	PG0104 Cosmetic and Reconstructive Surgery
21247	Reconstruction of mandibular condyle	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery	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	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	PG0104 Cosmetic and Reconstructive Surgery
21255	Reconstruction of zygomatic arch	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery	PG0104 Cosmetic and Reconstructive Surgery

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
21261	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
21263	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
21268	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
21270	Malar augmentation, prosthetic material	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery	PG0104 Cosmetic and Reconstructive Surgery

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
21275	Secondary revision of orbital cranifacial Recon	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0226 Orthognathic Surgery. PG0104 Cosmetic and Reconstructive Surgery	
21280	Medial canthopexy (separate procedure)	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
21282	Lateral canthopexy	NON-COVERED	NON-COVERED	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. 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. PG0104 Cosmetic and Reconstructive Surgery	
21685	Hyoid myotomy and suspension	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0226 Orthognathic Surgery. and PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)-Archived 120124	
21811	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs	NON-COVERED	NON-COVERED		NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL. •CPT 21811 is non-covered, as in most instances fractures involving 1-3 ribs do not require internal fixation.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0026 Discogenic Pain Treatment-Archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0026 Discogenic Pain Treatment-Archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
22532	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~ EFFECTIVE 02/01/2025 NO PRIOR AUTHORIZATION REQUIRED	~~PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA~~ EFFECTUVE 02/01/2025 NO PRIOR AUTHORIZATION REQUIRED	~~PG0463 Spinal Fusion-Archived 020125~~	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-Archived 020125~~	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 in addition to code for primary procedure)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	~~PG0463 Spinal Fusion-Archived 020126~~	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~~ EFFECTIVE 02/01/2025 NO PRIOR AUTHORIZATION REQUIRED	~~PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA~~ EFFECTUVE 02/01/2025 NO PRIOR AUTHORIZATION REQUIRED	~~PG0463 Spinal Fusion-Archived 020127~~	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 C2	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	~~PG0463 Spinal Fusion-Archived 020128~~	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 C2, each additional space (List	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	~~PG0463 Spinal Fusion-Archived 020129~~	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
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-Archived 020130~~	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~~ EFFECTIVE 02/01/2025 NO PRIOR AUTHORIZATION REQUIRED	~~PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA~~ EFFECTUVE 02/01/2025 NO PRIOR AUTHORIZATION REQUIRED	~~PG0463 Spinal Fusion-Archived 020131~~	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 region	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	~~PG0463 Spinal Fusion-Archived 020132~~	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 separately in addition to code for primary procedure)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	~~PG0463 Spinal Fusion-Archived 020133~~	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
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace	NON-COVERED	NON-COVERED	PG0043 Experimental/Investigational Procedures/Services	
22590	Arthrodesis, posterior technique, craniocervical (Occiput - C2)	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~ EFFECTIVE 02/01/2025 NO PRIOR AUTHORIZATION REQUIRED	~~PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA~~ EFFECTUVE 02/01/2025 NO PRIOR AUTHORIZATION REQUIRED	~~PG0463 Spinal Fusion-Archived 020133~~	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~~ EFFECTIVE 02/01/2025 NO PRIOR AUTHORIZATION REQUIRED	~~PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA~~ EFFECTUVE 02/01/2025 NO PRIOR AUTHORIZATION REQUIRED	~~PG0463 Spinal Fusion-Archived 020134~~	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~ EFFECTIVE 02/01/2025 NO PRIOR AUTHORIZATION REQUIRED	~~PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA~~ EFFECTUVE 02/01/2025 NO PRIOR AUTHORIZATION REQUIRED	~~PG0463 Spinal Fusion-Archived 020135~~	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-Archived 020136~~	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-Archived 020137~~	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 procedure)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	~~PG0463 Spinal Fusion-Archived 020138~~	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); lumbar	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	~~PG0463 Spinal Fusion-Archived 020139~~	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); each additional interspace. (List separately in addition to code for primary procedure)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	~~PG0463 Spinal Fusion-Archived 020140~~	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 interspace, single interspace and segment (other than for decompression); each additional	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	~~PG0463 Spinal Fusion-Archived 020141~~	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 spinal cord decompression and microdissection), second level, cervical (List separately in addition	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0027 Artificial Intervertebral Disc Replacement	
22860	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0027 Artificial Intervertebral Disc Replacement	
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	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 open decompression, lumbar; second level (List separately in addition to code for primary	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0213 Interspinous and Interlaminar Stabilization/Distraction Devices (Spacers)-Archived	
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	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 when performed, lumbar; second level (List separately in addition to code for primary procedure)	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 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 morphogenetic protein-2 and protein-7, see medical policy PG0365 Bone Graft Substitutes for coverage detail.
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 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 morphogenetic protein-2 and protein-7, see medical policy PG0365 Bone Graft Substitutes for coverage detail.
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 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 morphogenetic protein-2 and protein-7, see medical policy PG0365 Bone Graft Substitutes for coverage detail.
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 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 morphogenetic protein-2 and protein-7, see medical policy PG0365 Bone Graft Substitutes for coverage detail.
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 arthroplasty), with or without autograft or allograft	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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 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.
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	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.
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft	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.
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft	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.
27275	Manipulation, hip joint, requiring general anesthesi	NON-COVERED	NON-COVERED	PG0422 Manipulation Under Anesthesia	
27278	PG0043 Experimental/Investigational Procedures/Services	NON-COVERED	NON-COVERED	PG0043 Experimental/Investigational Procedures/Services	
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 resorbable polymers]	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
27445	Arthroplasty, knee, hinge prosthesis (e.g., Walldius type)	ProMedica Employee Health Plans Administered by Paramount PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION NOT REQUIRED	PG0452 Knee Replacement Surgery (Arthroplasty) - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	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 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.
27446	Arthroplasty, knee, condyle and plateau; medial or lateral compartment	ProMedica Employee Health Plans Administered by Paramount PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION NOT REQUIRED	PG0452 Knee Replacement Surgery (Arthroplasty) - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	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 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.
27447	Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)	ProMedica Employee Health Plans Administered by Paramount PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION NOT REQUIRED	PG0452 Knee Replacement Surgery (Arthroplasty) - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	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 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.
27486	Revision of total knee arthroplasty, with or without allograft; 1 component	ProMedica Employee Health Plans Administered by Paramount PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION NOT REQUIRED	PG0452 Knee Replacement Surgery (Arthroplasty) - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	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 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.
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	ProMedica Employee Health Plans Administered by Paramount PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION NOT REQUIRED	PG0452 Knee Replacement Surgery (Arthroplasty) - Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	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 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.
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 be recombinant human bone morphogenetic protein-2 and protein-7, see medical policy PG0365 Bone Graft Substitutes for coverage detail.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 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 morphogenetic protein-2 and protein-7, see medical policy PG0365 Bone Graft Substitutes for coverage detail.
28890	Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia	NON-COVERED	NON-COVERED	PG0004 Extracorporeal Shock Wave Therapy for Musculoskeletal Conditions and Soft Tissue Wounds-Archived 090124; PG0043 Experimental Investigationals Procedures Services	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 of the patella] [excludes synthetic resorbable polymers]	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
30120	Excision or surgical planning of skin of nose for rhinophyma	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
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-Archived 080124. PG0104 Cosmetic and Reconstructive Surgery	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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- Archived 080124. PG0104 Cosmetic and Reconstructive Surgery	
30420	Rhinoplasty, primary; including major septal repair	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0009 Rhinoplasty and Septoplasty- Archived 080124. 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- Archived 080124. 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- Archived 080124. 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- Archived 080124. 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
	Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL **{i.e., ViVaer (30469)}**
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	PRIORI AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe	NON-COVERED	NON-COVERED	PG0316 Bronchial Thermoplasty; PG0043 Experimental Investigational Procedures Services. Archived,080124. PG0043 Experimental/Investigational Procedures/Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	NON-COVERED	NON-COVERED	PG0316 Bronchial Thermoplasty; PG0043 Experimental Investigational Procedures Services. Archived,080124. PG0043 Experimental/Investigational Procedures/Services	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) - **Archived Policy**	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, oversewing, ligation, plication, clip)	NON-COVERED	NON-COVERED	PG0366 Left Atrial Appendage Closure (LAAC) (Occlusion)-Archived 090124; PG0043 Experimental Investigational Procedures Services	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 evaluation (eg, interrogation or programming), when performed	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-Archived; 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 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 Advantage members only: approval if the member is participating in an FDA approved post approval trial that is registered.
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-Archived; 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 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 Advantage members only: approval if the member is participating in an FDA approved post approval trial that is registered.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~ PRIOR AUTHORIZATION NOT REQUIRED	~~PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA~~ PRIOR AUTHORIZATION NOT REQUIRED	PG0039 Ambulatory External and Implantable Electrocardiographic Monitoring-Archived 110124	~~Effective 06/01/2021 procedure 33285 requires a prior authorization.~~ Effective 11/01/2024 procedure 33285 does not require a prior authorization.
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor for longterm hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery	NON-COVERED	NON-COVERED	**PG0377 Pulmonary Artery Pressure Monitoring (CardioMEMS)-Archived 090124;** PG0043 Experimental/Investigational Procedures/Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
33370	Transcatheter placement and subsequent removal of cerebral embolic protection device(s), including arterial access, catheterization, imaging, and radiological supervision and interpretation, percutaneous	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures-Archived; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
36468	Injection(s) of sclerosant for spider veins (telangiectasia); limb or trunk	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	
36473	Endovenous ablation therapy of incompetent vein, extremity inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	Mechanical occlusion chemical ablation (MOCA) of the saphenous vein is a nonthermal technique that combines mechanical epithelial injury via a catheter-directed rotating wire with concomitant chemical ablation via simultaneous administration of a sclerosing agent (e.g., sodium tetradecyl sulfate, polidocanol) over the rotating wire. Ultrasonography is used to continuously guide the procedure. For saphenous vein incompetence, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment
36474	Endovenous ablation therapy of incompetent vein, extremity inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	Mechanical occlusion chemical ablation (MOCA) of the saphenous vein is a nonthermal technique that combines mechanical epithelial injury via a catheter-directed rotating wire with concomitant chemical ablation via simultaneous administration of a sclerosing agent (e.g., sodium tetradecyl sulfate, polidocanol) over the rotating wire. Ultrasonography is used to continuously guide the procedure. For saphenous vein incompetence, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment
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

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
41512	Tongue base suspension, permanent suture technique	NON-COVERED	~~PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA~~ EFFECTIVE 02/01/2025 NON-COVERED	PG0043 Experimental Investigational Procedures Services; PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)-Archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL. **Effective 02/01/2025 procedure 41512 is Non-Covered for the Medicare plans.**
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 Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
41899	Unlisted procedure, dentoalveolar structures	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0536 Anesthesia Services for Dental Procedures in the Facility Setting	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).
42975	Drug-induced sleep endoscopy, with dynamic evaluation of velum, pharynx, tongue base, and larynx for evaluation of sleep-disordered breathing, flexible, diagnostic	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0537 Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea	
43236	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance (not covered for GERD procedure) (Bulking agent)	NON-COVERED	NON-COVERED	PG0166 Endoscopic Therapies for Gastroesophageal Reflux Disease (GERD)-Archived 090124; PG0043 Experimental Investigational Procedures Services	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 Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)	NON-COVERED	NON-COVERED	PG0163 Metabolic and Bariatric Surgery; PG0043 Experimental Investigational Procedures Services	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) Gastric peroral endoscopic myotomy (G-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	Elite Medicare Advantage	Policy	DETAILS/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 gastroplasty	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 gastroplasty	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0163 Metabolic and Bariatric Surgery	PG0104 Cosmetic and Reconstructive Surgery

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)	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 reconstruction; without vagotomy	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)	
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

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 hemorrhoid columns/groups, including ultrasound guidance, with mucopexy, when performed	~~NON-COVERED~~	~~NON-COVERED~~	~~PG0329 Hemorrhoidal Dearterialization- Archived 10/01/2024; PG0043 Experimental Investigational Procedures Services~~	~~NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL~~ **Effective 10/01/2024 procedure 46948 is covered, without a prior authorization, for all product lines.**
48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIIRED - MEDICAL POLICY	PG0415 Pancreatic Islet Cell Transplantation	
52284	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
52441	Cystourethroscopy, with insertion of permanent adjustable trans-prostatic implant; single implant (Urolift System)	EFFECTIVE 04/01/2025 PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	EFFECTIVE 04/01/2025 PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0534 Treatments for Benigh Prostatic Hypertrophy (BPH)	
52442	Cystourethroscopy, with insertion of permanent adjustable trans-prostatic implant; each additional permanent adjustable trans-prostatic implant (List separately in addition to code for primary procedure) (Urolift System)	EFFECTIVE 04/01/2025 PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	EFFECTIVE 04/01/2025 PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0534 Treatments for Benigh Prostatic Hypertrophy (BPH)	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
53451	Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services; PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments and Devices-archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
53452	Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services; PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments and Devices-archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
53453	Periurethral transperineal adjustable balloon continence device; removal, each balloon	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services; PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments and Devices-archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
53454	Periurethral transperineal adjustable balloon continence device; percutaneous adjustment of balloon(s) fluid volume	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services; PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments and Devices-archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy (Rezūm System)	EFFECTIVE 04/01/2025 PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	EFFECTIVE 04/01/2025 PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0534 Treatments for Benign Prostatic Hypertrophy (BPH)	
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	Use of a temporary prostatic stent (53855) is considered experimental or investigational, for the treatment of benign prostatic hyperplasia, for all indications.
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
55880	Ablation of malignant prostate tissue, transrectal, with high-intensity focused ultrasound (HIFU), including ultrasound guidance	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0504 High-Intensity Focused Ultrasound (HIFU)-archived 110124	Effective 11/01/2024 procedure 558800, Commercial Plans, went from noncovered, to covered, with a prior authorization, per InterQual coverage critieria
55970	Intersex surgery; male to female	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0311 Gender Reaffirming 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 Reaffirming 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 trajectory for 1 simple lesion	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.
61737	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)	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 utilizing needle-based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0026 Discogenic Pain Treatment-Archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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-Archived 120124.	
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-Archived 120124.	
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-Archived 120124.	
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, 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-Archived 120124.	
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-Archived 120124.	
64405	Injection, anesthetic agent; greater occipital nerve	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY- See Details/Notes	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY- See Details/Notes	PG0389 Occipital Nerve Block Therapy for the Treatment of Headache and Occipital Neuralgia	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, including imaging guidance	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0471 Genicular Nerve Blocks and Ablation for Chronic Knee Pain	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
64582	Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0537 Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea	
64583	Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0537 Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea	
64584	Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0537 Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea	
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0471 Genicular Nerve Blocks and Ablation for Chronic Knee Pain	
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (fluoroscopy or CT)	NON-COVERED	NON-COVERED	PG0361 Radiofrequency Methods of Denervation for Chronic Spinal Pain; PG0043 Experimental Investigational Procedures Services	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 Pain-Archived 110124	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 addition to code for primary procedure) (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 Pain-Archived 110124	Effective 11/01/2022 procedure codes 64628, 64629REQUIRES A PRIOR AUTHORIZATION. Coverage went from non-covered to covered with a PA

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
65760	Keratomileusis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0289 Refractive Surgery	
65765	Keratophakia	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0289 Refractive Surgery	
65771	Radial keratotomy (RK)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0289 Refractive Surgery	
65785	Implantation of intrastromal corneal ring segments	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0289 Refractive Surgery	
65820	Goniotomy	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services; PG0327 Surgical Treatments for Glaucoma	When goniotomy (CPT Code 65820) is determined to be trabectome (ab interno trabeculectomy).
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 Authorization per InterQual Coverage Criteria	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift-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. Additional review : PG0104 Cosmetic and Reconstructive Surgery

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 Authorization per InterQual Coverage Criteria	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift-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. Additional review : PG0104 Cosmetic and Reconstructive Surgery
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 Authorization per InterQual Coverage Criteria	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift-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. Additional review : PG0104 Cosmetic and Reconstructive Surgery
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 Authorization per InterQual Coverage Criteria	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift-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. Additional review : PG0104 Cosmetic and Reconstructive Surgery
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 Authorization per InterQual Coverage Criteria	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift-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. Additional review : PG0104 Cosmetic and Reconstructive Surgery
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 Authorization per InterQual Coverage Criteria	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift-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. Additional review : PG0104 Cosmetic and Reconstructive Surgery
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 Authorization per InterQual Coverage Criteria	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift-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. Additional review : PG0104 Cosmetic and Reconstructive Surgery

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 Authorization per InterQual Coverage Criteria	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift-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. Additional review : PG0104 Cosmetic and Reconstructive Surgery
67911	Correction of lid retraction	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 Authorization per InterQual Coverage Criteria	Medical Policy PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift, 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. Additional review : PG0104 Cosmetic and Reconstructive Surgery
68841	Insertion of drug-eluting implant, including punctal dilation when performed, into lacrimal canaliculus, each	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services; PG0327 Surgical Treatmenst for Glaucoma	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
69090	Ear piercing	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
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-Archived 11/01/2024	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 NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0218 Implantable Bone Conduction and Bone-Anchored Hearing Aids-Archived 11/01/2024	Effective 11/01/2024 procedure 69711 does not require a prior authorization for all product lines

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/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-Archived 11/01/2024	
69716	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or resulting in removal of less than 100 sq mm service area of bone deep to the outer cranial cortex	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0218 Implantable Bone Conduction and Bone-Anchored Hearing Aids-Archived 11/01/2024	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-Archived 11/01/2024	
69719	Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech process, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0218 Implantable Bone Conduction and Bone-Anchored Hearing Aids-Archived 11/01/2024	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 removal of greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0218 Implantable Bone Conduction and Bone-Anchored Hearing Aids-Archived 11/01/2024	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 the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0218 Implantable Bone Conduction and Bone-Anchored Hearing Aids-Archived 11/01/2024	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 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 spreadsheet.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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. Maintain Prior Authorization per InterQual Coverage Criteria	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 prior authorization excel spreadsheet.
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. Maintain Prior Authorization per InterQual Coverage Criteria	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 prior authorization excel spreadsheet.
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. Maintain Prior Authorization per InterQual Coverage Criteria	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 prior authorization excel spreadsheet.
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. Maintain Prior Authorization per InterQual Coverage Criteria	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 prior authorization excel spreadsheet.
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. Maintain Prior Authorization per InterQual Coverage Criteria	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 prior authorization excel spreadsheet.
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. Maintain Prior Authorization per InterQual Coverage Criteria	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 prior authorization excel spreadsheet.
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. Maintain Prior Authorization per InterQual Coverage Criteria	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 prior authorization excel spreadsheet.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 images, if performed	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 Investigational Procedures Services. Archived 06/01/2024. Maintain Prior Authorization per InterQual Coverage Criteria	~~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 absorptiometry (DXA) or other imaging data on gray scale variogram, calculation, with interpretation and report on fracture risk	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
77090	Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical preparation and transmission of data for analysis to be performed elsewhere	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
77091	Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical calculation only	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
77092	Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk only by other qualified health care professional	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
78350	Bone density (bone mineral content) study, 1 or more sites; single photon absorptiometry	NON-COVERED	~~NON-COVERED~~ PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0320 Bone Density Measurements; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL Effective 11/01/2024 covered with a prior authorization for the Elite (Medicare Advantage) Plans per InterQual coverage criteria
78351	Bone density (bone mineral content) study, 1 or more sites; dual photon absorptiometry, 1 or more sites	NON-COVERED	~~NON-COVERED~~ PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0320 Bone Density Measurements; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL Effective 11/01/2024 covered with a prior authorization for the Elite (Medicare Advantage) Plans per InterQual coverage criteria
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. Maintain Prior Authorization per InterQual Coverage Criteria	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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/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. Maintain Prior Authorization per InterQual Coverage Criteria	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.
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. Maintain Prior Authorization per InterQual Coverage Criteria	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.
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. Maintain Prior Authorization per InterQual Coverage Criteria	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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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. Maintain Prior Authorization per InterQual Coverage Criteria	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.
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization 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. Maintain Prior Authorization per InterQual Coverage Criteria	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.
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization 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. Maintain Prior Authorization per InterQual Coverage Criteria	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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization 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. Maintain Prior Authorization per InterQual Coverage Criteria	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.
80145	Adalimumab	~~NON-COVERED~~ PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	~~NON-COVERED~~ PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0341 Immunopharmacologic Monitoring of Therapeutic Serum Antibodies. Effective 12/01/2024 reimbursement is allowed for drug and/or antibody concentration testing for anti-tumor necrosis factor (anti-TNF) therapies and for vedolizumab or ustekinumab therapies in individuals with inflammatory bowel disease (IBD) with a prior authorization.	
80230	Infliximab	~~NON-COVERED~~ PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	~~NON-COVERED~~ PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0341 Immunopharmacologic Monitoring of Therapeutic Serum Antibodies. Effective 12/01/2024 reimbursement is allowed for drug and/or antibody concentration testing for anti-tumor necrosis factor (anti-TNF) therapies and for vedolizumab or ustekinumab therapies in individuals with inflammatory bowel disease (IBD) with a	
80280	Vedolizumab	~~NON-COVERED~~ PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	~~NON-COVERED~~ PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0341 Immunopharmacologic Monitoring of Therapeutic Serum Antibodies. Effective 12/01/2024 reimbursement is allowed for drug and/or antibody concentration testing for anti-tumor necrosis factor (anti-TNF) therapies and for vedolizumab or ustekinumab therapies in individuals with inflammatory bowel disease (IBD) with a prior authorization.	
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., utilizing immunoassay [e.g., dipsticks, cups, cards, or cartridges]), includes sample	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - See Details/Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - See Details/Notes	PG0069 Drug Testing	Effective 01/01/2024: Presumptive drug screening (CPT code 80305, 80306 or 80307) and Definitive drug testing (HCPCs code G0480, G0481, G0482, G0483, or G0659) ARE ONLY REIMBURSABLE 45 times total every 365 days [any combination of procedures 80305, 80306, 80307, G0480, G0481, G0483, or G0659], when the coverage criteria, Medical Policy PG0069 Drug Testing, are met.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 immunoassay [e.g., dipsticks, cups, cards, or cartridges]), includes sample validation when performed	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - See Details/Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - See Details/Notes	PG0069 Drug Testing	Effective 01/01/2024: Presumptive drug screening (CPT code 80305, 80306 or 80307) and Definitive drug testing (HCPCs code G0480, G0481, G0482, G0483, or G0659) ARE ONLY REIMBURSABLE 45 times total every 365 days [any combination of procedures 80305, 80306, 80307, G0480, G0481, G0483, or G0659], when the coverage criteria, Medical Policy PG0069 Drug Testing, are met.
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., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - See Details/Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - See Details/Notes	PG0069 Drug Testing	Effective 01/01/2024: Presumptive drug screening (CPT code 80305, 80306 or 80307) and Definitive drug testing (HCPCs code G0480, G0481, G0482, G0483, or G0659) ARE ONLY REIMBURSABLE 45 times total every 365 days [any combination of procedures 80305, 80306, 80307, G0480, G0481, G0483, or G0659], when the coverage criteria, Medical Policy PG0069 Drug Testing, are met.
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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	
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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	
80345	Barbiturates	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0069 Drug Testing	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	
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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	Elite Medicare Advantage	Policy	DETAILS/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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	
81105	Human Platelet Antigen 1 genotyping (HPA-1), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-1a/b (L33P)	NON-COVERED - NO COMMERCIAL INTERQUAL	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 [NAIT], posttransfusion purpura), gene analysis, common variant, HPA-2a/b (T145M)	NON-COVERED - NO COMMERCIAL INTERQUAL	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, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis	NON-COVERED - NO COMMERCIAL 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	Elite Medicare Advantage	Policy	DETAILS/NOTES
81108	Human Platelet Antigen 4 genotyping (HPA-4), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-4a/b	NON-COVERED - NO COMMERCIAL INTERQUAL	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 thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant (eg, HPA-5a/b	NON-COVERED - NO COMMERCIAL INTERQUAL	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 thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-6a/b	NON-COVERED - NO COMMERCIAL INTERQUAL	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, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis	NON-COVERED - NO COMMERCIAL INTERQUAL	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), gene analysis, common variant, HPA-15a/b	NON-COVERED - NO COMMERCIAL INTERQUAL	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, R132C)	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	
81121	IDH2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial) (eg, glioma), common variants (eg, R140W, R172M)	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 Muscular Dystrophy)-**Archived 06/01/2024**	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 sequence analysis and full duplication/deletion analysis (i.e., detection of large gene	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.
81163	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, 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)-**Archived 090124**	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 duplication/deletion analysis (i.e., detection of large gene rearrangements)	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)-**Archived 090124**	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)-**Archived 090124**	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 rearrangements)	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)-**Archived 090124**	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 rearrangements)	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)-**Archived 090124**	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
81168	CCND1/IGH (t(11;14)) (eg, mantle cell lymphoma) translocation analysis, major breakpoint, qualitative and quantitative, if performed	NON-COVERED - NO COMMERCIAL INTERQUAL	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 inhibitor resistance), gene analysis, variants in the kinase domain	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 methylation status)	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	NON-COVERED - NO COMMERCIAL INTERQUAL	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), 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	Elite Medicare Advantage	Policy	DETAILS/NOTES
81176	ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; targeted sequence analysis (eg, exon 12)	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	NON-COVERED - NO COMMERCIAL INTERQUAL	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	NON-COVERED - NO COMMERCIAL INTERQUAL	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	NON-COVERED - NO COMMERCIAL INTERQUAL	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)	NON-COVERED - NO COMMERCIAL INTERQUAL	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	NON-COVERED - NO COMMERCIAL INTERQUAL	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	NON-COVERED - NO COMMERCIAL 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	Elite Medicare Advantage	Policy	DETAILS/NOTES
81183	ATXN10 (ataxin 10) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	NON-COVERED - NO COMMERCIAL INTERQUAL	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	NON-COVERED - NO COMMERCIAL INTERQUAL	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	NON-COVERED - NO COMMERCIAL INTERQUAL	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	NON-COVERED - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 08/01/24	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 08/01/24	Prior authorization is required for ALL genetic testing unless otherwise noted.
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 08/01/24	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, expanded size or methylation status)	NON-COVERED - NO COMMERCIAL INTERQUAL	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, G278S, E422X)	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 breakpoint, qualitative or quantitative	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 breakpoint, qualitative or quantitative	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 breakpoint, qualitative or quantitative	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 090124	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 090124	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 090124	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 090124	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, full gene sequence	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
81219	CALR (calreticulin) (eg, myeloproliferative disorders), gene analysis, common variants in exon 9	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 Genetic Diseases	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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)	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.	PRIOR AUTHORIZATION REQUIRED - 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.
81228	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants, comparative genomic hybridization [CGH] microarray analysis)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0296 Comparative Genomic Hybridization (CGH)/Chromosomal Microarray Analysis (CMA)-Archived 090124	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 (SNP) variants, comparative genomic hybridization [CGH] microarray analysis	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0296 Comparative Genomic Hybridization (CGH)/Chromosomal Microarray Analysis (CMA)-Archived 090124	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 - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
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 - NO COMMERCIAL INTERQUAL	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, *5, *6)	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
81233	BTK (Bruton's tyrosine kinase) (eg, chronic lymphocytic leukemia) gene analysis, common variants (eg, C481S, C481R, C481F)	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
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, G719S, L861Q) (LCD L32288)	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 syndrome, myeloproliferative neoplasms) gene analysis, full gene sequence	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81237	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (eg, diffuse large B-cell lymphoma) gene analysis, common variant(s) (eg, codon 646)	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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-Archived 090124	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-Archived 090124	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.
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. 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 status)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing. 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 duplication (ITD) variants (i.e., exons 14, 15)	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 domain (TKD) variants (eg, D835, I836)	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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, Q347X)	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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 232kb [del(GJB6-D13S1854)])	NON-COVERED - NO COMMERCIAL 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.
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., C282Y, H63D)	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 or variant (e.g., Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, and	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 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.
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, common variants (e.g., 2507+6T>C, R696P)	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
81261	IGH@ (Immunoglobulin heavy chain locus) (e.g., leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplified methodology (e.g., polymerase chain reaction)	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 rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (e.g., Southern blot)	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 somatic mutation analysis	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 rearrangement analysis, evaluation to detect abnormal clonal population(s)	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 (e.g., pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [e.g., buccal swab or other germline tissue	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., additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in	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), includes comparison to previously performed baseline analyses; without cell selection	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
81268	Chimerism (engraftment) analysis, post transplantation specimen (e.g., hematopoietic stem cell), includes comparison to previously performed baseline analyses; with cell selection (e.g., CD3, CD33), each cell type	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 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.
81270	JAK2 (Janus kinase 2) (e.g., myeloproliferative disorder) gene analysis, p.Val617Phe (V617F) variant	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	PG0041 Genetic Testing. PG0533 Genetic Testing for Neurodegenerative Disorders-Archived 020125	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 stromal tumor [GIST], acute myeloid leukemia, melanoma), gene analysis, targeted sequence analysis (eg, exons 8, 11, 13, 17, 18)	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 analysis, D816 variant(s)	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	PG0041 Genetic Testing. PG0533 Genetic Testing for Neurodegenerative Disorders-Archived 020125	New Medical Policy, PG0533 Genetic Testing for Neurodegenerative Disorders, procedure codes went from noncovered to covered effective 02/01/2024

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
81275	KRAS (Kirsten rat sarcoma viral oncogene homolog) (e.g., carcinoma) gene analysis, variants in exon 2 (eg, codons 12 and 13)	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; additional variant(s) (eg, codon 61, codon 146)	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 chromosomal abnormalities	NON-COVERED - NO COMMERCIAL 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 (MBR) and minor cluster region (mcr) breakpoints, qualitative or quantitative	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, exons 12 and 13)	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 - NO COMMERCIAL INTERQUAL	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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
81285	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; characterization of alleles (eg, expanded size)	NON-COVERED - NO COMMERCIAL INTERQUAL	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.
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 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 08/01/24	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, 1298C)	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0355 Genetic Testing for Hereditary Thrombophilia-Archived 090124, PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 08/01/24	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 08/01/25	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 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 08/01/26	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 08/01/27	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 08/01/28	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 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 08/01/29	Prior authorization is required for ALL genetic testing unless otherwise noted.
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 08/01/30	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 08/01/31	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 08/01/32	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., BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed	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 08/01/33	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, lymphoplasmacytic leukemia) gene analysis, p.Leu265Pro (L265P) variant	NON-COVERED - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	NON-COVERED - NO COMMERCIAL 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, exons 7, 9, 20)	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.
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 analysis, variants in exon 2 (eg, codons 12 and 13) and exon 3 (eg, codon 61)	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	NON-COVERED - NO COMMERCIAL 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	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 Cancer-**archived 020425**.	Prior authorization is required for ALL genetic testing unless otherwise noted.
81314	PDGFRA (platelet-derived growth factor receptor, alpha polypeptide) (eg, gastrointestinal stromal tumor [GIST]), gene analysis, targeted sequence analysis (eg, exons 12, 18)	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., promyelocytic leukemia) translocation analysis; common breakpoints (e.g., intron 3 and intron 6), qualitative or quantitative	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., promyelocytic leukemia) translocation analysis; single breakpoint (e.g., intron 3, intron 6 or exon 6), qualitative or quantitative	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 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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
81320	PLCG2 (phospholipase C gamma 2) (eg, chronic lymphocytic leukemia) gene analysis, common variants (eg, R665W, S707F, L845F)	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 Coverage Criteria	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 coverage criteria will follow the InterQual criteria.
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 Coverage Criteria	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 coverage criteria will follow the InterQual criteria.
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 Coverage Criteria	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 coverage criteria will follow the InterQual criteria.
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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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)	NON-COVERED - NO COMMERCIAL INTERQUAL	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 (survival of motor neuron 2, centromeric) analysis , if performed	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing. PG0398 Genetic Testing for Spinal Muscular Atrophy-archived 020125	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, L302P, fsP330)	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), 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.
81332	SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (e.g., alpha-1-antitrypsin deficiency), gene analysis, common variants (e.g., *S and *Z)	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)	NON-COVERED - NO COMMERCIAL 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	Elite Medicare Advantage	Policy	DETAILS/NOTES
81334	RUNX1 (runt related transcription factor 1) (eg, acute myeloid leukemia, familial platelet disorder with associated myeloid malignancy), gene analysis, targeted sequence analysis (eg, exons 3-8)	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.
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. PG0398 Genetic Testing for Spinal Muscular Atrophy-archived 020125	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. PG0398 Genetic Testing for Spinal Muscular Atrophy-archived 020125	Prior authorization is required for ALL genetic testing unless otherwise noted.
81338	MPL (MPL proto-oncogene , thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; common variants (eg, W515A, W515K, W515L, W515R)	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 analysis; sequence analysis, exon 10	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 analysis to detect abnormal clonal population(s); using amplification methodology (e.g., polymerase chain reaction	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
81341	TRB@ (T cell antigen receptor, beta) (e.g., leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (e.g., Southern blot)	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 analysis, evaluation to detect abnormal clonal population(s)	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	NON-COVERED - NO COMMERCIAL INTERQUAL	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	NON-COVERED - NO COMMERCIAL INTERQUAL	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, promoter region)	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 - NO COMMERCIAL INTERQUAL	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) gene analysis, common variants (eg, A672T, E622D, L833F, R625C, R625L)	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
81348	SRSF2 (serine and arginine-rich splicing factor 2) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variants (eg, P95H, P95L)	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.
81349	Cytogenomic constitutional (genome-wide) microarray analysis; Interrogation of genomic regions for copy number loss-of-heterozygosity variants, low-pass sequencing	NON-COVERED - NO COMMERCIAL INTERQUAL	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, *37)	PRIOR AUTHORIZATION REQUIRED- INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing PG0391 UGT1A1 Targeted Mutation Analysis for Irinotecan Response - **Archived 6/10/2025**	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 analysis (eg, 4 oncology)	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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
81357	U2AF1 (U2 small nuclear RNA auxiliary factor 1) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variants (eg, S34F, S34Y, Q157R, Q157P)	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, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variant(s) (eg, E65fs, E122fs, R448fs)	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, -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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
81371	HLA Class I and II typing, low resolution (e.g., antigen equivalents); HLA-A, -B, and -DRB1/3/4/5 (e.g., verification typing)	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), each	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, -DQB1, -DQA1, -DPB1, or -DPA1), each	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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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, -DRB4, -DRB5, -DQB1, -DQA1, -DPB1, or -DPA1), each	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-DQB1*06:02P), each	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 digestion or melt curve 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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
81401	Molecular pathology procedure, Level 2 (e.g., 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)	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 for Lynch Syndrome and Polyposis Syndromes Archived 08/01/24, PG0442 Carrier Screening for Genetic Diseases, PG0467 Genetic Testing for Epilepsy, PG0412 Genetic Testing Age-Related Macular Degeneration	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 analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants of 1	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.
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 independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)	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 Carrier Screening for Genetic Diseases, PG0467 Genetic Testing for Epilepsy	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 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)	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 11-25 exons, regionally targeted cytogenomic array analysis)	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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
81406	Molecular pathology procedure, Level 7 (e.g., analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)	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 Carrier Screening for Genetic Diseases,PG0467 Genetic Testing for Epilepsy	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 exons, sequence analysis of multiple genes on the one platform)	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 gene sequence NF1 (neurofibromin 1) (e.g., neurofibromatosis, type 1), full gene sequence RYR1 (ryanodine receptor 1, skeletal)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0411 Genetic Testing for Dystrophinopathies (Duchenne and Becker Muscular Dystrophy-Archived 06/01/2024, PG0412 Genetic Testing Age-Related Macular Degeneration	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 analysis panel, must include analyses for TGFBR1, TGFBR2, MYH11, and COL3A1	NON-COVERED - NO COMMERCIAL 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 analysis panel, must include analyses for TGFBR1, TGFBR2, MYH11, and COL3A1	NON-COVERED - NO COMMERCIAL 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, Tay-Sachs disease), genomic sequence analysis panel, must include sequencing of at least 9	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 for Genetic Diseases	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 sequence analysis panel, must include sequencing of at least 10 genes, including ANK2, CASQ2	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 for Cardiac Conditions	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
81414	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); duplication/deletion gene analysis panel, must include analysis of at least 2 genes, including KCNH2	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 for Cardiac Conditions	Prior authorization is required for ALL genetic testing unless otherwise noted.
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 Sequencing (WES) and Whole Genome Sequencing (WGS)	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 in addition to code for primary procedure)	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 Sequencing (WES) and Whole Genome Sequencing (WGS)	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 or unrelated condition/syndrome)	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 Sequencing (WES) and Whole Genome Sequencing (WGS)	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 CYP2D6 duplication/deletion analysis	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 Testing for Mental Health Conditions-Archived 090124	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, PCDH19, POLG, PRRT2, SCN1A, SCN1B, SCN2A, SCN8A, SLC2A1, SLC9A6, STXBP1	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0453 Germline Multi-Gene Panel Testing-**Archived 080124**, and PG0467 Genetic Testing for Epilepsy	Prior authorization is required for ALL genetic testing unless otherwise noted.
81420	Fetal chromosomal aneuploidy (eg, trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18, and 21	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0287 Non-Invasive Prenatal Screening (NIPS)/Cell-Free DNA Screening for Fetal Aneuploidy	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
81422	Fetal chromosomal microdeletion(s) genomic sequence analysis (eg. DiGeorge syndrome, Cri-du- chat syndrome), circulating cell-free fetal DNA in maternal blood	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0287 Non-Invasive Prenatal Screening (NIPS)/Cell-Free DNA Screening for Fetal Aneuploidy	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 in addition to code for primary procedure	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 knowledge or unrelated condition/syndrome	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 genes, including CDH23, CLRN1, GJB2, GPR98, MTRNR1, MYO7A, MYO15A, PCDH15, OTOF	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 analyses for STRC and DFNB1 deletions in GJB2 and GJB6 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.
81432	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 10 genes, always including BRCA1, BRCA2, CDH1, MLH1, MSH2, MSH6, PALB2, PTEN, STK11, and TP53	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 Multi-Gene Panel Testing-Archived 080124	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
81433	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); duplication/deletion analysis panel, must include analyses for BRCA1, BRCA2, MLH1, MSH2, and STK11	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 Multi-Gene Panel Testing-Archived 080124	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 sequencing of at least 15 genes, including ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31	NON-COVERED - NO COMMERCIAL 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 analysis panel, must include analysis of at least 10 genes, including APC, BMPR1A, CDH1, MLH1, MSH2, MSH6, MUTYH,	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 PG0453 Germline Multi-Gene Panel Testing-Archived 080124	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 gene analysis panel, must include analysis of at least 5 genes, including MLH1, MSH2, EPCAM, SMAD4, and STK11	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 PG0453 Germline Multi-Gene Panel Testing-Archived 080124	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 analysis panel, must include sequencing of at least 6 genes, including MAX, SDHB, SDHC	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; duplication/deletion analysis panel, must include analyses for SDHB, SDHC, SDHD, and VHL	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 sequence analysis panel, must include sequencing of at least 5 cardiomyopathy-related genes (eg	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-Archived 080124	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
81440	Nuclear encoded mitochondrial genes (eg, neurologic or myopathic phenotypes), genomic sequence panel, must include analysis of at least 100 genes, including BCS1L, C10orf2, COQ2, COX10, DGUOK, MPV17, OPA1, PDSS2, POLG, POLG2, RRM2B, SCO1, SCO2	NON-COVERED - NO COMMERCIAL 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, GATA2 deficiency syndrome, congenital amegakaryocytic thrombocytopenia) 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.
81442	Noonan spectrum disorders (eg, Noonan syndrome, cardio-facio-cutaneous syndrome, Costello syndrome, LEOPARD syndrome, Noonan-like syndrome), genomic sequence analysis panel, must include sequencing of at least 12 genes, including BRAF, CBL	NON-COVERED - NO COMMERCIAL 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.
81443	Genetic testing for severe inherited conditions (eg, cystic fibrosis, Ashkenazi Jewish-associated disorders [eg, Bloom syndrome, Canavan disease, Fanconi anemia type C, mucolipidosis type VI, Gaucher disease, Tay-Sachs disease], beta hemoglobinopathies	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 Genetic Diseases	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, EGFR, ERBB2, KIT, KRAS, NRAS, MET, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, if performed	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 Malignancies-Archived 10012024, and PG0298 Molecular Markers in Fine Needle Aspirates of Thyroid Nodules-Acrhived 07012024.	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 neuropathy-related genes (eg, BSCL2, GJB1, MFN2, MPZ, REEP1, SPAST, SPG11, SPTLC1)	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
81449	Targeted genomic sequence analysis panel, solid organ neoplasm, 5-50 genes (eg, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, MET, NRAS, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, if performed; RNA analysis	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 Malignancies-Archived 100124	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, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KRAS, KIT, MLL, NRAS, NPM1, NOTCH1), interrogation for sequence variants, and copy number variants or rearrangements, or isoform	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 Malignancies-Archived 100124	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, KIT, KRAS, MLL, NOTCH1, NPM1, NRAS), interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; RNA analysis	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 Malignancies-Archived 100124	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 (eg, ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MLL, NPM1, NRAS, MET, NOTCH1, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN	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 Malignancies-Archived 100124	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, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MET, MLL, NOTCH1	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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
81458	Solid organ neoplasm, genomic sequence analusis panel, interrogation for sequence variants; DNA analysis, copy number variants and microsatelite 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.
81459	Solid organ neoplasm, genomic sequence analusis panel, interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants, microsatellite instability, tumor mutation burden, and rearrangements	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.
81460	Whole mitochondrial genome (eg, Leigh syndrome, mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes [MELAS], myoclonic epilepsy with ragged-red fibers [MERFF], neuropathy, ataxia, and retinitis pigmentosa [NARP], Leber	NON-COVERED - NO COMMERCIAL 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 combined DNA and RNA analysis, copy number variants and rearrangements	NON-COVERED - NO COMMERCIAL INTERQUAL	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 combined DNA and RNA analysis; DNA analysis, copy number variants, and microsatellite instability	NON-COVERED - NO COMMERCIAL INTERQUAL	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 combined DNA and RNA analysis; DNA analysis or combined DNA and RNA analysis, copy number variants	NON-COVERED - NO COMMERCIAL INTERQUAL	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 heteroplasmy detection, if performed	NON-COVERED - NO COMMERCIAL 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	Elite Medicare Advantage	Policy	DETAILS/NOTES
81470	X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); genomic sequence analysis panel, must include sequencing of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1	NON-COVERED - NO COMMERCIAL 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 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1	NON-COVERED - NO COMMERCIAL 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, prognostic algorithm reported as a disease activity score	NON-COVERED - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION **NOT** REQUIRED	PG0041 Genetic Testing and PG0362 Vectra® DA; PG0043 Experimental Investigational Procedures Services	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 - NO COMMERCIAL INTERQUAL	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 - NO COMMERCIAL INTERQUAL	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 reported as a risk score	NON-COVERED - NO COMMERCIAL 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	Elite Medicare Advantage	Policy	DETAILS/NOTES
81504	Oncology (tissue of origin), microarray gene expression profiling of > 2000 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as tissue similarity scores	NON-COVERED - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION **NOT** REQUIRED	PG0041 Genetic Testing and PG0364 Gene Expression Profiling for Cancers of Unknown Primary Site	Prior authorization is required for ALL genetic testing unless otherwise noted.
81506	Endocrinology (type 2 diabetes), biochemical assays of seven analytes (glucose, HbA1c, insulin, hs-CRP, adiponectin, ferritin, interleukin 2-receptor alpha), utilizing serum or plasma, algorithm reporting a risk score	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 plasma, algorithm reported as a risk score for each trisomy	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0287 Non-Invasive Prenatal Screening (NIPS)/Cell-Free DNA Screening for Fetal Aneuploidy	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]), utilizing maternal serum, algorithm reported as a risk score	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], DIA), utilizing maternal serum, algorithm reported as a risk score	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 form]), utilizing maternal serum, algorithm reported as a risk score)	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 form], DIA) utilizing maternal serum, algorithm reported as a risk score (may include additional results from previous biochemical testing)	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for ALL genetic testing unless otherwise noted.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
81512	Fetal congenital abnormalities, biochemical assays of five analytes (AFP, uE3, total hCG, hyperglycosylated hCG, DIA) utilizing maternal serum, algorithm reported as a risk score	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 tissue, algorithms reported as percentage risk for metastatic recurrence and likelihood of benefit from extended	NON-COVERED - NO COMMERCIAL 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 recurrence score	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.
81520	Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin embedded tissue, algorithm reported as a recurrence risk score	NON-COVERED - NO COMMERCIAL 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.
81521	Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and 465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin embedded tissue, algorithm reported as index related to risk of distant metastasis	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.
81522	Oncology (breast), mRNA, gene expression profiling by RT-PRC of 12 genes (8 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk score	NON-COVERED - NO COMMERCIAL 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.
81523	Oncology (breast), mRNA, next-generation sequencing gene expression profiling of 70 content genes and 31 housekeeping genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk to distant metastasis	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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
81525	Oncology (colon), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin- embedded tissue, algorithm reported as a recurrence score	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing and PG0357 Gene Expression Profiling for Colorectal Cancer	ColoPrint®, GeneFx Colon®, OncoDefender-CRC® are non-covered for Commercial and Medicare product lines
81528	Oncology (colorectal) screening, quantitative real- time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result	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 embedded tissue, algorithm reported as recurrence risk, including likelihood of sentinel lymph node metastasis	NON-COVERED - NO COMMERCIAL 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 morphology, predictive algorithm reported as a drug response score; first single drug or drug combination	NON-COVERED	NON-COVERED	PG0122 In Vitro Chemoresistance & Chemosensitivity Assays PG0041 Genetic Testing; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
81536	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; each additional single drug or drug combination (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0122 In Vitro Chemoresistance & Chemosensitivity Assays PG0041 Genetic Testing; PG0043 Experimental Investigational Procedures Services	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 poor overall survival	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.

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81539	Oncology (high-grade prostate cancer), biochemical assay of four proteins (Total PSA, Free PSA, Intact PSA and human kallikrein-2 [hK2]), utilizing plasma or serum, prognostic algorithm reported as a probability score	NON-COVERED - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing. -PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate Cancer-**archived 020425.**. PG0031 Prostate Cancer Screening	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 92 genes (87 content and 5 housekeeping) to classify tumor into main cancer type and subtype, utilizing formalin-fixed paraffin-embedded tissue, algorithm	NON-COVERED - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing and PG0364 Gene Expression Profiling for Cancers of Unknown Primary Site	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 tissue, algorithm reported as a disease-specific mortality 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 Prostate Cancer-**archived 020425**. PG0367 Archived.	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 reported as metastasis 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 Prostate Cancer-archived 020425.**	Prior authorization is required for ALL genetic testing unless otherwise noted.
81546	Oncology (thyroid), mRNA, gene expression analysis of 10,196 genes, utilizing fine needle aspirate, algorithm reported as a categorical result (eg, benign or suspicious) (Afirma Genomic Sequencing Classifier)	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing and PG0298 Molecular Markers in Fine Needle Aspirates of Thyroid Nodules,Archived 07012024	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, algorithm reported as a likelihood of prostate cancer detection on repeat biopsy	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 Cancer-**archived 020425**.	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)	NON-COVERED - NO COMMERCIAL 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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
81554	Pulmonary disease (idiopathic pulmonary fibrosis [IPF]), mRNA, gene expression analysis of 190 genes, utilizing transbronchial biopsies, diagnostic algorithm reported as categorical result (eg, positive or negative for high probability of usual interstitial	NON-COVERED - NO COMMERCIAL INTERQUAL	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 third-party-induced CD154+T-cytotoxic memory cells, utilizing whole peripheral blood, algorithm reported as a rejection risk score	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 genes (11 content and 9 housekeeping), utilizing subfraction of peripheral blood, algorithm reported as a rejection risk score	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0041 Genetic Testing and PG0525 Molecular Testing for Solid Organ Allograft Rejection	Prior authorization is required for ALL genetic testing unless otherwise noted.
81596	Infectious disease, chronic hepatitis C virus (HCV) infection, six biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, and haptoglobin) utilizing serum, prognostic algorithm reported as scores for fibrosis and	NON-COVERED - NO COMMERCIAL INTERQUAL	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	NON-COVERED - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0119 Gene Expression Profiling of Melanomas- Archived 07/01/2024, PG0298 Molecular Markers in Fine Needle Aspirates of Thyroid Nodules-**Archived 07/01/2024**	Prior authorization is required for ALL genetic testing unless otherwise noted.
83516	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semiquantitative; multiple step method (may be utilized for RAST, MAST, FAST, PRIST, RIST, MRT (modified RAST), VAST, ELISA, or ImmunoCAP)	NON-COVERED - See Notes	NON-COVERED - See Notes	PG0188 Allergy Testing and Treatments	83516 is denied when billed with diagnosis- K52.21-K52.29, Z91.010-Z91.018, Z91.02, as noncovered, experimental/investigational
83037	Hemoglobin; glycosylated (A1c) by device cleared by fda for home use	PRIOR AUTHORIZATION NOT REQUIRED-SEE NOTES FOR COVERAGE DETAILS	PRIOR AUTHORIZATION NOT REQUIRED-SEE NOTES FOR COVRAGE DETAILS		Hemoglobin A1c testing device for home use, in the management of diabetes, is considered experimental/investigational. Its incremental benefit above home glucose monitoring has not been established. Procedure 83037 is not covered for home use (i.e. not an all-inclusive listing, place of service 02, 03, 04, 10, 12, 13, 14, 16, 18). using an FDA approved point-of-care device (83037), in the physician's office is considered established for diabetes management. It may be used as an alternative to laboratory measured hemoglobin A1c (i.e. not an all-inclusive listing, place of service 11, 15, 22). Point-of-care A1C assays have not been prospectively studied for the diagnosis of diabetes and are not recommended for diabetes diagnosis; if used, they should be

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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	

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84431	Thromboxane metabolite(s), including thromboxane if performed, urine	NON-COVERED	NON-COVERED	PG0392 Cardiovascular Disease (CVD) Risk Testing	
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, circulating tumor cells in blood);	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and PG0500 Liquid Biopsy-**Archived 100124**	Prior authorization is required for ALL genetic testing unless otherwise noted.
86153	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and PG0500 Liquid Biopsy-**Archived 100124**	Prior authorization is required for ALL genetic testing unless otherwise noted.
86343	Leukocyte histamine release test (LHR)	NON-COVERED	NON-COVERED	PG0188 Allergy Testing and Treatments	
87623	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), low-risk types (e.g., 6, 11, 42, 43, 44)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0369 Human Papillomavirus (HPV) Screening	87623, 87624, 87625, 87626, 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-risk types (e.g.,16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0369 Human Papillomavirus (HPV) Screening	87623, 87624, 87625, 87626, 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.

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87625	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0369 Human Papillomavirus (HPV) Screening	87623, 87624, 87625, 87626, 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.
87626	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), separately reported high-risk types (eg, 16, 18, 31, 45, 51, 52) and high-risk pooled result(s)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0369 Human Papillomavirus (HPV) Screening	87623, 87624, 87625, 87626, 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 bioinformatics	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures ServicesPG0346. HIV Genotyping and Phenotyping Laboratory Testing-archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
88230	Tissue culture for non-neoplastic disorders; lymphocyte	PRIOR AUTHORIZATION REQUIRED - INTERQUAL- 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - 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-	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-**Archived**	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 - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications, diagnosis C00-D49	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-**Archived**	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,
88235	Tissue culture for non-neoplastic disorders; amniotic fluid or chorionic villus cells	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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
88237	Tissue culture for neoplastic disorders; bone marrow, blood cells	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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

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88239	Tissue culture for neoplastic disorders; solid tumor	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-**Archive**d	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
88240	Cryopreservation, freezing and storage of cells, each cell line	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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
88241	Thawing and expansion of frozen cells, each aliquot	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-**Archived**	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
88245	Chromosome analysis for breakage syndromes; baseline Sister Chromatid Exchange (SCE), 20-25 cells	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-**Archived**	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
88248	Chromosome analysis for breakage syndromes; baseline breakage, score 50-100 cells, count 20 cells, 2 karyotypes (eg, for ataxia telangiectasia, Fanconi anemia, fragile X)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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
88249	Chromosome analysis for breakage syndromes; score 100 cells, clastogen stress (eg, diepoxybutane, mitomycin C, ionizing radiation, UV radiation)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-**Archived**	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
88261	Chromosome analysis; count 5 cells, 1 karyotype, with banding	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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

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88262	Chromosome analysis; count 15-20 cells, 2 karyotypes, with banding	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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
88263	Chromosome analysis; count 45 cells for mosaicism, 2 karyotypes, with banding	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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
88264	Chromosome analysis; analyze 20-25 cells	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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
88267	Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, 1 karyotype, with banding	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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
88269	Chromosome analysis, in situ for amniotic fluid cells, count cells from 6-12 colonies, 1 karyotype, with banding	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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
88271	Molecular cytogenetics; DNA probe, each (eg, FISH)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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
88272	Molecular cytogenetics; chromosomal in situ hybridization, analyze 3-5 cells (eg, for derivatives and markers)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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

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88273	Molecular cytogenetics; chromosomal in situ hybridization, analyze 10-30 cells (eg, for microdeletions)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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
88274	Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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,
88275	Molecular cytogenetics; interphase in situ hybridization, analyze 100-300 cells	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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
88280	Chromosome analysis; additional karyotypes, each study	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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
88283	Chromosome analysis; additional specialized banding technique (eg, NOR, C-banding)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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
88285	Chromosome analysis; additional cells counted, each study	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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
88289	Chromosome analysis; additional high resolution study	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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

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88291	Cytogenetics and molecular cytogenetics, interpretation and report	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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
88299	Unlisted cytogenetic study	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - 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	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - - Molecular cytogenetic testing does require prior authorization for all product lines, except when used for Hematology/Oncology indications	PG0041 Genetic Testing and PG0375 Molecular Cytogenetic Testing-Archived	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
90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each [Synagis]	SEE NOTES	SEE NOTES	PG0528 Respiratory Syncytial Virus Infection Prophylaxis-archived 020125	RSV Monoclonal Antibody Palivizumab (**Synagis**), medical benefit, is covered with a prior authorization when the coverage criteria below are met, through Prime Therapeutics @ https://www.primetherapeutics.com/ ~~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.

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90651	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 2 or 3 dose schedule, for intramuscular use	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
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). Paramount considers EMDR threapy experimental/investigational for all other indications.
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). Paramount considers EMDR threapy experimental/investigational for all other indications.
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). Paramount considers EMDR threapy experimental/investigational for all other indications.
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). Paramount considers EMDR threapy experimental/investigational for all other indications.

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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). Paramount considers EMDR threapy experimental/investigational for all other indications.
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). Paramount considers EMDR threapy experimental/investigational for all other indications.
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). Paramount considers EMDR threapy experimental/investigational for all other indications.
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). Paramount considers EMDR threapy experimental/investigational for all other indications.
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). Paramount considers EMDR threapy experimental/investigational for all other indications.
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). Paramount considers EMDR threapy experimental/investigational for all other indications.
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). Paramount considers EMDR threapy experimental/investigational for all other indications.

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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). Paramount considers EMDR threapy experimental/investigational for all other indications.
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). Paramount considers EMDR threapy experimental/investigational for all other indications.
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). Paramount considers EMDR threapy experimental/investigational for all other indications.
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). Paramount considers EMDR threapy experimental/investigational for all other indications.
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, 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. Accelerated repetitive transcranial magnetic stimulation (rTMS), Navigated transcranial magnetic stimulation (nTMS), and Theta burst stimulation (TBS) are non-covered.
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. Accelerated repetitive transcranial magnetic stimulation (rTMS), Navigated transcranial magnetic stimulation (nTMS), and Theta burst stimulation (TBS) are non-covered.
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. Accelerated repetitive transcranial magnetic stimulation (rTMS), Navigated transcranial magnetic stimulation (nTMS), and Theta burst stimulation (TBS) are non-covered.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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). Paramount considers EMDR threapy experimental/investigational for all other indications.
90870	Electroconvulsive therapy (includes necessary monitoring)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0485 Electroconvulsive Therapy (ECT)- Archived 10/01/2024	
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented behavior modifying or supportive psychotherapy); 30 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). Paramount considers EMDR threapy experimental/investigational for all other indications.
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). Paramount considers EMDR threapy experimental/investigational for all other indications.
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). Paramount considers EMDR threapy experimental/investigational for all other indications.
90882	Environmental intervention for medical management purposes on a psychiatri patient's behalf with agencies, employers, or institutions	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 (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD). Paramount considers EMDR threapy experimental/investigational for all other indications.
90885	Psychatric evaluation of hospital records, other psychiatic reports, psychometric and/or projective tests, and other accumlated data for medical diagnostic purposes	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 (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD). Paramount considers EMDR threapy experimental/investigational for all other indications.

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90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures or accumulated data to family or other responsible persons, or advising them how to assist patient	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 (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD). Paramount considers EMDR threapy experimental/investigational for all other indications.
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals agencies, or insurance carriers	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 (EMDR) therapy. Paramount considers EMDR therapy medically necessary for the tx of post-traumatic stress disorer (PTSD). Paramount considers EMDR threapy experimental/investigational for all other indications.
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). Paramount considers EMDR threapy experimental/investigational for all other indications.
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, with interpretation and report	NON-COVERED	NON-COVERED	PG0028 Wireless Capsule Endoscopy & Gastrointestinal Motility Monitoring System-archived 07/01/24	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	

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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
92015	Determination of refractive state	SEE NOTES	SEE NOTES	PG0331 Refractive Vision Services - Archived. **See Reimbursement Policy RM038 Refractive Vision Services**	Effective 01/01/2024 Refraction: CPT 92015 describes refraction and any necessary prescription of lenses. Refraction is not separately reimbursed as part of a routine eye exam or as part of a medical examination and evaluation with or without treatment/diagnostic program, as it is considered included.
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	
92066	Orthoptic training; under supervision of a physician or other qualified health care professional	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0318 Vision Therapy	
92081	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (e.g., tangent screen, autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)	PRIOR AUTHORIZATION NOT REQUIRED - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - SEE NOTES		Visual field examinations (92081, 92082, and 92083) performed by providers, who are specialized in ophthalmology, retinology, optometry, neurology or plastic surgery do not require prior authorization.
92082	Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (e.g., at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold	PRIOR AUTHORIZATION NOT REQUIRED - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - SEE NOTES		Visual field examinations (92081, 92082, and 92083) performed by providers, who are specialized in ophthalmology, retinology, optometry, neurology or plastic surgery do not require prior authorization.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
92083	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30, or quantitative, automated threshold perimetry, octopus	PRIOR AUTHORIZATION NOT REQUIRED - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - SEE NOTES		Visual field examinations (92081, 92082, and 92083) performed by providers, who are specialized in ophthalmology, retinology, optometry, neurology or plastic surgery do not require prior authorization.
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report	NON-COVERED	NON-COVERED	PG0317 Corneal Hysteresis Determination by Air Impulse Stimulation-archived 11/01/2024; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
92512	Nasal function studies (e.g., rhinomanometry)	NON-COVERED	NON-COVERED	PG0045 Rhinomanometry & Acoustic – Optical Rhinometry-Archived; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
92517	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP)	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0323 Vestibular Function Testing; PG0043 Experimental Investigational Procedures Services	~~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 (oVEMP)	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0323 Vestibular Function Testing; PG0043 Experimental Investigational Procedures Services	~~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 (cVEMP) and ocular (oVEMP)	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED	PG0323 Vestibular Function Testing; PG0043 Experimental Investigational Procedures Services	~~NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL~~ Effective 07/01/2024 procedures 92517, 92518, 92519 are covered without a prior authorization, when the coverage criteria are met.
92520	Laryngeal function studies (ie, aerodynamic testing and acoustic testing)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
92548	Computerized dynamic posturography	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~ EFFECTIVE 03/01/2025 NON-COVERED	~~PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA~~ EFFECTIVE 03/01/2025 NON-COVERED	PG0323 Vestibular Function Testing	Effective 03/01/2025 Computerized Dynamic Posturography (CDP) testing, procedures 92548 and 92549, are noncovered for all product lines.
92549	Computerized dynamic posturography with motor control test (MCT) and adaptation test (ADT)	~~PRIOR AUTHORIZATION REQUIRED - INTERQUAL~~ EFFECTIVE 03/01/2025 NON-COVERED	~~PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA~~ EFFECTIVE 03/01/2025 NON-COVERED	PG0323 Vestibular Function Testing	Effective 03/01/2025 Computerized Dynamic Posturography (CDP) testing, procedures 92548 and 92549, are noncovered for all product lines.
92972	Percutaneous transluminal coronary lithotripsy (list separately in addition to code for primary procedure)	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 weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care	NON-COVERED	NON-COVERED	PG0377 Pulmonary Artery Pressure Monitoring (CardioMEMS)-Archived 090124; PG0043 Experimental Investigational Procedures Services	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-Archived; PG0043 Experimental Investigational Procedures Services	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-Archived; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
93592	Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures-Archived; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
93668	Peripheral arterial disease (PAD) rehabilitation, per session	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0414 Peripheral Artery Disease (PAD) Rehabilitation-Archived 01/01/2025.Prior Authorization to follow InterQual	Effective 01/01/2024 covered for Paramount Commercial Insurance Plans - PROR AUTHORIZATION IS REQUIRED
93701	Bioimpedance-derived physiologic cardiovascular analysis	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0282 Thoracic Electrical Bioimpedance for the Measurement of Cardiac Output-Archived; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL. Effective 10/01/2024 procedure 93701 changed from noncovered to covered without a prior authorization for the Elite (Medicare Advantage) Plans, per NCD in InterQual
93702	Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services; PG0295 Treatment of Lymphedema-archived 120124	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
93797	Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)	PRIOR AUTHORIZATION NOT REQUIRES - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA -SEE NOTES		The number of Phase II cardiac rehabilitation sessions is limited to a maximum of 2 1-hour sessions per day, utilizing any combination of the CPT or HCPCS codes (93798, 93797 or G0422, G0423), for up to 36 sessions or as the members benefit contract limitation indicates, over up to 36 weeks. The following are considered not medically necessary and are therefore non-covered: · Outpatient phase II cardiac rehabilitation for any indications other than those listed above; and · Phase III cardiac rehabilitation programs, or self-directed, self-controlled, or monitored exercise programs; and
93798	Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)	PRIOR AUTHORIZATION NOT REQUIRES - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA -SEE NOTES		The number of Phase II cardiac rehabilitation sessions is limited to a maximum of 2 1-hour sessions per day, utilizing any combination of the CPT or HCPCS codes (93798, 93797 or G0422, G0423), for up to 36 sessions or as the members benefit contract limitation indicates, over up to 36 weeks. The following are considered not medically necessary and are therefore non-covered: · Outpatient phase II cardiac rehabilitation for any indications other than those listed above; and · Phase III cardiac rehabilitation programs, or self-directed, self-controlled, or monitored exercise programs; and · Phase IV cardiac rehabilitation programs or maintenance therapy that may be safely conducted without medical supervision; and · Cardiac rehabilitation when used in a preventive or prophylactic way, such as for angina, hypertension, or diabetes; and Any cardiac rehabilitation services that are considered primarily educational or training in nature.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
95060	Ophthalmic mucous membrane tests	NON-COVERED	NON-COVERED	PG0188 Allergy Testing and Treatments	
95065	Direct nasal mucous membrane test	NON-COVERED	NON-COVERED	PG0188 Allergy Testing and Treatments	
95120	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; single injection	NON-COVERED	NON-COVERED	PG0188 Allergy Testing and Treatments	
95125	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; two or more injections	NON-COVERED	NON-COVERED	PG0188 Allergy Testing and Treatments	
95130	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; single stinging insect venom	NON-COVERED	NON-COVERED	PG0188 Allergy Testing and Treatments	
95131	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; 2 stinging insect venom	NON-COVERED	NON-COVERED	PG0188 Allergy Testing and Treatments	
95132	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; 3 stinging insect venoms	NON-COVERED	NON-COVERED	PG0188 Allergy Testing and Treatments	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
95133	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; 4 stinging insect venom	NON-COVERED	NON-COVERED	PG0188 Allergy Testing and Treatments	
95134	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; 5 stinging insect venoms	NON-COVERED	NON-COVERED	PG0188 Allergy Testing and Treatments	
~~95708~~	~~Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored~~	~~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 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 Policy PG0333 Archived.
~~95709~~	~~Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance~~	~~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 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 Policy PG0333 Archived.
~~95710~~	~~Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance~~	~~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 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 Policy PG0333 Archived.
~~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 Policy PG0333 Archived.
~~95715~~	~~Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance~~	~~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 Policy PG0333 Archived.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
~~95716~~	~~Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance~~	~~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 Policy PG0333 Archived.
~~95719~~	~~Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording~~	~~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 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 Policy PG0333 Archived.
~~95720~~	~~Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording~~	~~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 Policy PG0333 Archived.
~~95725~~	~~Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of~~	~~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 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 Policy PG0333 Archived.
~~95726~~	~~Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of~~	~~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 Policy PG0333 Archived.
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone), and sleep time	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - See Details	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - See Details	PG0207 Sleep Study Testing-archived 120124. PG0247 Testing and Management of Obstructive Sleep Apnea	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 ONLY required for additional repeat unattended (unsupervised) adult home sleep study testing. Pediatric home sleep study testing (95800, 95801, 95806, G0398, G0399, and G0400) is non-covered.**
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 - See Details	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - See Details	PG0207 Sleep Study Testing-archived 120124. PG0247 Testing and Management of Obstructive Sleep Apnea	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 ONLY required for additional repeat unattended (unsupervised) adult home sleep study testing. Pediatric home sleep study testing (95800, 95801, 95806, G0398, G0399, and G0400) is non-covered.**

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
95803	Actigraphy, testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	NON-COVERED	NON-COVERED	PG0198 Actigraphy and Accelerometry Sleep Diagnostics - Archived 07/01/2024; PG0043 Experimental Investigational Procedures Services	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 - See Details	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - See Details	PG0207 Sleep Study Testing-archived 120124. PG0247 Testing and Management of Obstructive Sleep Apnea	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 ONLY required for additional repeat unattended (unsupervised) adult home sleep study testing. Pediatric home sleep study testing (95800, 95801, 95806, G0398, G0399, and G0400) is non-covered.**
95867	Needle electromyography; cranial nerve supplied muscle(s), unilateral	NON-COVERED ≤ 18 years old	NO PRIOR AUTH REQUIRED		
95919	Quantitative pupillometry with physician or qualified health care professional interpretation and report, unilateral or bilateral	NON-COVERED	NON-COVERED	PG0319 Quantitative Pupillometry/Pupillography; PG0043 Experimental Investigational Procedues Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
95941	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)	SEE NOTES	NON-COVERED	PG0326 Intraoperative Neurological onitoring - ARCHIVED 7/2024	Commercial Plans - Intraoperative neurological monitoring does not require prior authorization. Intraoperative monitoring is considered reimbursable as a separate service only when a licensed physician, other than the operating surgeon or anesthesiologist, **performs the monitoring while in attendance in the operating room throughout the procedure.**
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. 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.
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. 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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family **Deleted effective 01/01/2025**	SEE NOTES	SEE NOTES	PG0041 Genetic Testing and Genetic Counseling	Genetic Counseling (96040) provided by a trained genetic counselor does not require a prior authorization.
96041	Medical genetics and genetic counseling services, each 30 minutes of total time provided by the genetic counselor on the date of the encounter. New Code Effective 01/01/2025	SEE NOTES	SEE NOTES	PG0041 Genetic Testing and Genetic Counseling	Genetic Counseling (96041) provided by a trained genetic counselor does not require a prior authorization.
96567	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PG0348 Acne Surgery, Dermabrasion and Chemical Peels	Not Covered for acne treatment – diagnosis L70.0 - L70.9
96570	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s), first 30 minutes	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PG0348 Acne Surgery, Dermabrasion and Chemical Peels	Not Covered for acne treatment – diagnosis L70.0 - L70.9
96571	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s), each additional 15 minutes	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PG0348 Acne Surgery, Dermabrasion and Chemical Peels	Not Covered for acne treatment – diagnosis L70.0 - L70.9
96573	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PG0348 Acne Surgery, Dermabrasion and Chemical Peels	Not Covered for acne treatment – diagnosis L70.0 - L70.9

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
96574	Debridement of premalignant hyperkeratotic lesion(s) (ie, targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PG0348 Acne Surgery, Dermabrasion and Chemical Peels	Not Covered for acne treatment – diagnosis L70.0 - L70.9
96900	Actinotherapy (ultraviolet light)	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - MEDICAL POLICY - SEE NOTES	PG0348 Acne Surgery, Dermabrasion and Chemical Peels	Not Covered for acne treatment – diagnosis L70.0 - L70.9
96931	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, first lesion	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
96932	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, first lesion	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 report only, first lesion	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 and interpretation and report, each additional lesion (List separately in addition to code for primary procedure)	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 only, each additional lesion (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
96936	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, each additional lesion (List separately in addition to code for primary procedure)	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 07/01/2024	
97152	Behavior identification assessment by technician under direction of qualified health care professional, each 15 minutes	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0335 Children's Adaptive Behavior Services. Archived 07/01/2024	
97153	Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to one patient, each 15 minutes	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0335 Children's Adaptive Behavior Services. Archived 07/01/2024	
97154	Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to multiple patients, each 15 minutes	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0335 Children's Adaptive Behavior Services. Archived 07/01/2024	
97155	Adaptive behavior treatment with protocol modification administered by qualified health care professional to one patient, each 15 minutes	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0335 Children's Adaptive Behavior Services. Archived 07/01/2024	
97156	Family adaptive behavior treatment guidance by qualified health care professional (with or without patient present), each 15 minutes	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0335 Children's Adaptive Behavior Services. Archived 07/01/2024	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
97157	Family adaptive behavior treatment guidance by qualified health care professional without patient present, each 15 minutes	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0335 Children's Adaptive Behavior Services. Archived 07/01/2024	
97158	Group adaptive behavior treatment with protocol modification administered by qualified health care professional to multiple patients, each 15 minutes	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0335 Children's Adaptive Behavior Services. Archived 07/01/2024	
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 be administered annually.
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 separately in addition to code for primary procedure)	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 be administered annually.
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 be administered annually.
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 separately in addition to code for primary procedure)	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 be administered annually.
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY. See Details/Notes	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).** Effective 1/1/2021 a PRIOR AUTHORIZATION REQUIRED for all chiropractic visits exceeding 30 per year. This policy includes all combination of procedure codes 98940, 98941 and 98942

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY. See Details/Notes	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**). Effective 1/1/2021 a PRIOR AUTHORIZATION REQUIRED for all chiropractic visits exceeding 30 per year. This policy includes all combination of procedure codes 98940, 98941 and 98942
98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY. See Details/Notes	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**). Effective 1/1/2021 a PRIOR AUTHORIZATION REQUIRED for all chiropractic visits exceeding 30 per year. This policy includes all combination of procedure codes 98940, 98941 and 98942
98943	Chiropractic manipulative treatment (CMT); extraspinal, one or more regions	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY. See Details/Notes	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 children under 4 years of age. **Coverage per CMS criteria of subluxation (98940-98942).** Effective 1/1/2021 a PRIOR AUTHORIZATION REQUIRED for all chiropractic visits exceeding 30 per year. This policy includes all combination of procedure codes 98940, 98941 and 98942
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 reported	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 algorithm reported as a risk score	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0002U	Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition, algorithm reported as	NON-COVERED	NON-COVERED	PG0065 Colorectal Cancer Screening PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0003U	Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II, follicle stimulating hormone, human epididymis protein 4, transferrin), utilizing serum, algorithm reported as a likelihood score	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0005U	Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3, and SPDEF), urine, algorithm reported as risk score	NON-COVERED - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0367 Genetic and Protein Biomarkers for Diagnosis.and Risk Assessment of Prostate Cancer-**archived 020425**.	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 carcinoma tumor tissue, with alpha-fetoprotein level, algorithm reported as a risk classifier	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	
0007M	Oncology (gastrointestinal neuroendocrine tumors), real-time PCR expression analysis of 51 genes, utilizing whole peripheral blood, algorithm reported as a nomogram of tumor disease index	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	
0007U	Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service	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 paraffin embedded tissue isolated using image- based dielectrophoresis (DEP) sorting, reported as ERBB2 gene amplified or non-amplified	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)-Archived 10/01/2024	
0011M	Oncology, prostate cancer, mRNA expression assay of 12 genes (10 content and 2 housekeeping), RT-hyphenPCR test utilizing blood plasma and/or urine, algorithms to predict high-hyphengrade prostate cancer risk	NON-COVERED	NON-COVERED	PG0041 Genetic Testing. and PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate Cancer-**archived 020125**	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0011U	Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, using oral fluid, reported as a comparison to an estimated steady-state range, per date of service including all drug compounds and metabolites	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0012M	Oncology (urothelial), mRNA, gene expression profiling by real-hyphentime quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and XCR2), utilizing urine, algorithm reported as a risk score for having urothelial carcinoma	NON-COVERED - NO COMMERCIAL INTERQUAL	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 five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma	NON-COVERED - NO COMMERCIAL INTERQUAL	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 peptide [PIIINP], tissue inhibitor of metalloproteinase 1 [TIMP-1]), using immunoassays, utilizing serum, prognostic algorithm reported as a risk score and risk of	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 and clinical parameters, prognostic algorithm reported as a clinical risk and integrated clinical steroid risk for adrenal cortical carcinoma, adenoma, or other adrenal	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 molecular subtype (luminal, luminal infiltrated, basal, basal claudin-low, neuroendocrine-like)	NON-COVERED - NO COMMERCIAL 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.
0016U	Oncology (hematolymphoid neoplasia), RNA, BCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR amplification, blood or bone marrow, report of fusion not detected or detected with quantitation	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
0017M	Oncology (diffuse large B-cell lymphoma [DLBCL]), mRNA, gene expression profiling by fluorescent probe hybridization of 20 genes, formalin-fixed paraffinembedded tissue, algorithm reported as cell of origin	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	
0017U	Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected	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 CD154+Tcytotoxic memory cells, utilizing whole peripheral blood, algorithm reported as a rejection risk score	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 needle aspirate, algorithm reported as a positive or negative result for moderate to high risk of malignancy	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0298 Molecular Markers in Fine Needle Aspirates of Thyroid Nodules-**Archived 07/01/2024**	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 algorithm reported as 4-year likelihood of coronary event in high-risk polulations	NON-COVERED	NON-COVERED	PG0392 Cardiovascular Disease (CVD) Risk Testing	
0019U	Oncology, RNA, gene expression by whole transcriptome sequencing, formalin-fixed paraffin embedded tissue or fresh frozen tissue, predictive algorithm reported as potential targets for therapeutic agents	NON-COVERED	NON-COVERED		
0021U	Oncology (prostate), detection of 8 autoantibodies (ARF 6, NKX3-1, 5GÇÖUTR-BMI1, CEP 164, 3GÇÖ-UTRRopporin, Desmocollin, AURKAIP-1, CSNK2A2), multiplexed immunoassay and flow cytometry serum, algorithm reported as risk score	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. and PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate Cancer-**archived 020425.**	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0022U	Targeted genomic sequence analysis panel, non-small cell lung neoplasia, DNA and RNA analysis, 23 genes, interrogation for sequence variants and rearrangements, reported as presence/absence of variants and associated therapy(ies) to consider	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 Malignancies-Archived 100124	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, p.D835, p.I836, using mononuclear cells, reported as detection or non-detection of FLT3 mutation and indication for or against the use of midostaurin	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, quantitative	NON-COVERED	NON-COVERED	PG0392 Cardiovascular Disease (CVD) Risk Testing; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0025U	Tenofovir, by liquid chromatography with tandem mass spectrometry (LC-MS/MS), urine, quantitative	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 categorical result ("Positive, high probability of malignancy" or "Negative, low probability of	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 07/01/2024	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
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, CYP4F2, SLCO1B1, VKORC1 and rs12777823)	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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 - NO COMMERCIAL 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.
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, HTR2A rs7997012 [c.614-2211T>C], HTR2C rs3813929 [c.-759C>T] and rs1414334 [c.551-	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, TPMT *2, *3A, *3B, *3C, *4, *5, *6, *8, *12; NUDT15 *3, *4, *5)	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 normal specimen, sequence analyses	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 amplifications, gene rearrangements, microsatellite instability and tumor mutational burden	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 Malignancies-Archived 100124	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0038U	Vitamin D, 25 hydroxy D2 and D3, by LCMS/MS, serum microsample, quantitative	~~NON-COVERED~~ Effective 02/01/2025 COVERED, WITHOUT A PRIOR AUTHORIZAITON	~~NON-COVERED~~ Effective 02/01/2025 COVERED, WITHOUT A PRIOR AUTHORIZAITON	PG0433 Vitamin D Testing-Archived 020125; ~~PG0043 Experimental Investigational Procedures Services -~~ effective 02/01/2025 procedure 0038U is covered without a prior authorization, for all product lines.	-
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-fixed paraffin-embedded tissue, algorithm reported as recurrence score	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) variants, 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.
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 tissue, algorithm reported as a 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 Prostate Cancer-**archived 020425.**	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 mutations and microsatellite instability, matched with normal specimens, utilizing formalin-fixed paraffin-	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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0050U	Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants, copy number variants or rearrangements	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, reported as quantitative results, detected or not detected, per date of service	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 lipoprotein classes and subclasses of HDL, LDL, and VLDL by vertical auto profile ultracentrifugation	NON-COVERED	NON-COVERED	PG0392 Cardiovascular Disease (CVD) Risk Testing; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0054T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0128 Computer Assisted Surgery-archived-Medical Policy PG0128 Robotic & Computer Assisted Surgery/Navigation is being converted to Reimbursement Policy RM031	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0054U	Prescription drug monitoring, 14 or more classes of drugs and substances, definitive tandem mass spectrometry with chromatography, capillary blood, quantitative report with therapeutic and toxic ranges, including steady-state range for the prescribed dose	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0055T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0128 Computer Assisted Surgery Medical Policy-archived-Medical Policy PG0128 Robotic & Computer Assisted Surgery/Navigation is being converted to Reimbursement Policy RM031	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0055U	Cardiology (heart transplant), cell-free DNA, PCR assay of 96 DNA target sequences (94 single nucleotide polymorphism targets and two control target(s), plasma	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0058U	Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus oncoprotein (small T antigen), serum, quantitative	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 protein (VP1), serum, reported as positive or negative	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 DNA in maternal blood	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], oxyhemoglobin [ctHbO2], deoxyhemoglobin [ctHbR], papillary and reticular dermal hemoglobin concentrations [ctHb1 and ctHb2]), using spatial frequency domain imaging (SFDI) and multi-spectral	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 serum, algorithm reported with a risk score (SLEkey® Rule Out, Veracis Inc, Veracis Inc)	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 (BioPlex 2200 Syphilis Total & RPR Assay, Bio-Rad Laboratories, Bio-Rad Laboratories)	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-vaginal fluid, each specimen	NON-COVERED	NON-COVERED	PG0048 Tests for the Evaluation of Preterm Labor and Premature Rupture of Membranes; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0067U	Oncology (breast), immunohistochemistry, protein expression profiling of 4 biomarkers (matrix metalloproteinase-1 [MMP-1], carcinoembryonic antigen-related cell adhesion molecule 6 [CEACAM6], hyaluronoglucosaminidase	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0069U	Oncology (colorectal), microRNA, RT-PCR expression profiling of miR-31-3p, formalin-fixed paraffin-embedded tissue, algorithm reported as an expression score	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, *9, *10, *11, *12, *13, *14A, *14B, *15, *17, *29, *35, *36, *41, *57, *61*63, *68, CYP2D6	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 volume less than 200 cc of tissue	NON-COVERED	NON-COVERED	PG0344 Uterine Fibroid Surgical Treatments-Archived 080124. PG0043 Experimental/Investigational	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 primary procedure) (Use 0071U in conjunction with 0070U)	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 volume greater or equal to 200 cc of tissue	NON-COVERED	NON-COVERED	PG0344 Uterine Fibroid Surgical Treatments-Archived 080124. PG0043 Experimental/Investigational	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 gene) (List separately in addition to code for primary procedure) (Use 0072U in conjunction with 0070U)	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
0073U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, CYP2D7-2D6 hybrid gene) (List separately in addition to code for primary procedure) (Use 0073U in conjunction with 0070U)	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 duplication/multiplication is trans) (List separately in addition to code for primary procedure) (Use 0074U	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) (List separately in addition to code for primary procedure) (Use 0075U in conjunction with 0070U)	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) (List separately in addition to code for primary procedure) (Use 0076U in conjunction with 0070U)	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 spectrometry, blood or urine, including isotype (M-Protein Detection and Isotyping by MALDI-TOF Mass Spectrometry, Mayo Clinic Laboratory Developed Test)	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, HTR2A, HTTLPR, MTHFR, MUOR, OPRK1, OPRM1), buccal swab or other germline tissue sample	NON-COVERED - NO COMMERCIAL 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.
0079U	Comparative DNA analysis using multiple selected single-nucleotide polymorphisms (SNPs), urine and buccal DNA, for specimen identity verification	NON-COVERED - NO COMMERCIAL 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	Elite Medicare Advantage	Policy	DETAILS/NOTES
0080U	Oncology (lung), mass spectrometric analysis of galectin-3-binding protein and scavenger receptor cysteine-rich type 1 protein M130, with five clinical risk factors (age, smoking status, nodule diameter, nodule-speculation status and nodule	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-COVERED 0092U.
0082U	Drug test(s), definitive, 90 or more drugs or substances, definitive chromatography with mass spectrometry, and presumptive, any number of drug classes, by instrument chemistry analyzer (utilizing immunoassay), urine, report of presence or absence of	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0083U	Oncology, response to chemotherapy drugs using motility contrast tomography, fresh or frozen tissue, reported as likelihood of sensitivity or resistance to drugs or drug combinations	NON-COVERED	NON-COVERED	PG0122 In Vitro Chemoresistance & Chemosensitivity Assays; PG0043 Experimental Investigational Procedures Services	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 - NO COMMERCIAL 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.
0086U	Infectious disease (bacterial and fungal), organism identification, blood culture, using Rrna FISH, 6 or more organism targets, reported as positive or negative with phenotypic minimum inhibitory concentration (MIC)-based antimicrobial susceptibility	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0087U	Cardiology (heart transplant), mRNA gene expression profiling by microarray of 1283 genes, transplant biopsy tissue, allograft rejection and injury algorithm reported as a	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 genes, utilizing transplant biopsy tissue, algorithm reported as a probability score for rejection	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
0089U	Oncology (melanoma), gene expression profiling by RTqPCR, PRAME and LINC00518, superficial collection using adhesive patch(es)	NON-COVERED - NO COMMERCIAL 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-embedded tissue, algorithm reported as a categorical result (ie, benign, intermediate, malignant)	NON-COVERED - NO COMMERCIAL 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. (i.e., MyPath Melanoma)
0091U	Oncology (colorectal) screening, cell enumeration of circulating tumor cells, utilizing whole blood, algorithm, for the presence of adenoma or cancer, reported as a positive or negative result	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, plasma, algorithm reported as risk score for likelihood of malignancy	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 reported detected or not detected	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, cervical (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0027 Artificial Intervertebral Disc Replacement	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0095U	Inflammation (eosinophilic esophagitis), ELISA analysis of eotaxin-3 (CCL26 [C-C motif chemokine ligand 26]) and major basic protein (PRG2 [proteoglycan 2, pro eosinophil major basic protein]), specimen obtained by swallowed nylon string, algorithm	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), male urine	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 additional interspace, cervical (List separately in addition to code for primary procedure)	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 of intra-ocular retinal electrode array, with vitrectomy	NON-COVERED	NON-COVERED	PG0418 Retinal Prosthesis	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0101T	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified, high energy	NON-COVERED	NON-COVERED	PG0004 Extracorporeal Shock Wave (ESWT)-Archived 090124	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0101U	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with	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 local, involving lateral humeral epicondyle	NON-COVERED	NON-COVERED	PG0004 Extracorporeal Shock Wave (ESWT)-Archived 090124	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0102U	Hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with MmRNA analytics to resolve variants of unknown significance	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, Sanger,,MLPA, and array CGH, with MmRNA analytics to resolve variants of unknown significance	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 immunoassay (ECLIA) of tumor necrosis factor receptor 1A, receptor superfamily 2 (TNFR1, TNFR2), and kidney injury molecule-1 (KIM-1) combined with	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 pressure stimuli to assess large diameter sensation	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) spirulina substrate, analysis of each specimen by gas isotope ratio mass spectrometry, reported as rate of 13Cos excretion	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 stimuli to assess large diameter fiber sensation	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, multiple-step method	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0108T	Quantitative sensory testing (QST), testing and interpretation per extremity; using cooling stimuli to assess small nerve fiber sensation and hyperalgesia	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0108U	Gastroenterology (Barrett's esophagus), whole slide-digital imaging, including morphometric analysis, computer-assisted quantitative immunolabeling of 9 protein biomarkers (p16, AMACR, p53, CD68, COX-2, CD45RO, HIF1a, HER-2, K20) and	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 stimuli to assess small nerve fiber sensation and hyperalgesia	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 to assess sensation	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 mass spectrometry with chromatography, serum or plasma from capillary blood or venous blood, quantitative report with steady-state range for the	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 genes) with drug-resistance gene	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 reported as risk score (MyProstateScore, Lynx DX)	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate Cancer. and PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate Cancer-**archived 020125**	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0114U	Gastroenterology (Barrett's esophagus), VIM and CCNA1 methylation analysis, esophageal cells, algorithm reported as likelihood for Barrett's esophagus	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 and 2 bacterial targets, amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected	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-MS/MS, oral fluid, algorithm results reported as a patient-compliance measurement with risk of drug-to-drug interactions for prescribed medications	NON-COVERED	NON-COVERED	PG0252 Noninvasive Tests for Hepatic Fibrosis; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0117U	Pain management, analysis of 11 endogenous analytes (methylmalonic acid, xanthurenic acid, homocysteine, pyroglutamic acid, vanilmandelate, 5-hydroxyindoleacetic acid, hydroxymethylglutarate, ethylmalonate, 3- hydroxypropyl	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 donor-derived cell-free DNA in the total cell-free DNA [when specified for heart transplant rejection] [Allosure	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 report with risk score for major cardiovascular events MI-HEART Ceramides, Plasma	NON-COVERED	NON-COVERED	PG0392 Cardiovascular Disease (CVD) Risk Testing; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0120U	Oncology (B-cell lymphoma classification), mRNA, gene expression profiling by fluorescent probe hybridization of 58 genes (45 content and 13 housekeeping genes), formalin-fixe paraffin-embedded tissue, algorithm reported as likelihood for primary	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 deletion/duplication analysis panel (ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2	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 sequence analysis panel (APC, CDH1, CHEK2, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN, 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.
0131U	Hereditary breast cancer–related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (13 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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0132U	Hereditary ovarian cancer–related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (17 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.
0133U	Hereditary prostate cancer–related disorders, targeted mRNA sequence analysis panel (11 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.
0134U	Hereditary pan cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (18 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.
0135U	Hereditary gynecological cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (12 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.
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 - NO COMMERCIAL 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.
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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0140U	Infectious disease (fungi), fungal pathogen identification, DNA (15 fungal targets), blood culture, amplified probe technique, each target reported as detected or not detected	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 element detection, DNA (20 gram-positive bacterial targets, 4 resistance genes, 1 pan gram-negative bacterial target, 1 pan Candida target), blood culture	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 element detection, DNA (21 gram-negative bacterial targets, 6 resistance genes, 1 pan gram-positive bacterial target, 1 pan Candida target), amplified probe	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 with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per	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 with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per	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 with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per	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 with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0147U	Drug assay, definitive, 85 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per	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 with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per	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 with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per	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 with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per	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 (DNA or RNA), 33 targets, real-time semi-quantitative PCR, bronchoalveolar lavage, sputum, or endotracheal aspirate, detection of 33 organismal and antibiotic	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, untargeted next-generation sequencing, report for significant positive pathogens	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0153U	Oncology (breast), mRNA, gene expression profiling by next-generation sequencing of 101 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a triple negative breast cancer clinical subtype(s) with information on	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
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], p.S249C [c.746C>G], p.G370C [c.1108G>T], p.Y373C [c.1118A>G], FGFR3-TACC3v1	NON-COVERED - NO COMMERCIAL 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.
0155U	Oncology (breast cancer), DNA, PIK3CA (phosphatidylinositol-4,5-bisphosphate 3- kinase, catalytic subunit alpha) (eg, breast cancer) gene analysis (ie, p.C420R, p.E542K, p.E545A, p.E545D [g.1635G>T only], p.E545G, p.E545K, p.Q546E	NON-COVERED - NO COMMERCIAL 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 - NO COMMERCIAL 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.
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 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.
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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0161U	PMS2 (PMS1 homolog 2, mismatch repair system component) (eg, hereditary nonpolyposis colorectal 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.
0162U	Hereditary colon cancer (Lynch syndrome), targeted mRNA sequence analysis panel (MLH1, MSH2, MSH6, PMS2) (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.
0163T	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)	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 plasma or serum proteins (teratocarcinoma derived growth factor-1 [TDGF-1, Cripto-1], carcinoembryonic antigen [CEA], extracellular matrix protein [ECM1]	NON-COVERED	NON-COVERED	PG0065 Colorectal Cancer Screening; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0164T	Removal of total disc arthroplasty, (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)	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 antibodies, utilizing plasma, algorithm for elevated or not elevated qualitative results	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0165T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0027 Artificial Intervertebral Disc Replacement	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0165U	Peanut allergen-specific IgE and quantitative assessment of 64 epitopes using enzyme-linked immunosorbent assay (ELISA), blood, individual epitope results and interpretation	NON-COVERED	NON-COVERED	PG0188 Allergy Testing and Treatments. PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0166U	Liver disease, 10 biochemical assays (α2-macroglobulin, haptoglobin, apolipoprotein A1, bilirubin, GGT, ALT, AST, triglycerides, cholesterol, fasting glucose) and biometric and demographic data, utilizing serum, algorithm reported as scores for	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 of ASD diagnosis	NON-COVERED - NO COMMERCIAL 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.
0171U	Targeted genomic sequence analysis panel, acute myeloid leukemia, myelodysplastic syndrome, and myeloproliferative neoplasms, DNA analysis, 23 genes, interrogation for sequence variants, rearrangements 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.
0172U	Oncology (solid tumor as indicated by the label), somatic mutation analysis of BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) and analysis of homologous recombination deficiency pathways, DNA, formalin-fixed paraffin-	NON-COVERED - NO COMMERCIAL 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	Elite Medicare Advantage	Policy	DETAILS/NOTES
0173U	Psychiatry (ie, depression, anxiety), genomic analysis panel, includes variant analysis of 14 genes	NON-COVERED - NO COMMERCIAL 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.
0174T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed	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 tissue, prognostic and predictive algorithm reported as likely, unlikely, or uncertain benefit of 39 chemotherapy and targeted therapeutic oncology agents	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 detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed remote	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 - NO COMMERCIAL 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 0175U from noncovered to covered with a prior authorization, InterQual, for Elite, effective 11/01/2024.
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 subunit alpha) gene analysis of 11 gene variants utilizing plasma, reported as PIK3CA gene mutation status	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
0178U	Peanut allergen-specific quantitative assessment of multiple epitopes using enzyme-linked immunosorbent assay (ELISA), blood, report of minimum eliciting exposure for a clinical reaction	NON-COVERED	NON-COVERED	PG0188 Allergy Testing and Treatments. 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 without prior knowledge of partner/breakpoint, copy number variations), with report of significant	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0500 Liquid Biopsy-Archived 100124	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-N-acetylgalactosaminyltransferase and alpha 1-3-galactosyltransferase) gene	NON-COVERED - NO COMMERCIAL 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.
0181U	Red cell antigen (Colton blood group) genotyping (CO), gene analysis, AQP1 (aquaporin 1 [Colton blood group]) exon 1	NON-COVERED - NO COMMERCIAL 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.
0182U	Red cell antigen (Cromer blood group) genotyping (CROM), gene analysis, CD55 (CD55 molecule [Cromer blood group]) exons 1-10	NON-COVERED - NO COMMERCIAL 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.
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 - NO COMMERCIAL 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.
0184U	Red cell antigen (Dombrock blood group) genotyping (DO), gene analysis, ART4 (ADP-ribosyltransferase 4 [Dombrock blood group]) exon 2	NON-COVERED - NO COMMERCIAL 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	Elite Medicare Advantage	Policy	DETAILS/NOTES
0185U	Red cell antigen (H blood group) genotyping (FUT1), gene analysis, FUT1 (fucosyltransferase 1 [H blood group]) exon 4	NON-COVERED - NO COMMERCIAL 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.
0186U	Red cell antigen (H blood group) genotyping (FUT2), gene analysis, FUT2 (fucosyltransferase 2) exon 2	NON-COVERED - NO COMMERCIAL 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.
0187U	Red cell antigen (Duffy blood group) genotyping (FY), gene analysis, ACKR1 (atypical chemokine receptor 1 [Duffy blood group]) exons 1-2	NON-COVERED - NO COMMERCIAL 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.
0188U	Red cell antigen (Gerbich blood group) genotyping (GE), gene analysis, GYPC (glycophorin C [Gerbich blood group]) exons 1-4	NON-COVERED - NO COMMERCIAL 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.
0189U	Red cell antigen (MNS blood group) genotyping (GYPA), gene analysis, GYPA (glycophorin A [MNS blood group]) introns 1, 5, exon 2	NON-COVERED - NO COMMERCIAL 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.
0190U	Red cell antigen (MNS blood group) genotyping (GYPB), gene analysis, GYPB (glycophorin B [MNS blood group]) introns 1, 5, pseudoexon 3	NON-COVERED - NO COMMERCIAL 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.
0191U	Red cell antigen (Indian blood group) genotyping (IN), gene analysis, CD44 (CD44 molecule [Indian blood group]) exons 2, 3, 6	NON-COVERED - NO COMMERCIAL 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	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 - NO COMMERCIAL 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.
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 - NO COMMERCIAL 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.
0194U	Red cell antigen (Kell blood group) genotyping (KEL), gene analysis, KEL (Kell metallo-endopeptidase [Kell blood group]) exon 8	NON-COVERED - NO COMMERCIAL 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.
0195U	KLF1 (Kruppel-like factor 1), targeted sequencing (ie, exon 13)	NON-COVERED - NO COMMERCIAL 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.
0196U	Red cell antigen (Lutheran blood group) genotyping (LU), gene analysis, BCAM (basal cell adhesion molecule [Lutheran blood group]) exon 3	NON-COVERED - NO COMMERCIAL 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.
0197U	Red cell antigen (Landsteiner-Wiener blood group) genotyping (LW), gene analysis, ICAM4 (intercellular adhesion molecule 4 [Landsteiner-Wiener blood group]) exon 1	NON-COVERED - NO COMMERCIAL 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.
0198T	Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services and PG0041 Genetic Testing	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0198U	Red cell antigen (RH blood group) genotyping (RHD and RHCE), gene analysis Sanger/chain termination/conventional sequencing, RHD (Rh blood group D antigen) exons 1-10 and RHCE (Rh blood group CcEe antigens) exon 5	NON-COVERED - NO COMMERCIAL 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.
0199U	Red cell antigen (Scianna blood group) genotyping (SC), gene analysis, ERMAP (erythroblast membrane associated protein [Scianna blood group]) exons 4, 12	NON-COVERED - NO COMMERCIAL 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.
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral	NON-COVERED	NON-COVERED	PG0038 Percutaneous Vertebroplasty, Kyphoplasty, and Sacroplasty-Archived. PG0043 Experimental Investigational Procedures Services	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 - NO COMMERCIAL 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.
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed	NON-COVERED	NON-COVERED	PG0038 Percutaneous Vertebroplasty, Kyphoplasty, and Sacroplasty-archived. PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0201U	Red cell antigen (Yt blood group) genotyping (YT), gene analysis, ACHE (acetylcholinesterase [Cartwright blood group]) exon 2	NON-COVERED - NO COMMERCIAL 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.
0202T	Posterior vertebral joint(s) arthroplasty (e.g., facet joint[s] replacement) including facetectomy, laminectomy, foraminotomy and vertebral column fixation, with or without injection of bone cement, including fluoroscopy, single level, lumbar	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0203U	Autoimmune (inflammatory bowel disease), mRNA, gene expression profiling by quantitative RT-PCR, 17 genes (15 target and 2 reference genes), whole blood, reported as a continuous risk score and classification of inflammatory bowel disease aggressiveness	NON-COVERED - NO COMMERCIAL 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.
0204U	Oncology (thyroid), mRNA, gene expression analysis of 593 genes (including BRAF, RAS, RET, PAX8, and NTRK) for sequence variants and rearrangements, utilizing fine needle aspirate, reported as detected or not detected	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, reported as positive or negative for neovascular age-related macular-degeneration risk associated with	NON-COVERED	NON-COVERED	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 kinase C-epsilon (PKCe) concentration in response to amylospheroid treatment by ELISA, cultured skin fibroblasts, each reported as positive or negative for Alzheimer	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 response to bradykinin treatment by in situ immunofluorescence, using cultured skin fibroblasts, reported as a probability index for Alzheimer disease (List separately in addition	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

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0208U	Oncology (medullary thyroid carcinoma), mRNA, gene expression analysis of 108 genes, utilizing fine needle aspirate, algorithm reported as positive or negative for medullary thyroid carcinoma [Deleted Code 01/01/2023]	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 for copy number, structural changes and areas of homozygosity for chromosomal abnormalities	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	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.
0209U	Cytogenomic constitutional (genome-wide) analysis, interrogation of genomic regions for copy number, structural changes and areas of homozygosity for chromosomal abnormalities	NON-COVERED - NO COMMERCIAL 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

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0211U	Oncology (pan-tumor), DNA and RNA by next-generation sequencing, utilizing formalin-fixed paraffin-embedded tissue, interpretative report for single nucleotide variants, copy number alterations, tumor mutational burden, and microsatellite	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 combined), automated	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0212U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely	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, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely	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 nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level	NON-COVERED	NON-COVERED	PG0354 Facet Joint Injections	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0213U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely	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.
0213U	Rare diseases (constitutional/heritable disorders), whole genome and mitochodrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
0214T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; second level	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, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely	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, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely	NON-COVERED - NO COMMERCIAL 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 nerves innervating that joint) with ultrasound guidance, cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)	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, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely	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, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely	NON-COVERED - NO COMMERCIAL 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 nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level	NON-COVERED	NON-COVERED	PG0354 Facet Joint Injections	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0216U	Neurology (inherited ataxias), genomic DNA sequence analysis of 12 common genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva	NON-COVERED - NO COMMERCIAL 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.
0217T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; second level (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0354 Facet Joint Injections	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0217U	Neurology (inherited ataxias), genomic DNA sequence analysis of 51 genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and	NON-COVERED - NO COMMERCIAL 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.
0218T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)	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 regions, blood or saliva, identification and characterization of genetic variants	NON-COVERED - NO COMMERCIAL 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.
0219T	Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0219U	Infectious agent (human immunodeficiency virus), targeted viral next-generation sequence analysis (ie, protease [PR], reverse transcriptase [RT], integrase [INT]), algorithm reported as prediction of antiviral drug susceptibility	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures ServicesPG0346. HIV Genotyping and Phenotyping Laboratory Testing-archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0220T	Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic	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 immunohistochemical features, reported as a recurrence score	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 of bone graft(s) or synthetic device(s), single level; lumbar	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 and alpha 1-3-galactosyltransferase) gene	NON-COVERED - NO COMMERCIAL 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.
0222T	Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (List separately in addition to code for primary procedure)	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 introns 2-3	NON-COVERED - NO COMMERCIAL 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.
0223U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0225U	Infectious disease (bacterial or viral respiratory tract infection) pathogen specific DNA and RNA, 21 targets, including severe acute respiratory syndrome coronavirus 2 (SARSCoV-2), amplified probe technique, including multiplex reverse transcription for 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 mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, includes sample validation	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0228U	Oncology (prostate), multianalyte molecular profile by photometric detection of macromolecules adsorbed on nanosponge array slides with machine learning, utilizing first morning voided urine, algorithm reported as likelihood of prostate cancer	NON-COVERED - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing. ~~PG0043 Experimental Investigational Procedures Services~~ and PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate Cancer- **archived 020124.**	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0229U	BCAT1 (Branched chain amino acid transaminase 1) or IKZF1 (IKAROS family zinc finger 1) (eg, colorectal cancer) promoter methylation analysis	NON-COVERED - NO COMMERCIAL 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.
0230U	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation), full sequence analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR)	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 regions, deletions, duplications, short tandem repeat (STR) gene expansions, mobile element	NON-COVERED - NO COMMERCIAL 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.
0232T	Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0293 Platelet Rich Plasma-Archived, PG0043 Experimental Investigational Procedures Services	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0232U	CSTB (cystatin B) (eg, progressive myoclonic epilepsy type 1A, Unverricht-Lundborg disease), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element	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 (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions	NON-COVERED - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing. PG0533 Genetic Testing for Neurodegenerative Disorders- **Archived 020125**	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0234T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; renal artery	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, duplications, mobile element insertions, and variants in non-uniquely mappable regions	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 radiological supervision and interpretation; visceral artery (except renal), each vessel	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 in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in	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 radiological supervision and interpretation; abdominal aorta	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 changes in exonic and intronic regions, duplications and deletions, and mobile element insertions	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 radiological supervision and interpretation; brachiocephalic trunk and branches, each vessel	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 sequence analysis panel including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1	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 radiological supervision and interpretation; iliac artery, each vessel	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0238U	Oncology (Lynch syndrome), genomic DNA sequence analysis of MLH1, MSH2, MSH6, PMS2, and EPCAM, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-	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 variants, including substitutions, insertions, deletions, select rearrangements, and copy number variations	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0500 Liquid Biopsy-**Archived 100124**	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 variants, gene copy number amplifications, and gene rearrangements	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0500 Liquid Biopsy-**Archived 100124**	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0243U	Obstetrics (preeclampsia), biochemical assay of placental-growth factor, time-resolved fluorescence immunoassay, maternal serum, predictive algorithm reported as a risk score for preeclampsia	NON-COVERED	NON-COVERED	PG0048 Tests for the Evaluation of Preterm Labor and Premature Rupture of Membranes; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0244U	Oncology (solid organ), DNA, comprehensive genomic profiling, 257 genes, interrogation for single-nucleotide variants, insertions/deletions, copy number alterations, gene rearrangements, tumor mutational burden and microsatellite instability, utilizing formalin-fixed paraffin embedded	NON-COVERED - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0438 Molecular Profiling (Somatic Testing) Panels for Solid Cancer Tumors and Hematologic Malignancies-Archived 100124	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, report includes associated risk of malignancy expressed as a percentage	NON-COVERED - NO COMMERCIAL INTERQUAL	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 - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0500 Liquid Biopsy-**Archived 100124**	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 globulin (SHBG), quantitative measurement by LC-MS/MS, utilizing maternal serum, combined with clinical data, reported as predictive-risk stratification for	NON-COVERED	NON-COVERED	PG0048 Tests for the Evaluation of Preterm Labor and Premature Rupture of Membranes; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0248U	Oncology (brain), spheroid cell culture in a 3D microenvironment, 12 drug panel, tumor-response prediction for each drug	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services, PG0122 In Vitro Chemoresistance & Chemosensitivity Assays	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0249U	Oncology (breast), semiquantitative analysis of 32 phosphoproteins and protein analytes, includes laser capture microdissection, with algorithmic analysis and interpretative report (Used to report the Theralink® Reverse Phase Protein Array (RPPA) test)	NON-COVERED	NON-COVERED	PG0301 Genetic Expression Assays for Breast Cancer Prognosis-Archived 090124, PG0122 In Vitro Chemoresistance & Chemosensitivity Assays	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0250U	Oncology (solid organ neoplasm), targeted genomic sequence DNA analysis of 505 genes, interrogation for somatic alterations (SNVs [single nucleotide variant], small insertions and deletions, one amplification, and four translocations), microsatellite	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.
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 of conception, reported as normal (euploidy), monosomy, trisomy, or partial deletion/duplications, mosaicism, and segmental aneuploidy	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0287 Non-Invasive Prenatal Screening (NIPS)/Cell-Free DNA Screening for Fetal Aneuploidy	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0253T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space	NON-COVERED	NON-COVERED	PG0327 Surgical Treatments for Glaucoma	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0253U	Reproductive medicine (endometrial receptivity analysis), RNA gene expression profile, 238 genes by next generation sequencing, endometrial tissue, predictive algorithm reported as endometrial window of implantation (e.g., pre-receptive, receptive, post-	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0254U	Reproductive medicine (preimplantation genetic assessment), analysis of 24 chromosomes using embryonic DNA genomic sequence analysis for aneuploidy, and a mitochondrial DNA score in euploid embryos, results reported as normal	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0255U	Andrology (infertility), sperm-capacitation assessment of ganglioside GM1 distribution patterns, fluorescence microscopy, fresh or frozen specimen, reported as percentage of capacitated sperm and probability of generating a pregnancy score	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0256U	Trimethylamine/trimethylamine N-oxide (TMA/TMAO) profile, tandem mass spectrometry (MS/MS), urine, with algorithmic analysis and interpretive report	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 blood	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 reported as likelihood of response to psoriasis biologics	NON-COVERED - NO COMMERCIAL 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.
0259U	Nephrology (chronic kidney disease), nuclear magnetic resonance spectroscopy measurement of myo-inositol, valine, and creatinine, algorithmically combined with cystatin C (by immunoassay) and demographic data to determine	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 variants by optical genome mapping	NON-COVERED - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS), PG0043 Experimental Investigational Procedures Services	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 histologic and immunohistochemical features (CD3 and CD8 within tumor-stroma border and tumor core), tissue, reported as immune response and	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, AR, PI3K, MAPK, HH, TGFB, Notch), formalin-fixed paraffin embedded (FFPE), algorithm reported as gene pathway activity score	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0263T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest	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 carbon metabolites (ie, αketoglutarate, alanine, lactate, phenylalanine, pyruvate, succinate, carnitine, citrate, fumarate, hypoxanthine, inosine, malate, S-sulfocysteine	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, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest	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 variants by optical genome mapping	NON-COVERED - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS), PG0043 Experimental Investigational Procedures Services	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, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone	NON-COVERED	NON-COVERED	PG0400 Stem Cell Therapy for Orthopedic Applications	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0265U	Rare constitutional and other heritable disorders, whole genome and mitochondrial DNA sequence analysis, blood, frozen and formalin-fixed paraffin embedded (FFPE) tissue, saliva, buccal swabs or cell lines, identification of single nucleotide and copy number	NON-COVERED - NO COMMERCIAL INTERQUAL	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 generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0266U	Unexplained constitutional or other heritable disorders or syndromes, tissue specific gene expression by whole transcriptome and next-generation sequencing, blood, formalin-fixed paraffin embedded (FFPE) tissue or fresh frozen tissue, reported as presence or	NON-COVERED - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS), PG0043 Experimental Investigational Procedures Services	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 (includes intra-operative interrogation, programming, and repositioning, when performed)	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 variants by optical genome mapping and whole genome sequencing	NON-COVERED - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing, PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS), PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	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 - NO COMMERCIAL 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.
0269T	Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)	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 - NO COMMERCIAL 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	Elite Medicare Advantage	Policy	DETAILS/NOTES
0270T	Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)	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 - NO COMMERCIAL 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.
0271T	Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	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 - NO COMMERCIAL 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.
0272T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (e.g., battery status, lead impedance	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 - NO COMMERCIAL 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.
0273T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (e.g.	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0273U	Hematology (genetic hyperfibrinolysis, delayed bleeding), genomic sequence analysis of 8 genes (F13A1, F13B, FGA, FGB, FGG, SERPINA1, SERPINE1, SERPINF2, PLAU), 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.
0274T	Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0026 Discogenic Pain Treatment-Archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0274U	Hematology (genetic platelet disorders), genomic sequence analysis of 43 genes, blood, buccal swab, or amniotic fluid	NON-COVERED - NO COMMERCIAL 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.
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0026 Discogenic Pain Treatment-Archived 120124.	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 - NO COMMERCIAL 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.
0277U	Hematology (genetic platelet function disorder), genomic sequence analysis of 31 genes, blood, buccal swab, or amniotic fluid	NON-COVERED - NO COMMERCIAL 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	Elite Medicare Advantage	Policy	DETAILS/NOTES
0278T	Transcutaneous electrical modulation pain reprocessing (e.g., scrambler therapy), each treatment session (includes placement of electrodes)	NON-COVERED	NON-COVERED	PG0244 Electrical Nerve Stimulators-archived 120124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0278U	Hematology (genetic thrombosis), genomic sequence analysis of 12 genes, blood, buccal swab, or amniotic fluid	NON-COVERED - NO COMMERCIAL 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.
0282U	Red blood cell antigen typing, DNA, genotyping of 12 blood group system genes to predict 44 red blood cell antigen phenotypes	NON-COVERED - NO COMMERCIAL 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.
0285U	Oncology, response to radiation, cell-free DNA, quantitative branched chain DNA amplification, plasma, reported as a radiation toxicity score	NON-COVERED	NON-COVERED	PG0041 Genetic Testing, PG0122 In Vitro Chemoresistance & Chemosensitivity Assays, PG0043 Experimental Investigational Procedures Services	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, 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.
0287U	Oncology (thyroid), DNA and mRNA, nextgeneration sequencing analysis of 112 genes, fine needle aspirate or formalin fixed paraffin-embedded (FFPE) tissue, algorithmic prediction of cancer recurrence, reported as a categorical risk result (low	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) and 3 reference genes (ESD, TBP, YAP1), formalin-fixed paraffin-embedded (FFPE) tumor 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	Elite Medicare Advantage	Policy	DETAILS/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 - NO COMMERCIAL 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.
0290U	Pain management, mRNA, gene expression profiling by RNA sequencing of 36 genes, whole blood, algorithm reported as predictive risk score	NON-COVERED - NO COMMERCIAL 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.
0291U	Psychiatry (mood disorders), mRNA, gene expression profiling by RNA sequencing of 144 genes, whole blood, algorithm reported as predictive risk score	NON-COVERED - NO COMMERCIAL 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.
0292U	Psychiatry (stress disorders), mRNA, gene expression profiling by RNA sequencing of 72 genes, whole blood, algorithm reported as predictive risk score	NON-COVERED - NO COMMERCIAL 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.
0293U	Psychiatry (suicidal ideation), mRNA, gene expression profiling by RNA sequencing of 54 genes, whole blood, algorithm reported as predictive risk score	NON-COVERED - NO COMMERCIAL 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.
0294U	Longevity and mortality risk, mRNA, gene expression profiling by RNA sequencing of 18 genes, whole blood, algorithm reported as predictive risk score	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 proteins (COX2, FOXA1, HER2, Ki-67, p16, PR, SIAH2), with 4 clinicopathologic factors (size, age, margin status, palpability), utilizing formalin-fixed paraffin-embedded	NON-COVERED	NON-COVERED	PG0301 Genetic Expression Assays for Breast Cancer Prognosis-Archived 090124	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0296U	Oncology (oral and/or oropharyngeal cancer), gene expression profiling by RNA sequencing at least 20 molecular features (eg, human and/or microbial mRNA), saliva, algorithm reported as positive or negative for signature associated with	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, blood or bone marrow, comparative sequence analyses and variant identification	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 RNA specimens, fresh or formalin fixed paraffin embedded (FFPE) tissue, blood or bone marrow, comparative sequence analyses and expression level and	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	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.
0299U	Oncology (pan tumor), whole genome optical genome mapping of paired malignant and normal DNA specimens, fresh frozen tissue, blood, or bone marrow, comparative structural variant identification	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 bone marrow, comparative sequence analyses and variant identification	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, blood or bone marrow, comparative sequence analyses and variant identification	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, blood or bone marrow, comparative sequence analyses and expression level and chimeric transcript	NON-COVERED - NO COMMERCIAL 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	Elite Medicare Advantage	Policy	DETAILS/NOTES
0299U	Oncology (pan tumor), whole genome optical genome mapping of paired malignant and normal DNA specimens, fresh frozen tissue, blood, or bone marrow, comparative structural variant identification	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 bone marrow, comparative sequence analyses and variant identification	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 quintana, droplet digital PCR (ddPCR);	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 quintana, droplet digital PCR (ddPCR); following liquid enrichment	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0303U	Hematology, red blood cell (RBC) adhesion to endothelial/subendothelial adhesion molecules, functional assessment, whole blood, with algorithmic analysis and result reported as an RBC adhesion index; hypoxic	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0304U	Hematology, red blood cell (RBC) adhesion to endothelial/subendothelial adhesion molecules, functional assessment, whole blood, with algorithmic analysis and result reported as an RBC adhesion index; normoxic	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 blood, reported as a maximum elongation index	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0306U	Oncology (minimal residual disease [MRD]), next-generation targeted sequencing analysis, cell-free DNA, initial (baseline) assessment to determine a patient specific panel for future comparisons to evaluate for MRD	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 patient-specific panel, cell-free DNA, subsequent assessment with comparison to previously analyzed patient specimens to evaluate for MRD	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 prosthesis	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] troponin, adiponectin, and kidney injury molecule-1 [KIM-1]), plasma, algorithm reported as a risk score for obstructive CAD	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services, PG0392 Cardiovascular Disease (CVD) Risk Testing	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0309U	Cardiology (cardiovascular disease), analysis of 4 proteins (NT-proBNP, osteopontin, tissue inhibitor of metalloproteinase-1 [TIMP-1], and kidney injury molecule-1 [KIM-1]), plasma, algorithm reported as a risk score for major adverse cardiac event	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services, PG0392 Cardiovascular Disease (CVD) Risk Testing	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0310U	Pediatrics (vasculitis, Kawasaki disease [KD]), analysis of 3 biomarkers (NTproBNP, C-reactive protein, and T-uptake), plasma, algorithm reported as a risk score for KD	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0311U	Infectious disease (bacterial), quantitative antimicrobial susceptibility reported as phenotypic minimum inhibitory concentration (MIC)–based antimicrobial susceptibility for each organisms identified	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0312U	Autoimmune diseases (e.g., systemic lupus erythematosus [SLE]), analysis of 8 IgG autoantibodies and 2 cell-bound complement activation products using enzyme-linked immunosorbent immunoassay (ELISA), flow cytometry and	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 and analysis of CEA (CEACAM5) gene expression, pancreatic cyst fluid, algorithm reported as a categorical result (ie, negative, low probability of neoplasia or positive, high	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-embedded (FFPE) tissue, algorithm reported as a categorical result (ie, benign, intermediate, malignant)	NON-COVERED - NO COMMERCIAL 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.
0315U	Oncology (cutaneous squamous cell carcinoma), mRNA gene expression profiling by RT-PCR of 40 genes (34 content and 6 housekeeping), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a categorical risk result (ie, Class 1, Class 2A, Class 2B)	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
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, predictive algorithm generated evaluation reported as decreased or increased risk for lung cancer	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 - NO COMMERCIAL 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	Elite Medicare Advantage	Policy	DETAILS/NOTES
0319U	Nephrology (renal transplant), RNA expression by select transcriptome sequencing, using pretransplant peripheral blood, algorithm reported as a risk score for early acute rejection	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 peripheral blood, algorithm reported as a risk score for acute cellular rejection	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, identification of 20 bacterial and fungal organisms and identification of 16 associated antibiotic-resistance genes, multiplex amplified probe technique	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0322U	Neurology (autism spectrum disorder [ASD]), quantitative measurements of 14 acyl carnitines and microbiome-derived metabolites, liquid chromatography with tandem mass spectrometry (LC-MS/MS), plasma, results reported as negative or positive for	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, paclitaxel), tumor chemotherapy response prediction for each drug	NON-COVERED	NON-COVERED	PG0122 In Vitro Chemoresistance & Chemosensitivity Assays; PG0043 Experimental Investigational Procedures Services	**DELETED CODE 04/01/2023**
0325U	Oncology (ovarian), spheroid cell culture, poly (ADP-ribose) polymerase (PARP) inhibitors (niraparib, laparib, rucaparib, velparib), tumor response prediction for each drug	NON-COVERED	NON-COVERED	PG0122 In Vitro Chemoresistance & Chemosensitivity Assays; PG0043 Experimental Investigational Procedures Services	**DELETED CODE 04/01/2023**
0326U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 83 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatelite instability and tumor mutational	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
0327U	Fetal aneuploidy (trisome 13, 18, and 21), DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy, includes sex reporting, if performed	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0287 Non-Invasive Prenatal Screening (NIPS)/Cell-Free DNA Screening for Fetal Aneuploidy	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, microsatellite instability and tumor mutational burden utilizing DNA and RNA from tumor with DNA	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 100124, 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.
0329T	Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report	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 assessment	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0331U	Oncology (hematolymphoid neoplasia), optical genome mapping for copy number alterations and gene rearrangements utilizing DNA from blood or bone marrow, report of clinically significant alternations	NON-COVERED	NON-COVERED	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.
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0332U	Oncology (pan-tumor), genetic profiling of 8 DNA-regulatory (epigenetic) markers by quantitative polymerase chain reaction (qPCR), whole blood, reported as a high or low probability of responding to immune checkpoint–inhibitor therapy	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 methylation patterns on circulating cell-free DNA (cfDNA) plus measurement of serum of AFP/AFP-L3 and oncoprotein des-gammacarboxy-prothrombin	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, interrogation for sequence variants, gene copy number amplifications, gene rearrangements	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 Malignancies-**Archived 100124**	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 Investigational Procedure Services	NON-COVERED in Adults age ≥ 19 years of age. Prior Authorization required for ages 0-18.
0335U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis, including small sequence changes, copy number variants, deletions, duplications, mobile element insertions, uniparental disomy (UPD), inversions, aneuploidy	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and 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.
0336U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis, including small sequence changes, copy number variants, deletions, duplications, mobile element insertions, uniparental disomy (UPD), inversions, aneuploidy	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and 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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0337U	Oncology (plasma cell disorders and myeloma), circulating plasma cell immunologic selection, identification, morphological characterization, and enumeration of plasma cells based on differential CD138, CD38, CD19, and CD45 protein biomarker	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 puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural road mapping and radiological supervision and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0338U	Oncology (solid tumor), circulating tumor cell selection, identification, morphological characterization, detection and enumeration based on differential EpCAM, cytokeratins 8, 18, and 19, and CD45 protein biomarkers, and quantification of HER2 protein	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 puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural road mapping and radiological supervision and	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 digital rectal examination, algorithm reported as probability of high-grade cancer (SelectMDx for	NON-COVERED - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing. PG0367 Genetic and Protein Biomarkers for Diagnosis-**archived 020425.**	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 sequencing of the patient's tumor and germline DNA, reported as absence or presence of MRD, with	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 digital rectal examination, algorithm reported as probability of high-grade cancer	NON-COVERED - NO COMMERCIAL 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	Elite Medicare Advantage	Policy	DETAILS/NOTES
0340U	Oncology (pan-cancer), analysis of minimal resifual disease (MRD) from plasma, with assays personalized to each patient bades on prior next-generation sequencing of the patient's tumor and germline DNA, reported as absence or presence of MRD, with	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, reported as normal (euploidy), monosomy, trisomy, or partial deletion/duplication, mosaicism, and segmental aneuploid	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, osteoprotegerin (OPG), gelsolin, IGFBP3, CA125 and multiplex electrochemiluminescent immunoassay (ECLIA) for CA19-9, serum, diagnostic algorithm	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 quantitative reverse transcription polymerase chain reaction (RT-qPCR), urine, reported as molecular evidence of no-, low-, intermediate- or high-risk of	NON-COVERED - NO COMMERCIAL 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.
0344U	Hepatology (nonalcoholic fatty liver disease [NAFLD]), semiquantitative evaluation of 28 lipid markers by liquid chromatography with tandem mass spectrometry (LC-MS/MS), serum, reported as at-risk for nonalcoholic steatohepatitis (NASH) or not NASH	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-Archived; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0345U	Psychiatry (eg, depression, anxiety, attention deficit hyperactivity disorder [ADHD]), genomic analysis panel, variant analysis of 15 genes, including deletion/duplication analysis of CYP2D6	NON-COVERED - NO COMMERCIAL 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), ratio, plasma [Not Covered] [CPT code that represents Quest Ad-Detect™. Per the manufacturer, this test measures plasma levels of Amyloid	NON-COVERED	NON-COVERED	PG0441 Genetic and Biomarker Testing for Alzheimer Disease; PG0043 Experimental Investigational Procedures Services	**DELETED CODE 01/01/2025**
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 and lumbosacral, when performed)	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 shoulder, elbow and wrist, when performed)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0349U	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	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, proximal femur, knee and ankle, when performed)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
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; real time intraoperative	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; interpretation and report, real time or referred	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 or referred	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0355U	APOL1 (apolipoprotein L1) (eg, chronic kidney disease), risk variants (G1, G2)	NON-COVERED - NO COMMERCIAL 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.
0356U	Oncology (oropharyngeal), evaluation of 17 DNA biomarkers using droplet digital PCR (ddPCR), cell-free DNA, algorithm reported as a prognostic risk score for cancer recurrence	NON-COVERED - NO COMMERCIAL 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.
0358T	Bioelectrical impedance analysis whole body composition assessment, supine position, with interpretation and report	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, chemiluminescence enzyme immunoassay, cerebral spinal fluid, reported as positive, likely positive, or negative	NON-COVERED	NON-COVERED	PG0441 Genetic and Biomarker Testing for Alzheimer Disease; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0359U	Oncology (prostate cancer), analysis of all prostate-specific antigen (PSA) structural isoforms by phase separation and immunoassay, plasma, algorithm reports risk of cancer (IsoPSA, Cleveland Diagnostics)	NON-COVERED - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing. PG0367 Genetic and Protein Biomarkers for Diagnosis- **archived 020425.**	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, CAGE, GBU4-5, SOX2, MAGE A4, and HuD), plasma, algorithm reported as a categorical result for risk of malignancy Nodify CDT®, Biodesix, Inc. Biodesix, Inc.	NON-COVERED	NON-COVERED		NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0361U	Neurofilament light chain, digital immunoassay, plasma, quantitative (Effective 1/1/2023) [Not Covered] [CPT code that represents Neurofilament Light Chain (NfL), by Mayo Clinic. Per the lab, this is a plasma-based assay that can determine if	NON-COVERED	NON-COVERED	PG0441 Genetic and Biomarker Testing for Alzheimer Disease; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0362T	Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0362U	Oncology (papillary thyroid cancer), gene-expression profiling via targeted hybrid capture–enrichment RNA sequencing of 82 content genes and 10 housekeeping genes, formalin-fixed paraffin embedded (FFPE) tissue, algorithm reported as one of three molecular subtypes	NON-COVERED	NON-COVERED	PG0041 Genetic Testing, PG0298 Molecular Markers in Fine Needle Aspirates of Thyroid Nodules-**Archived 07/01/2023**	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 (MDK, HOXA13, CDC2 [CDK1], IGFBP5, andCXCR2), utilizing urine, algorithm incorporates age, sex, smoking history, and macrohematuria frequency	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 next-generation sequencing with algorithm, quantification of dominant clonal sequence(s), reported as presence or absence of minimal residual disease (MRD)	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, CTNNB1, KRAS, NRAS, PIK3CA, SMAD4, and TP53, and methylation markers (MYO1G, KCNQ5, C9ORF50	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.
0373T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0335 Children's Adaptive Behavior Services-Arcived 07/01/2024; PG0043 Experimental Investigational Procedures Services	
0376U	Oncology (prostate cancer), image analysis of at least 128 histologic features and clinical factors, prognostic algorithm determining the risk of distant metastases, and prostate cancer-specific mortality, includes predictive algorithm to androgen deprivation therapy	NON-COVERED	NON-COVERED	PG0041 Genetic Testing. and PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate Cancer-**archived 020425.**	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0377U	Cardiovascular disease, quantification of advanced serum or plasma lipoprotein profile, by nuclear magnetic resonance (NMR) spectrometry with report of a lipoprotein profile (including 23 variables)	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 patient-initiated data transmitted to a remote surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health	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-primed PCR, blood, saliva, or buccal swab	NON-COVERED - NO COMMERCIAL 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.
0379T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient-initiated data transmitted to a remote surveillance center for up to 30 days; technical support and patient instructions, surveillance, analysis and transmission of daily	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, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite	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 Malignancies-Archived 100124	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 with reported genotype and phenotype	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0500 Liquid Biopsy-Archived 100124	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
0313U	Oncology (pancreas), DNA and mRNA next-generation sequencing analysis of 74 genes and analysis of CEA (CEACAM5) gene expression, pancreatic cyst fluid, algorithm reported as a categorical result (ie, negative, low probability of neoplasia or positive, high probability of neoplasia)	NON-COVERED	NON-COVERED	PG0041 Genetic Testing	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0388U	Oncology (non-small cell lung cancer), next-generation sequencing with identification of single nucleotide variants, copy number variants, insertions and deletions, and structural variants in 37 cancer-related genes, plasma, with report for alteration detection	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing and PG0500 Liquid Biopsy-Archived 100124	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 deletions, and structural variants in 37 cancer-related genes, plasma, with report for alteration detection	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.
0398T	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed	PRIOR AUTHORIZATION NOT REQUIRED	PRIOR AUTHORIZATION NOT REQUIRED		Effective 02/01/2024 procedure 0398T does not require a prior authoriztion for the Commercial Plans. Procedure 0398T does not/has not rerquired a prior authorization for the Medicare Plans. Archived Medical Policy PG0440 Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Essential Tremor - **Code 0398T Deleted 12/31/2024 (New code 61715 01/01/2025)**
0389U	Pediatric febrile illness (Kawasaki disease [KD]), interferon alphainducible protein 27 (IFI27) and mast cell-expressed membrane protein 1 (MCEMP1), RNA, using reverse transcription polymerase chain reaction (RT-qPCR), blood, reported as a risk	NON-COVERED - NO COMMERCIAL 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.
0391U	Oncology (solid tumor), DNA and RNA by next-generation sequencing, utilizing formalin-fixed paraffin-embedded (FFPE) tissue, 437 genes, interpretive report for single nucleotide variants, splicesite 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 Malignancies-archived 100124	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 deletion/duplication analysis of CYP2D6, reported as impact of gene-drug interaction for each drug	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), detection of misfolded a-synuclein protein by seed amplification assay, qualitative	NON-COVERED	NON-COVERED		

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0394T	High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed	NON-COVERED	NON-COVERED	PG0315 Electronic Brachytherapy-Archived 100824; PG0043 Experimental Investigational Procedures Services	
0395T	High dose rate electronic brachytherapy, interstitial or intracavitary treatment, per fraction, includes basic dosimetry, when performed	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0315 Electronic Brachytherapy-Archived 100824; PG0043 Experimental Investigational Procedures Services	Effective 11/01/2024 procedure 0395T is covered with a prior authorization (from noncovered) per the InterQual coverage criteria.
0396U	Obstetrics (pre-implantation genetic testing), evaluation of 300000 DNA single-nucleotide polymorphisms (SNPs) by microarray, embryonic tissue, algorithm reported as a probability for single-gene germline conditions [Effective 07/01/2023]	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 endomicroscopy (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0398U	Gastroenterology (Barrett esophagus), P16, RUNX3, HPP1, and FBN1 DNA methylation analysis using PCR, formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as risk score for progression to high-grade dysplasia or cancer [Effective 07/01/2023]	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 amplification, DNA, reported as carrier positive or negative	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 a coronary event	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
0403T	Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day	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 examination urine (or processed first-catch urine), algorithm reported as percentage of likelihood of detecting clinically significant prostate cancer (MyProstateScore	NON-COVERED - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing. and PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate Cancer-**archived 020125**	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], CD206, CD66b, CD3, CD19), algorithm reported as likelihood of lung cancer CyPath Lung (bioAffinity Technologies)	NON-COVERED	NON-COVERED	PG0476 Proteomic Testing in the Management of Pulmonary Nodules; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0408T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization Therapy-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0409T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization Therapy-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0410T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization Therapy-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0410U	Oncology (pancreatic), DNA, whole genome sequencing with 5-hydroxymethylcytosine enrichment, whole blood or plasma, algorithm reported as cancer detected or not detected	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0410U	Oncology (pancreatic), DNA, whole genome sequencing with 5-hydroxymethylcytosine enrichment, whole blood or plasma, algorithm reported as cancer detected or not detected	NON-COVERED - NO COMMERCIAL 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.
0411T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only)	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization Therapy-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0411U	Psychiatry (eg, depression, anxiety, attention deficit hyperactivity disorder [ADHD]), genomic analysis panel, variant analysis of 15 genes, including deletion/duplication analysis of CYP2D6	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 Therapy-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0412U	Beta amyloid, AB42/40 ratio, immunoprecipitation with quantitation by liquid chromatography with tandem mass spectrometry (LC-MS/MS) and qualitative ApoE isoform-specific proteotyping, plasma combined with age, algorithm reported as	NON-COVERED	NON-COVERED		
0413T	Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization Therapy-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTNAL, INVESTIGATIONAL
0413U	Oncology (hematolymphoid neoplasm), optical genome mapping for copy number alterations, aneuploidy, and balanced/complex structural rearrangements, DNA from blood or bone marrow, report of clinically significant alterations	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0413U	Oncology (hematolymphoid neoplasm), optical genome mapping for copy number alterations, aneuploidy, and balanced/complex structural rearrangements, DNA from blood or bone marrow, report of clinically significant alterations	NON-COVERED - NO COMMERCIAL 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.
0414T	Removal and replacement of permanent cardiac contractility modulation system pulse generator only	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization Therapy-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0415T	Repositioning of previously implanted cardiac contractility modulation transvenous electrode, (atrial or ventricular lead)	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization Therapy-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0415U	Cardiovascular disease (acute coronary syndrome [ACS]), IL-16, FAS, FASLigand, HGF, CTACK, EOTAXIN, and MCP-3 by immunoassay combined with age, sex, family history, and personal history of diabetes, blood, algorithm reported as a 5-year (deleted risk)	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 Therapy-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0417T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization Therapy-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0417U	Rare diseases (constitutional/heritable disorders), whole mitochondrial genome sequence with heteroplasmy detection and deletion analysis, nuclear encoded mitochondrial gene analysis of 335 nuclear genes, including sequence	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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0417U	Rare diseases (constitutional/heriable disorders), whole mitochondrial genome sequence with heteroplasmy detection and deletion analysis, nuclear-encoded mitochondial gene analysis of 335 nuclear genes, including sequence	NON-COVERED - NO COMMERCIAL 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.
0418T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable cardiac contractility modulation system	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization Therapy-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0419T	Destruction neurofibromata, extensive, (cutaneous, dermal extending into subcutaneous); face, head and neck, greater than 50 neurofibromata	NON-COVERED	NON-COVERED	PG0104 Cosmetic&Reconstructive Surgery; PG0043 Experimental/Investigational Procedures/Services	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); trunk and extremities, extensive, greater than 100 neurofibromata	NON-COVERED	NON-COVERED	PG0104 Cosmetic&Reconstructive Surgery; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0421T	Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included	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 markers (GAPDH, SMAD4, ACY1, AREG, CDH1, KRAS, TNFRSF10B, and EGLN2) and fecal hemoglobin, algorithm reported as a positive or negative	NON-COVERED	NON-COVERED	PG0065 Colorectal Cancer Screening; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 risk of drug toxicity by condition	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; complete system (transvenous placement of right or left stimulation	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0508 Phrenic Nerve Stimulation for Central Sleep Apnea (eg, remede System)- Archived 110124	Prior authorization required effective August 1, 2022.
0424U	Oncology (prostate), exosome-based analysis of 53 small noncoding RNAs (sncRNAs) by quantitative reverse transcription polymerase chain reaction (RTqPCR), urine, reported as no molecular evidence, low-, moderate- or elevated-risk of	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS), PG0041 Genetic Testing	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 System)- Archived 110124	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 System)- Archived 110124	Prior authorization required effective August 1, 2022.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 System)- Archived 110124	Prior authorization required effective August 1, 2022.
0431T	Removal and replacement of neurostimulator system for treatment of central sleep apnea, pulse generator only	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0508 Phrenic Nerve Stimulation for Central Sleep Apnea (eg, remede System)- Archived 110124	Prior authorization required effective August 1, 2022.
0431U	Glycine receptor alpha1 IgG, serum or cerebrospinal fluid (CSF), live cell-binding assay (LCBA), qualitative	NON-COVERED	NON-COVERED		
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 sequence analysis	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.
0433U	Oncology (prostate), 5 DNA regulatory markers by quantitative PCR, whole blood, algorithm, including prostate-specific antigen, reported as likelihood of cancer (Episwitch Prostate Screening Test, Oxford BioDynamics Inc.)	NON-COVERED - NO COMMERCIAL INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0041 Genetic Testing. PG0367 Genetic and Protein Biomarkers for Diagnosis and Risk Assessment of Prostate Cancer- **archived 020124**	Prior authorization is required for genetic testing unless otherwise noted in one of our policies.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0434U	Drug metabolism (adverse drug reactions and drug response), genomic analysis panel, variant analysis of 25 genes with reported phenotypes	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED		Added, effective 11/01/2024
0435U	Oncology, chemotherapeutic drug cytotoxicity assay of cancer stem cells (CSCs), from cultured CSCs and primary tumor cells, categorical drug response reported based on cytotoxicity percentage observed, minimum of 14 drugs or drug combinations	NON-COVERED	NON-COVERED	PG0122 In Vitro Chemoresistance & Chemosensitivity Assays; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0437T	Implantation of non-biologic or synthetic implant (e.g., polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery; PG0043 Experimental/Investigational Procedures/Services	
0438U	Drug metabolism (adverse drug reactions and drug response), buccal specimen, gene-drug interactions, variant analysis of 33 genes, including deletion/duplication analysis of CYP2D6, including reported phenotypes and impacted gene-drug interactions	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED		Added, effective 11/01/2024
0439T	Myocardial contrast perfusion echocardiography; at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (e.g., brachial plexus, pudendal nerve)	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
0443U	Neurofilament light chain (NfL), ultra-sensitive immunoassay, serum or cerebrospinal fluid	NON-COVERED	NON-COVERED	PG0441 Genetic and Biomarker Testing for Alzheimer Disease; 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, and insertion, unilateral or bilateral	NON-COVERED	NON-COVERED	PG0327 Surgical Treatments for Glaucoma; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0445T	Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training, and removal of existing insert, unilateral or bilateral	NON-COVERED	NON-COVERED	PG0327 Surgical Treatments for Glaucoma; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0445U	B-amyloid (Abeta42) and phospho tau (181P) (pTau181), electrochemiluminescent immunoassay (ECLIA), cerebral spinal fluid, ratio reported as positive or negative for amyloid pathology	NON-COVERED	NON-COVERED	PG0441 Genetic and Biomarker Testing for Alzheimer Disease; PG0043 Experimental Investigational Procedures Services	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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 system activation	NON-COVERED	COVERED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0177 Continuous Blood Glucose Monitoring Services	
0454U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome Mapping	NON-COVERED	NON-COVERED	PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	
0456U	Autoimmune (rheumatoid arthritis), next-generation sequencing (NGS), gene expression testing of 19 genes, whole blood, with analysis of anti-cyclic citrullinated peptides (CCP) levels, combined with sex, patient global assessment, and body mass index (BMI) algorithm	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 spinal fluid, ratio reported as positive or negative for amyloid pathology	NON-COVERED	NON-COVERED	PG0441 Genetic and Biomarker Testing for Alzheimer Disease; PG0043 Experimental Investigational Procedures Services	
0460U	Oncology, whole blood or buccal, DNA single-nucleotide polymorphism (SNP) genotyping by real-time PCR of 24 genes, with variant analysis and reported phenotypes	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 variant analysis, including impacted gene-drug interactions and reported phenotypes	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		Added, effective 11/01/2025

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0464T	Visual evoked potential, testing for glaucoma, with interpretation and report	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0468U	Hepatology (nonalcoholic steatohepatitis [NASH]), miR-34a-5p, alpha 2-macroglobulin, YKL40, HbA1c, serum and whole blood, algorithm reported as a single score for NASH activity and fibrosis	NON-COVERED	NON-COVERED	PG0252 Noninvasive Tests for Hepatic Fibrosis; PG0043 Experimental Investigational Procedures Services	NON-COVERED
0469U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis for chromosomal abnormalities, copy number variants, duplications/deletions, inversions, unbalanced translocations, regions of homozygosity (ROH), inheritance	NON-COVERED	NON-COVERED	PG0468 Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS)	
0490U	Oncology (cutaneous or uveal melanoma), circulating tumor cell selection, morphological characterization and enumeration based on differential CD146, high molecular–weight melanoma-associated antigen, CD34 and CD45 protein biomarkers	NON-COVERED	NON-COVERED		
0491U	Oncology (solid tumor), circulating tumor cell selection, morphological characterization and enumeration based on differential epithelial cell adhesion molecule (EpCAM), cytokeratins 8, 18, and 19, CD45 protein biomarkers, and quantification of estrogen receptor	NON-COVERED	NON-COVERED		
0492U	Oncology (solid tumor), circulating tumor cell selection, morphological characterization and enumeration based on differential epithelial cell adhesion molecule (EpCAM), cytokeratins 8, 18, and 19, CD45 protein biomarkers, and quantification of PD-L1 protein	NON-COVERED	NON-COVERED		
0493U	Transplantation medicine, quantification of donor-derived cell-free DNA (cfDNA) using next-generation sequencing, plasma, reported as percentage of donor-derived cell-free DNA	NON-COVERED	NON-COVERED	PG0525 Molecular Testing for Solid Organ Allograft Rejection	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/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, image acquisition, interpretation, and report; first lesion	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, image acquisition, interpretation, and report; each additional lesion (List separately in addition to code for primary procedure)	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., retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values	NON-COVERED	COVERED	PG0418 Retinal Prosthesis; PG0043 Experimental Investigational Procedures Services	
0473T	Device evaluation and interrogation of intra-ocular retinal electrode array (e.g., retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional	NON-COVERED	COVERED	PG0418 Retinal Prosthesis; PG0043 Experimental Investigational Procedures Services	
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 Surgical Treatments for Glaucoma; PG0043 Experimental Investigational Procedures Services	
0475T	Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording and storage, data scanning with signal extraction, technical analysis, and result, as well as supervision, review, and interpretation of report by a physician or other qualified health	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0476T	Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording, data scanning, with raw electronic signal transfer of data and storage	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, technical analysis, and result	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, report by physician or other qualified health care professional	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; first 100 cm2 or part thereof, or 1% of body surface area of infants and children	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0479U	Tau, phosphorylated, pTau217	NON-COVERED	NON-COVERED	PG0441 Genetic and Biomarker Testing for Alzheimer Disease; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0480T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; each additional 100 cm2, or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure)	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, including image guidance, harvesting and preparation, when performed	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0483T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures-Archived; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0484T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (eg, thoracotomy, transapical)	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures-Archived; PG0043 Experimental Investigational Procedures Services	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	PG0043 Experimental Investigational Procedures Services; PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments and Devices-archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0488T	Preventive behavior change, online/electronic structured intensive program for prevention of diabetes using a standardized diabetes prevention program curriculum, provided to an individual, per 30 days	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0489T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; adipose tissue harvesting, isolation and preparation of harvested cells including incubation with cell dissociation enzymes, removal of non-viable cells and debris	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0490T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; multiple injections in one or both hands	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, total treatment surface area; first 20 sq cm or less	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, total treatment surface area; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	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 organ perfusion system, including decannulation, separation from the perfusion system, and cold preservation of the allograft prior to implantation, when performed	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 physician or qualified health care professional, including physiological and laboratory assessment (e.g., pulmonary artery flow, pulmonary artery pressure, left atrial pressure	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 physician or qualified health care professional, including physiological and laboratory assessment (e.g., pulmonary artery flow, pulmonary artery pressure, left atrial pressure	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0497T	External patient-activated, physician- or other qualified health care professional-prescribed, electrocardiographic rhythm derived event recorder without 24 hour attended monitoring; in-office connection	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, electrocardiographic rhythm derived event recorder without 24 hour attended monitoring; review and interpretation by a physician or other qualified health care	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0499T	Cystourethroscopy, with mechanical dilation and urethral therapeutic drug delivery for urethral stricture or stenosis, including fluoroscopy, when performed	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 more separately reported high-risk HPV types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) (i.e., genotyping)	NON-COVERED	NON-COVERED	PG0369 Human Papillomavirus (HPV) Screening; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0503U	Neurology (Alzheimer disease), beta amyloid (AB40, AB42, AB42/40 ratio) and tau-protein (ptau217, np-tau217, ptau217/np-tau217 ratio), blood, immunoprecipitation with quantitation by liquid chromatography with tandem mass	NON-COVERED	NON-COVERED	PG0441 Genetic and Biomarker Testing for Alzheimer Disease; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0505T	Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed	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 bilateral, with interpretation and report)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0507T	Near-infrared dual imaging (i.e., simultaneous reflective and trans-illuminated light) of meibomian glands, unilateral or bilateral, with interpretation and report	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 density, tibia	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0508U	Transplantation medicine, quantification of donor-derived cell-free DNA using 40 single-nucleotide polymorphisms (SNPs), plasma, and urine, initial evaluation reported as percentage of donor-derived cell-free DNA with risk for active rejection	NON-COVERED	NON-COVERED	PG0525 Molecular Testing for Solid Organ Allograft Rejection	
0509T	Electroretinography (ERG) with interpretation and report, pattern (PERG)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0509U	Transplantation medicine, quantification of donor-derived cell-free DNA using up to 12 single-nucleotide polymorphisms (SNPs) previously identified, plasma, reported as percentage of donor-derived cell-free DNA with risk for active rejection	NON-COVERED	NON-COVERED	PG0525 Molecular Testing for Solid Organ Allograft Rejection	
0511T	Removal and reinsertion of sinus tarsi implant	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0321 Subtalar Arthroeresis; PG0043 Experimental Investigational Procedure Services	NON-COVERED in Adults age ≥ 19 years of age. Prior Authorization required for ages 0-18.
0511U	Oncology (solid tumor), tumor cell culture in 3D microenvironment, 36 or more drug panel, reported as tumor-response prediction for each drug	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	PARIS Test - NC

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0512T	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; initial wound	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 dressing care; each additional wound (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0514T	Intraoperative visual axis identification using patient fixation (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0514U	Gastroenterology (irritable bowel disease [IBD]), immunoassay for quantitative determination of adalimumab (ADL) levels in venous serum in patients undergoing adalimumab therapy, results reported as a numerical value as micrograms per milliliter (ug/mL)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0341 Immunopharmacologic Monitoring of Therapeutic Serum Antibodies	
0515U	Gastroenterology (irritable bowel disease [IBD]), immunoassay for quantitative determination of infliximab (IFX) levels in venous serum in patients undergoing infliximab therapy, results reported as a numerical value as micrograms per milliliter (ug/mL)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0341 Immunopharmacologic Monitoring of Therapeutic Serum Antibodies	
0515T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; complete system (includes electrode and generator [transmitter and	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization Therapy-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0516T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; electrode only	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization Therapy-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0517T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; pulse generator component(s) (battery and/or transmitter) only	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization Therapy-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0518T	Removal of only pulse generator component(s) (battery and/or transmitter) of wireless cardiac stimulator for left ventricular pacing	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization Therapy-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0519T	Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator component(s) (battery and/or transmitter)	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization Therapy-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0520T	Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator component(s) (battery and/or transmitter), including placement of a new electrode	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization Therapy-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0521T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording, and disconnection per patient encounter, wireless cardiac stimulator for left ventricular pacing	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization Therapy-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0522T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, wireless cardiac stimulator for left ventricular pacing	NON-COVERED	NON-COVERED	PG0233 Biventricular Pacing/Cardiac Resynchronization Therapy-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0523T	Intraprocedural coronary fractional flow reserve (FFR) with 3D functional mapping of color-coded FFR values for the coronary tree, derived from coronary angiogram data, for real-time review and interpretation of possible atherosclerotic stenosis(es)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0525T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; complete system (electrode and implantable monitor)	NON-COVERED	NON-COVERED	PG0039 Ambulatory External and Implantable Electrocardiographic Monitoring-Archived 110124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0525U	Oncology, spheroid cell culture, 11-drug panel (carboplatin, docetaxel, doxorubicin, etoposide, gemcitabine, niraparib, olaparib, paclitaxel, rucaparib, topotecan, veliparib) ovarian, fallopian, or peritoneal response prediction for each drug	NON-COVERED	NON-COVERED	PG0122 In Vitro Chemoresistance & Chemosensitivity Assays; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0526T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; electrode only	NON-COVERED	NON-COVERED	PG0039 Ambulatory External and Implantable Electrocardiographic Monitoring-Archived 110124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0527T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; implantable monitor only	NON-COVERED	NON-COVERED	PG0039 Ambulatory External and Implantable Electrocardiographic Monitoring-Archived 110124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0528T	Programming device evaluation (in person) of intracardiac ischemia monitoring system with iterative adjustment of programmed values, with analysis, review, and report	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, review, and report	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 interpretation; complete system (electrode and implantable monitor)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0531T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; electrode only	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 interpretation; implantable monitor only	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0532U	Rare diseases (constitutional disease/hereditary disorders), rapid whole genome and mitochondrial DNA sequencing for single-nucleotide variants, insertions/deletions, copy number variations, peripheral blood, buffy coat, saliva, buccal or tissue	NON-COVERED	NON-COVERED		
0533T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; includes set-up, patient training, configuration of monitor, data upload, analysis and initial report configuration, download review	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0533U	Drug metabolism (adverse drug reactions and drug response), genotyping of 16 genes (ie, ABCG2, CYP2B6, CYP2C9, CYP2C19, CYP2C, CYP2D6, CYP3A5, CYP4F2, DPYD, G6PD, GGCX, NUDT15, SLCO1B1, TPMT, UGT1A1, VKORC1)	NON-COVERED	NON-COVERED		
0534T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; setup, patient training, configuration of monitor	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0534U	Oncology (prostate), microRNA, single-nucleotide polymorphisms (SNPs) analysis by RT-PCR of 32 variants, using buccal swab, algorithm reported as a risk score	NON-COVERED	NON-COVERED		

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0535T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; data upload, analysis and initial report configuration	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0536U	Red blood cell antigen (fetal RhD), PCR analysis of exon 4 of RHD gene and housekeeping control gene GAPDH from whole blood in pregnant individuals at 10+ weeks gestation known to be RhD negative, reported as fetal RhD status	NON-COVERED	NON-COVERED		
0536T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; download review, interpretation and report	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 development of genetically modified autologous CAR-T cells, per day	NON-COVERED	NON-COVERED	PG0460 Chimeric Antigen Receptor (CAR)-T Cell Therapy; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0537U	Oncology (colorectal cancer), analysis of cell-free DNA for epigenomic patterns, next-generation sequencing, >2500 differentially methylated regions (DMRs), plasma, algorithm reported as positive or negative	NON-COVERED	NON-COVERED	PG0065 Colorectal Cancer Screening	
0538T	Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (e.g., cryopreservation, storage)	NON-COVERED	NON-COVERED	PG0460 Chimeric Antigen Receptor (CAR)-T Cell Therapy; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0538U	Oncology (solid tumor), next-generation targeted sequencing analysis, formalin-fixed paraffin-embedded (FFPE) tumor tissue, DNA analysis of 600 genes, interrogation for single-nucleotide variants, insertions/deletions, gene rearrangements, and copy number	NON-COVERED	NON-COVERED		

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0539T	Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration	NON-COVERED	NON-COVERED	PG0460 Chimeric Antigen Receptor (CAR)-T Cell Therapy; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0539U	Oncology (solid tumor), cell-free circulating tumor DNA (ctDNA), 152 genes, next-generation sequencing, interrogation for single-nucleotide variants, insertions/deletions, gene rearrangements, copy number alterations, and microsatellite	NON-COVERED	NON-COVERED		
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 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0540U	Transplantation medicine, quantification of donor-derived cell-free DNA using next-generation sequencing analysis of plasma, reported as percentage of donor-derived cell-free DNA to determine probability of rejection	NON-COVERED	NON-COVERED		
0541T	Myocardial imaging by magnetocardiography (MCG) for detection of cardiac ischemia, by signal acquisition using minimum 36 channel grid, generation of magnetic-field time-series images, quantitative analysis of magnetic dipoles, machine learning-derived	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 signal acquisition using minimum 36 channel grid, generation of magnetic-field time-series images, quantitative analysis of magnetic dipoles, machine learning-derived	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0543T	Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial chordae tendineae	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures-Archived; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0543U	Oncology (solid tumor), next-generation sequencing of DNA from formalin-fixed paraffin-embedded (FFPE) tissue of 517 genes, interrogation for single-nucleotide variants, multi-nucleotide variants, insertions and deletions from DNA, fusions in 24	NON-COVERED	NON-COVERED		
0544T	Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures-Archived; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0544U	Nephrology (transplant monitoring), 48 variants by digital PCR, using cell-free DNA from plasma, donor-derived cell-free DNA, percentage reported as risk for rejection	NON-COVERED	NON-COVERED		
0545T	Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures-Archived; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0546T	Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with report	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
0549U	Oncology (urothelial), DNA, quantitative methylated real-time PCR of TRNA-Cys, SIM2, and NKX1-1, using urine, diagnostic algorithm reported as a probability index for bladder cancer and/or upper tract urothelial carcinoma (UTUC)	NON-COVERED	NON-COVERED		

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0551U	Tau, phosphorylated, pTau217, by single-molecule array (ultrasensitive digital protein detection), using plasma	NON-COVERED	NON-COVERED	PG0441 Genetic and Biomarker Testing for Alzheimer Disease; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0553T	Percutaneous transcatheter placement of iliac arteriovenous anastomosis implant, inclusive of all radiological supervision and interpretation, intraprocedural road mapping, and imaging guidance necessary to complete the intervention	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 density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data, assessment of bone strength and fracture risk and bone	NON-COVERED	~~NON-COVERED~~ PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0320 Bone Density Measurements; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL Effective 11/01/2024 covered with a prior authorization for the Elite (Medicare Advantage) Plans per InterQual coverage criteria
0555T	Bone strength and fracture risk using finite element analysis of functional data, and bonemineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data	NON-COVERED	~~NON-COVERED~~ PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0320 Bone Density Measurements; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL Effective 11/01/2024 covered with a prior authorization for the Elite (Medicare Advantage) Plans per InterQual coverage criteria
0556T	Bone strength and fracture risk using finite element analysis of functional data, and bonemineral density, utilizing data from a computed tomography scan; assessment of bone strength and fracture risk and bone mineral density	NON-COVERED	~~NON-COVERED~~ PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0320 Bone Density Measurements; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL Effective 11/01/2024 covered with a prior authorization for the Elite (Medicare Advantage) Plans per InterQual coverage criteria
0557T	Bone strength and fracture risk using finite element analysis of functional data, and bonemineral density, utilizing data from a computed tomography scan; interpretation and report	NON-COVERED	~~NON-COVERED~~ PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0320 Bone Density Measurements; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL Effective 11/01/2024 covered with a prior authorization for the Elite (Medicare Advantage) Plans per InterQual coverage criteria

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0558T	Computed tomography scan taken for the purpose of biomechanical computed tomography analysis	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0559T	Anatomic model 3D-printed from image data set(s); first individually prepared and processed component of an anatomic structure	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0560T	Anatomic model 3D-printed from image data set(s); first individually prepared and processed component of an anatomic structure; each additional individually prepared and processed component of an anatomic structure (List separately	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 additional anatomic guide (List separately in addition to code for primary procedure)	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 treatment devices and manual gland expression, bilateral	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 and primary tumor cells, categorical drug response reported based on percent of cytotoxicity observed, a minimum of 14 drugs or drug combinations	NON-COVERED	NON-COVERED	PG0122 In Vitro Chemoresistance & Chemosensitivity Assays; PG0043 Experimental Investigational Procedures Services	**DELETED CODE 01/01/225**

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0565T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation	NON-COVERED	NON-COVERED	PG0400 Stem Cell Therapy for Orthopedic Applications; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0566T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral	NON-COVERED	NON-COVERED	PG0400 Stem Cell Therapy for Orthopedic Applications; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0567T	Permanent fallopian tube occlusion with degradable biopolymer implant, transcervical approach, including transvaginal ultrasound	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 tubes, transcervical approach, including transvaginal ultrasound and pelvic ultrasound	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-Archived; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0570T	Transcatheter tricuspid valve repair, percutaneous approach; each additional prosthesis during same session (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures-Archived; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0571T	Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s), including all imaging guidance and electrophysiological evaluation (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0224 Cardioverter Defibrillators-archived120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0572T	Insertion of substernal implantable defibrillator electrode	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0224 Cardioverter Defibrillators-archived120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0573T	Removal of substernal implantable defibrillator electrode	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0224 Cardioverter Defibrillators-archived120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0574T	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0224 Cardioverter Defibrillators-archived120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0575T	Programming device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0224 Cardioverter Defibrillators-archived120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0576T	Interrogation device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0224 Cardioverter Defibrillators-archived120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0577T	Electrophysiological evaluation of implantable cardioverter defibrillator system with substernal electrode (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0224 Cardioverter Defibrillators-archived120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0578T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0224 Cardioverter Defibrillators-archived120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0579T	interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0224 Cardioverter Defibrillators-archived120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0580T	Removal of substernal implantable defibrillator pulse generator only	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0224 Cardioverter Defibrillators-archived120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0581T	Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral	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, including intraoperative imaging and needle guidance	NON-COVERED	NON-COVERED	PG0534 ~~Fluid Jet System in the Treatment of Benign Prostatic Hyperplasia (BPH)~~ Treatments for Benign Prostatic Hypertrophy (BPH); PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0583T	Tympanostomy (requiring insertion of ventilating tube), using an automated tube delivery system, iontophoresis local anesthesia (Tula Iontophoresis 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 guidance, and radiological supervision and interpretation, when performed; percutaneous	NON-COVERED	NON-COVERED	PG0415 Pancreatic Islet Cell Transplantation; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0585T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; laparoscopic	NON-COVERED	NON-COVERED	PG0415 Pancreatic Islet Cell Transplantation; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0586T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; open	NON-COVERED	NON-COVERED	PG0415 Pancreatic Islet Cell Transplantation; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0587T	Percutaneous implantation or replacement of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services; PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments and Devices-archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0588T	Revision or removal of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services; PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments and Devices-archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0589T	Electronic analysis with simple programming of implanted integrated neurostimulation system (e.g., electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient selectable	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services; PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments and Devices-archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0590T	Electronic analysis with complex programming of implanted integrated neurostimulation system (e.g., electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient selectable	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services; PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments and Devices-archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0594T	Osteotomy, humerus, with insertion of an externally controlled intramedullary lengthening device, including intraoperative imaging, initial and subsequent alignment assessments, computations of adjustment schedules, and management of the intramedullary	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, including urethral measurement	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services; PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments and Devices-archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0597T	Temporary female intraurethral valve-pump (i.e., voiding prosthesis); replacement	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services; PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments and Devices-archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0598T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; first anatomic site (e.g., lower extremity)	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 session; each additional anatomic site (e.g., upper extremity) (List separately in addition to code for primary procedure)	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 guidance, when performed, percutaneous	NON-COVERED	NON-COVERED	PG0488 Irreversible Electroporation Ablation; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0601T	Ablation, irreversible electroporation; 1 or more tumors, including fluoroscopic and ultrasound guidance, when performed, open	NON-COVERED	NON-COVERED	PG0488 Irreversible Electroporation Ablation; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0602T	Glomerular filtration rate (GFR) measurement(s), transdermal, including sensor placement and administration of a single dose of fluorescent pyrazine agent	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0603T	Glomerular filtration rate (GFR) monitoring, transdermal, including sensor placement and administration of more than one dose of fluorescent pyrazine agent, each 24 hours	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0604T	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center unilateral or bilateral; initial device provision, set-up and patient education on use of equipment	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 transmission to a remote surveillance center unilateral or bilateral; remote surveillance center technical support, data analyses and reports, with a minimum of 8	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 transmission to a remote surveillance center unilateral or bilateral; review, interpretation and report by the prescribing physician or other qualified health care	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 measurement of radiofrequency derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (e.g., ECG data), transmitted to a	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 measurement of radiofrequency derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (e.g., ECG data), transmitted to a	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, or lumbar); acquisition of single voxel data, per disc, on biomarkers (i.e., lactic acid, carbohydrate, alanine, laal, propionic acid, proteoglycan, and collagen) in at	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, or lumbar); transmission of biomarker data for software analysis	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0611T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); post-processing for algorithmic analysis of biomarker data for determination of relative chemical differences between discs	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, or lumbar); interpretation and report	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 left heart catheterization, intracardiac echocardiography, and imaging guidance by the proceduralist, when performed (i.e., InterAtrial Shunt Device (IASD) and Ventura)	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 EyeBOX system)	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; without removal of crystalline lens or intraocular lens, without insertion of intraocular lens	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; with removal of crystalline lens and insertion of intraocular lens	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0618T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with secondary intraocular lens placement or intraocular lens exchange	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0619T	Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, when performed	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; PG0327 Surgical Treatmenst for Glaucoma	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services; PG0327 Surgical Treatmenst for Glaucoma	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0623T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission, computerized analysis of data, with	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0624T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0625T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; computerized analysis of data from coronary computed tomographic	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0626T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; review of computerized analysis output to reconcile discordant data	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, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level	NON-COVERED	NON-COVERED	PG0400 Stem Cell Therapy for Orthopedic Applications. PG0043 Experimental Investigational Procedures Services. PG0026 Discogenic Pain Treatment-Archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0400 Stem Cell Therapy for Orthopedic Applications. PG0043 Experimental Investigational Procedures Services. PG0026 Discogenic Pain Treatment-Archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level	NON-COVERED	NON-COVERED	PG0400 Stem Cell Therapy for Orthopedic Applications. PG0043 Experimental Investigational Procedures Services. PG0026 Discogenic Pain Treatment-Archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0630T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; each additional level (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0400 Stem Cell Therapy for Orthopedic Applications. PG0043 Experimental Investigational Procedures Services. PG0026 Discogenic Pain Treatment-Archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0631T	Transcutaneous visible light hyperspectral imaging measurement of oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation, with interpretation and report, per extremity	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0632T	Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0633T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast material	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 material(s)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0635T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast, followed by contrast material(s)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0636T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast material(s)	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 material(s)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0638T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast, followed by contrast material(s)	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 cerebrospinal fluid shunt, including ultrasound guidance, when performed	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0640T	Noncontact near-infrared spectroscopy studies of flap or wound (e.g., for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation [StO2]); image acquisition, interpretation and report, each flap or wound	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 deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation [StO2]); image acquisition only, each flap or wound	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 deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation [StO2]); interpretation and report only, each flap or wound	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 catheterization and left ventriculography when performed, arterial approach (i.e., Revivent TC)	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 suction (e.g., vacuum, aspiration) device, percutaneous approach, with intraoperative reinfusion of aspirated blood, including imaging guidance, when performed	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0645T	Transcatheter implantation of coronary sinus reduction device including vascular access and closure, right heart catheterization, venous angiography, coronary sinus angiography, imaging guidance, and supervision and interpretation, when performed	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0646T	Transcatheter tricuspid valve implantation/replacement (TTVI) with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures-Archived; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0647T	Insertion of gastrostomy tube, percutaneous, with magnetic gastropexy, under ultrasound guidance, image documentation and report	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), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same	NON-COVERED	NON-COVERED	PG0252 Noninvasive Tests for Hepatic Fibrosis; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0649T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation, and report, obtained with diagnostic MRI examination of the same	NON-COVERED	NON-COVERED	PG0252 Noninvasive Tests for Hepatic Fibrosis; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0650T	Programming device evaluation (remote) of subcutaneous cardiac rhythm monitor system, with iterative adjustment of the implantable device to test the function of the device and select optimal permanently programmed values with analysis, review and	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0651T	Magnetically controlled capsule endoscopy, esophagus through stomach, including intraprocedural positioning of capsule, with interpretation and report	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0652T	Esophagogastroduodenoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	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

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 guidance, with MR-fused images or other enhanced ultrasound 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 coronary revascularization during acute myocardial infarction, including catheter placement, imaging guidance (e.g., fluoroscopy), angiography, and	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 Surgical Treatments for Glaucoma; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0661T	Removal and reimplantation of anterior segment intraocular nonbiodegradable drug-eluting implant	NON-COVERED	NON-COVERED	PG0327 Surgical Treatments for Glaucoma; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0662T	Scalp cooling, mechanical; initial measurement and calibration of cap	NON-COVERED	Covered with No Prior Authorization Required	PG0535 Scalp Cooling Devices to Prevent Hair Loss During Chemotherapy; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL FOR COMMERCIAL PLANS; COVERED WITHOUT A PRIOR AUTHORIZATION FOR ELITE (MEDICARE ADVANTAGE PLANS)
0663T	Scalp cooling, mechanical; placement of device, monitoring, and removal of device (List separately in addition to code for primary procedure)	NON-COVERED	Covered with No Prior Authorization Required	PG0535 Scalp cooling Devices to Prevent Hair Loss During Chemotherapy; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL FOR COMMERCIAL PLANS; COVERED WITHOUT A PRIOR AUTHORIZATION FOR ELITE (MEDICARE ADVANTAGE PLANS)
0664T	Donor hysterectomy (including cold preservation); open, from cadaver donor	NON-COVERED	NON-COVERED	PG0461 Transplant Prior Authorization and Notification; PG0043 Experimental Investigational Procedures Services	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 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0666T	Donor hysterectomy (including cold preservation); laparoscopic or robotic, from living donor	NON-COVERED	NON-COVERED	PG0461 Transplant Prior Authorization and Notification; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0667T	Donor hysterectomy (including cold preservation); recipient uterus allograft transplantation from cadaver or living donor	NON-COVERED	NON-COVERED	PG0461 Transplant Prior Authorization and Notification; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0668T	Backbench standard preparation of cadaver or living donor uterine allograft prior to transplantation, including dissection and removal of surrounding soft tissues and preparation of uterine vein(s) and uterine artery(ies), as necessary	NON-COVERED	NON-COVERED	PG0461 Transplant Prior Authorization and Notification; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0669T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; venous anastomosis, each	NON-COVERED	NON-COVERED	PG0461 Transplant Prior Authorization and Notification; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0670T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; arterial anastomosis, each	NON-COVERED	NON-COVERED	PG0461 Transplant Prior Authorization and Notification; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0672T	Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the tissues surrounding the female bladder neck and proximal urethra for urinary incontinence	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 diaphragmatic stimulation system for augmentation of cardiac function, including an implantable pulse generator and diaphragmatic lead(s)	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 synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; first lead	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0676T	Laparoscopic insertion of new or replacement of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; each additional	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0677T	Laparoscopic repositioning of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; first repositioned lead	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0678T	Laparoscopic repositioning of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; each additional repositioned lead (List	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0679T	Laparoscopic removal of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0680T	Insertion or replacement of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, with connection to existing lead(s)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0681T	Relocation of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, with connection to existing dual leads	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0682T	Removal of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0683T	Programming device evaluation (in-person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional	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 or after a surgery, procedure, or test with analysis, review, and report by a physician or other qualified health care professional, permanent implantable	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 qualified health care professional, including connection, recording and disconnection per patient encounter, permanent implantable synchronized diaphragmatic	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 hepatocellular tissue, including image guidance	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0687T	Treatment of amblyopia using an online digital program; device supply, educational set-up, and initial session	NON-COVERED	NON-COVERED	PG0318 Vision Therapy; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0688T	Treatment of amblyopia using an online digital program; assessment of patient performance and program data by physician or other qualified health care professional, with report, per calendar month	NON-COVERED	NON-COVERED	PG0318 Vision Therapy; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0689T	Quantitative ultrasound tissue characterization (nonelastography) including interpretation and report; obtained with diagnostic ultrasound examination of the same anatomy (organ, gland, tissue target structure)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0690T	Quantitative ultrasound tissue characterization (nonelastographic), including interpretation and report, obtained with diagnostic ultrasound examination of the same anatomy (e.g., organ, gland, tissue, target structure) (List separately in	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 assessment of bone density when performed, data preparation, interpretation, and report	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental Investigational Procedures Services	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 report	NON-COVERED	NON-COVERED	PG0339 Gait Analysis-Archived; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0694T	3-dimensional volumetric imaging and reconstruction of breast or axillary lymph node tissue, each excised specimen, 3-dimensional automatic specimen reorientation, interpretation and report, real-time intraoperative	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 optimize electrical synchrony, cardiac resynchronization therapy device, including connection, recording, disconnection, review, and report; at time of implant or	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0224 Cardioverter Defibrillators-archived120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0696T	Body surface–activation mapping of pacemaker or pacing cardioverter-defibrillator lead(s) to optimize electrical synchrony, cardiac resynchronization therapy device, including connection, recording, disconnection, review, and report; at time of follow-up	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0224 Cardioverter Defibrillators-archived120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0697T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation, and report, obtained without diagnostic MRI examination of the same	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), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same	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 program ordered by a physician or other qualified health care professional; supply and technical support, per 30 days	NON-COVERED	NON-COVERED	PG0402 Cognitive Rehabilitation-Archived 110124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL. Codes 0701T and 0702T deleted as of 01/01/2023.
0703T	Remote therapeutic monitoring of a standardized online digital cognitive behavioral therapy program ordered by a physician or other qualified health care professional; management services by physician or other qualified health care professional, per calendar month	NON-COVERED	NON-COVERED	PG0402 Cognitive Rehabilitation-Archived 110124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL. Codes 0701T and 0702T deleted as of 01/01/2023.
0704T	Remote treatment of amblyopia using an eye tracking device; device supply with initial setup and patient education on use of equipment	NON-COVERED	NON-COVERED	PG0318 Vision Therapy; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0705T	Remote treatment of amblyopia using an eye tracking device; surveillance center technical support including data transmission with analysis, with a minimum of 18 training hours, each 30 days	NON-COVERED	NON-COVERED	PG0318 Vision Therapy; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0706T	Remote treatment of amblyopia using an eye tracking device; interpretation and report by physician or other qualified health care professional, per calendar month	NON-COVERED	NON-COVERED	PG0318 Vision Therapy; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0707T	Injection(s), bone-substitute material (e.g., calcium phosphate) into subchondral bone defect (i.e., bone marrow lesion, bone bruise, stress injury, microtrabecular fracture), including imaging guidance and arthroscopic assistance for joint visualization	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
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 computerized tomography angiography; including data preparation and transmission, quantification of the structure and composition of the vessel wall and	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 computerized tomography angiography; data preparation and transmission	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0712T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; quantification of the structure and composition of the vessel wall and assessment for lipid-rich necrotic core plaque to	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 computerized tomography angiography; data review, interpretation and report	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 (BPH)~~ Treatments for Benign Prostatic Hypertrophy (BPH); PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0715T	Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)	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 disease risk score	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 tear; adipose tissue harvesting, isolation and preparation of harvested cells, including incubation with cell dissociation enzymes, filtration, washing and	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 tear; injection into supraspinatus tendon including ultrasound guidance, unilateral	NON-COVERED	NON-COVERED	PG0400 Stem Cell Therapy of Orthopedic Applications	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0719T	Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment	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 interpretation and report, obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0722T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained with concurrent CT examination of any structure contained in the concurrently acquired diagnostic imaging dataset (List separately in addition	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0723T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation, and report, obtained without diagnostic magnetic resonance imaging (MRI) examination of the same anatomy	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0724T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation, and report, obtained with diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (e.g., organ, gland	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 - Archived 3/1/2025;**; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0726T	Removal of implanted vestibular device, unilateral	NON-COVERED	NON-COVERED	**PG0193 Treatment of Chronic Vertigo - Archived 3/1/2025;** PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0727T	Removal and replacement of implanted vestibular device, unilateral	NON-COVERED	NON-COVERED	**PG0193 Treatment of Chronic Vertigo - Archived 3/1/2025;**; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0728T	Diagnostic analysis of vestibular implant, unilateral; with initial programming	NON-COVERED	NON-COVERED	**PG0193 Treatment of Chronic Vertigo - Archived 3/1/2025;**; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0729T	Diagnostic analysis of vestibular implant, unilateral; with subsequent programming	NON-COVERED	NON-COVERED	**PG0193 Treatment of Chronic Vertigo - Archived 3/1/2025;**; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0730T	Trabeculotomy by laser, including optical coherence tomography (OCT) guidance	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services; PG0327 Surgical Treatmenst for Glaucoma	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

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0733T	Remote real-time, motion capture-based neurorehabilitative therapy ordered by a physician or other qualified health care professional; supply and technical support, per 30 days.	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 qualified health care professional, treatment management services by a physician or other qualified health care professional, per calendar month	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 intraoperative radiation therapy (IORT) concurrent with primary craniotomy	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 rectal catheter	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 data from previously performed magnetic resonance imaging (MRI) examination	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 intraprocedural, transperineal needle/catheter placement for nanoparticle installation and intraprocedural temperature monitoring, thermal dosimetry	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0743T	Bone strength and fracture risk using finite element analysis of functional data and bone mineral density (BMD), with concurrent vertebral fracture assessment, utilizing data from a computed tomography scan, retrieval and transmission of the scan data	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental Investigational Procedures Services	
0744T	Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound imaging guidance, when performed, including autogenous or nonautogenous patch graft (e.g., polyester, Eptfe, bovine pericardium), when performed	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 and mapping of arrhythmia site (nidus), derived from anatomical image data (e.g., CT, MRI, or myocardial perfusion scan) and	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 localization and mapping of arrhythmia site (nidus) into a multidimensional radiation treatment plan	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, arrhythmia	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., removal of setons, fistula curettage, closure of internal openings)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0749T	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X-ray data, assessment of bone	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0750T	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X-ray data, assessment of bone	NON-COVERED	NON-COVERED	PG0320 Bone Density Measurements; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0751T	Digitization of glass microscope slides for level II, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	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 examination (List separately in addition to code for primary procedure)	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 examination (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0754T	Digitization of glass microscope slides for level V, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	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 examination (List separately in addition to code for primary procedure)	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, for microorganisms (e.g., acid fast, methenamine silver) (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0757T	Digitization of glass microscope slides for special stain, including interpretation and report, group II, all other (e.g., iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry (List	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, histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)	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, for enzyme constituents (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0760T	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, initial single antibody stain procedure (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0761T	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, each additional single antibody stain procedure (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0762T	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry per specimen, each multiplex antibody stain procedure (List separately in addition to code for primary procedure)	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., Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure, manual (List	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0764T	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (e.g., low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to concurrently performed electrocardiogram (List separately	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, peripheral nerve, initial treatment, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction	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, peripheral nerve, subsequent treatment, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve	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 intra-articular implant(s) (eg, bone allograft[s], synthetic device[s])	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0776T	Therapeutic induction of intra-brain hypothermia, including placement of a mechanical temperature-controlled cooling device to the neck over carotids and head, including monitoring (e.g., vital signs and sport concussion assessment tool 5 [SCAT5]), 30	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 primary procedure)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0778T	Surface mechanomyography (Smmg) with concurrent application of inertial measurement unit (IMU) sensors for measurement of multi-joint range of motion, posture, gait, and muscle function	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0779T	Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report	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 circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; bilateral mainstem bronchi	NON-COVERED	NON-COVERED	PG0316 Bronchial Thermoplasty; PG0043 Experimental Investigational Procedures Services. Archived-080124. PG0043 Experimental/Investigational Procedures/Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0782T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; unilateral mainstem bronchus	NON-COVERED	NON-COVERED	PG0316 Bronchial Thermoplasty- Archived-080124. PG0043 Experimental/Investigational Procedures/Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0783T	Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment	NON-COVERED	NON-COVERED	PG0244 Electrical Nerve Stimulators-archived 120124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0789T	Electronic analysis with complex programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable	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 professional	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0793T	Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance	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, FLUOROSCOPY, VENOUS ULTRASOUND, RIGHT ATRIAL ANGIOGRAPHY, RIGHT VENTRICULOGRAPHY, FEMORAL VENOGRAPHY) AND DEVICE EVALUATION (EG, INTERROGATION OR PROGRAMMING), WHEN	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is participating in an FDA approved post approval trial that is registered.	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 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 Advantage members only: approval if the member is participating in an FDA approved post approval trial that is registered.
0796T	RIGHT ATRIAL PACEMAKER COMPONENT (WHEN AN EXISTING RIGHT VENTRICULAR SINGLE LEADLESS PACEMAKER EXISTS TO CREATE A DUAL-CHAMBER LEADLESS PACEMAKER SYSTEM)	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is participating in an FDA approved post approval trial that is registered.	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 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 Advantage members only: approval if the member is participating in an FDA approved post approval trial that is registered.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0797T	RIGHT VENTRICULAR PACEMAKER COMPONENT (WHEN PART OF A DUALCHAMBER LEADLESS PACEMAKER SYSTEM)	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is participating in an FDA approved post approval trial that is registered.	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 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 Advantage members only: approval if the member is participating in an FDA approved post approval trial that is registered.
0798T	TRANSCATHETER REMOVAL OF PERMANENT DUAL-CHAMBER LEADLESS PACEMAKER, INCLUDING IMAGING GUIDANCE (EG, FLUOROSCOPY, VENOUS ULTRASOUND, RIGHT ATRIAL ANGIOGRAPHY, RIGHT VENTRICULOGRAPHY, FEMORAL VENOGRAPHY), WHEN PERFORMED; COMPLETE SYSTEM (IE, RIGHT ATRIAL AND RIGHT	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is participating in an FDA approved post approval trial that is registered.	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 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 Advantage members only: approval if the member is participating in an FDA approved post approval trial that is registered.
0799T	RIGHT ATRIAL PACEMAKER COMPONENT	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is participating in an FDA approved post approval trial that is registered.	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 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 Advantage members only: approval if the member is participating in an FDA approved post approval trial that is registered.
0800T	RIGHT VENTRICULAR PACEMAKER COMPONENT (WHEN PART OF A DUALCHAMBER LEADLESS PACEMAKER SYSTEM)	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is participating in an FDA approved post approval trial that is registered.	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 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 Advantage members only: approval if the member is participating in an FDA approved post approval trial that is registered.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0801T	TRANSCATHETER REMOVAL AND REPLACEMENT OF PERMANENT DUAL-CHAMBER LEADLESS PACEMAKER, INCLUDING IMAGING GUIDANCE (EG, FLUOROSCOPY, VENOUS ULTRASOUND, RIGHT ATRIAL ANGIOGRAPHY, RIGHT VENTRICULOGRAPHY, FEMORAL VENOGRAPHY) AND DEVICE EVALUATION (EG, INTERROGATION OR PROGRAMMING), WHEN	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is participating in an FDA approved post approval trial that is registered.	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 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 Advantage members only: approval if the member is participating in an FDA approved post approval trial that is registered.
0802T	RIGHT ATRIAL PACEMAKER COMPONENT	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is participating in an FDA approved post approval trial that is registered.	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 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 Advantage members only: approval if the member is participating in an FDA approved post approval trial that is registered.
0803T	RIGHT VENTRICULAR PACEMAKER COMPONENT (WHEN PART OF A DUALCHAMBER LEADLESS PACEMAKER SYSTEM)	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is participating in an FDA approved post approval trial that is registered.	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 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 Advantage members only: approval if the member is participating in an FDA approved post approval trial that is registered.
0804T	PROGRAMMING DEVICE EVALUATION (IN PERSON) WITH ITERATIVE ADJUSTMENT OF IMPLANTABLE DEVICE TO TEST THE FUNCTION OF DEVICE AND TO SELECT OPTIMAL PERMANENT PROGRAMMED VALUES, WITH ANALYSIS, REVIEW, AND REPORT, BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, LEADLESS PACEMAKER SYSTEM IN DUAL	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is participating in an FDA approved post approval trial that is registered.	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 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 Advantage members only: approval if the member is participating in an FDA approved post approval trial that is registered.
0805T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); percutaneous femoral vein approach	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures-Archived; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0806T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); open femoral vein approach	NON-COVERED	NON-COVERED	PG0108 Transcatheter Heart Valve Procedures-Archived; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0809T	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, placement of transfixing device(s) and intra-articular implant(s), including allograft or synthetic device(s)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon	NON-COVERED	NON-COVERED	PG0163 Metabolic and Bariatric Surgery; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0814T	Percutaneous injection of calcium-based biodegradable osteoconductive material, proximal femur, including imaging guidance, unilateral	NON-COVERED	NON-COVERED	PG0365 Bone Graft Substitutes; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0816T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve;	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 electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve;	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 analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0819T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subfascial	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
0823T	Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is participating in an FDA approved post approval trial that is registered.	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 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 Advantage members only: approval if the member is participating in an FDA approved post approval trial that is registered
0824T	Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography), when performed	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is participating in an FDA approved post approval trial that is registered.	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 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 Advantage members only: approval if the member is participating in an FDA approved post approval trial that is registered
0825T	Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is participating in an FDA approved post approval trial that is registered.	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 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 Advantage members only: approval if the member is participating in an FDA approved post approval trial that is registered
0826T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional, leadless pacemaker system in single-cardiac chamber	NON-COVERED	PRIOR AUTHORIZATION NOT REQUIRED - Approval only permitted when the member is participating in an FDA approved post approval trial that is registered.	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 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 Advantage members only: approval if the member is participating in an FDA approved post approval trial that is registered

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0858T	Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report	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 components (battery and transmitter)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	
0862T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	
0863T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; transmitter component only	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	
0864T	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy Status Code C-Carriers price code	NON-COVERED	NON-COVERED	PG0004 Extracorporeal Shock Wave (ESWT)-Archived 090124. PG0043 Experimental Investigational Procedures Services	New code effective 01/01/2024
0865T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion identification, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the brain during the same session	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	New code effective 01/01/2024

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0866T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion detection, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the brain (List separately in addition to code for primary procedure)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	New code effective 01/01/2024
0889T	Personalized target development for accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation derived from a structural and resting-state functional MRI, including data preparation and transmission, generation of the target, motor threshold-starting	NON-COVERED	NON-COVERED	PG0294 Transcranial Magnetic Stimulation (TMS)	New Code Effective 7/1/2024
0890T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including target assessment, initial motor threshold determination, neuronavigation, delivery and management, initial treatment day	NON-COVERED	NON-COVERED	PG0294 Transcranial Magnetic Stimulation (TMS)	New Code Effective 7/1/2024
0891T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent treatment day	NON-COVERED	NON-COVERED	PG0294 Transcranial Magnetic Stimulation (TMS)	New Code Effective 7/1/2024
0892T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent motor threshold redetermination with delivery and management, per treatment day	NON-COVERED	NON-COVERED	PG0294 Transcranial Magnetic Stimulation (TMS)	New Code Effective 7/1/2024
0906T	Concurrent optical and magnetic stimulation (COMS) therapy, wound assessment and dressing care; first application, total wound(s) surface area less than or equal to 50 sq cm	NON-COVERED	NON-COVERED - See Detail/Notes	PG0043 Experimental Investigational Procedures Services	New code effective 01/01/2025. For recipients of Concurrent Optical and Magnetic Stimulation (COMS® One Therapy System) who ARE participating in the Medicare-approved Category B Investigational Device Exemption (IDE) study: This service may be covered by Medicare only if the member is enrolled

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
0907T	Concurrent optical and magnetic stimulation (COMS) therapy, wound assessment and dressing care; each additional application, total wound(s) surface area less than or equal to 50 sq cm (List separately in addition to code for primary	NON-COVERED	NON-COVERED - See Detail/Notes	PG0043 Experimental Investigational Procedures Services	New code effective 01/01/2025. For recipients of Concurrent Optical and Magnetic Stimulation (COMS® One Therapy System) who ARE participating in the Medicare-approved Category B Investigational Device Exemption (IDE) study: This service may be covered by Medicare only if the member is enrolled in the Medicare- approved Category B study
0936T	Photobiomodulation therapy of retina, single session [Valeda Photobiomodulation System(LumaThera)],	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	(New code 01/01/2025) [Valeda Photobiomodulation System(LumaThera)]
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 medical review)	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.
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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 (Effective 04/01/2022)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION **NOT** 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 (GCM), includes all supplies and accessories, 1 month supply = 1 unit of service (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.
A4252	Blood ketone test or reagent strip, each	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0155 Glucose Testing Supplies-archived-converted to RM032 Glucose Testing Supplies.100124	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-archived-converted to RM032 Glucose Testing Supplies.100124
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. See Notes	PG0155 Glucose Testing Supplies-archived-converted to RM032 Glucose Testing Supplies.100124	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. Refer to medical policy PG0155 Glucose Testing Supplies-archived-converted to RM032 Glucose Testing Supplies.100124
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-archived--archived-converted to RM032 Glucose Testing Supplies.100124	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-archived-converted to RM032 Glucose Testing Supplies.100124

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
A4256	Normal, low, and high calibrator solution/chips	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0155 Glucose Testing Supplies-archived-converted to RM032 Glucose Testing Supplies.100124	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-archived-converted to RM032 Glucose Testing Supplies.100124
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-archived-archived-converted to RM032 Glucose Testing Supplies.100124	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-archived-converted to RM032 Glucose Testing Supplies.100124
A4258	Spring-powered device for lancet, each	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0155 Glucose Testing Supplies-archived-archived-converted to RM032 Glucose Testing Supplies.100124	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-archived-converted to RM032 Glucose Testing Supplies.100124
A4259	Lancets, per box of 100	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA. See Notes	PG0155 Glucose Testing Supplies-archived-converted to RM032 Glucose Testing Supplies.100124	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. Refer to medical policy PG0155 Glucose Testing Supplies-archived-converted to RM032 Glucose Testing Supplies.100124
A4461	Surgical dressing holder, non-reusable, each	NoN-COVERED	NON-COVERED		
A4463	Surgical dressing holder, reusable, each	NoN-COVERED	NON-COVERED		
A4540	Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
A4541	Monthly supplies for use of device coded at E0733	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	
A4542	Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		
A4544	Electrode for external lower extremity nerve stimulator for restless legs syndrome	NON-COVERED	NON-COVERED		Nidra Tonic Motor Activation (TOMAC) system -Noctrix - Non-covered
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
A4563	Rectal control system for vaginal insertion, for long term use, includes pump and all supplies and accessories, any type each	NON-COVERED	NON-COVERED	PG0462 Rectal Control System for Fecal Incontinence (Eclipse)-Archived; PG0043 Experimental Investigational Procedures Services -Vaginal bowel control (eg, Eclipse system) for fecal incontinence are Not Covered.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL. 46999-Unlisted procedure, anus = noncovered when related to the treatment of Rectal Control System for Fecal Incontinence (Eclipse). 58999-Unlisted procedure, female genital system (nonobstetrical) = noncovered when related to the treatment of Rectal Control System for Fecal Incontinence (Eclipse)
A4575	Topical hyperbaric oxygen chamber, disposable	NON-COVERED	NON-COVERED	PG0205 Hyperbaric Oxygen Therapy (HBOT); PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
A4593	Neuromodulation stimulator system, adjunct to rehabilitation therapy regime, controlle	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
A4594	Neuromodulation stimulator system, adjunct to rehabilitation therapy regime, mouthpiece, each	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
A4633	Replacement bulb/lamp for ultraviolet light therapy system, each	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0383 Home Phototherapy for Dermatologic Conditions-archived-combined with medical policy PG0162 Phototherapy, PUVA, UV-A, UV-B and Targeted for Dermatologic Conditions, Office & Home	Effective 12/01/2024 procedure A4633 requires a prior authorization for all product lines.
A6000	Noncontact wound-warming wound cover for use with the noncontact wound-warming device and warming card	NON-COVERED	NON-COVERED		
A6025	Gel sheet for dermal or epidermal application, (e.g., silicone, hydrogel, other), each wound pouch, each	NON-COVERED	NON-COVERED		
A6413	Adhesive bandage, first-aid type, any size, each	NON-COVERED	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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
A7021	Supplies and accessories for lung expansion airway clearance, continuous high frequency oscillation, and nebulization device (e.g., handset, nebulizer kit, biofilter)	NON-COVERED	NON-COVERED	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 accessories (used for the Omni Pods)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION **NOT** 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.
A9276	Sensor; invasive (e.g., subcutaneous), disposable, for use with nondurable medical equipment interstitial continuous glucose monitoring system (CGM), on unit = 1 month supply	NON-COVERED	PRIOR AUTHORIZATION **NOT** REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	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 Coverage to follow CMS coverage guidelines.
A9277	Transmitter; external, for use with nondurable medical equipment interstitial continuous glucose monitoring system (CGM)	NON-COVERED	PRIOR AUTHORIZATION **NOT** REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	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 Coverage to follow CMS coverage guidelines.
A9278	Receiver (monitor); external, for use with nondurable medical equipment interstitial continuous glucose monitoring system (CGM)	NON-COVERED	PRIOR AUTHORIZATION **NOT** REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	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 Coverage to follow CMS coverage guidelines.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
A9291	Prescription digital behavioral therapy, FDA cleared, per course of treatment	NON-COVERED	NON-COVERED	PG0506 Prescription Digital Therapeutics (PDTs) Health Products; PG0043 Experimental Investigational Procedures Services	
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) Health Products; PG0043 Experimental Investigational Procedures Services	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)	**Prior Authorization is required through Prime Therapeutics @ https://www.primetherapeutics.com**
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.
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 CRITERIA	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, coverage indicated

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
B4149	Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	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, administered through an enteral feeding tube, 100 calories = 1 unit	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 minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	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 include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	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, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral	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 (e.g. glutamine, arginine), fat (e.g. medium chain triglycerides) or combination, administered through	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 minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	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	Elite Medicare Advantage	Policy	DETAILS/NOTES
B4158	Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit	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 include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit	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, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral	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, administered through an enteral feeding tube, 100 calories = 1 unit	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.
B4162	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	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

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
C1782	Morcellator	NON-COVERED	NON-COVERED	PG0344 Uterine Fibroid Surgical Treatments-Archived 080124	
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 System)	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 Prosthesis System)	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 system components	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-archived 120124; PG0043 Experimental Investigational Procedures Services	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 every request of intravenous infusion of Chimeric Antigen Receptor (CAR)-T Cell Therapy [including, but not limited to, tisagenlecleucel (Kymriah), axicabtagene ciloleucel (Yescarta), lisocabtagene maraleucel (Breyanzi), brexucabtagene autoleucel (Tecartus), and idecabtagene vicleucel (Abecma)]. Effective March 1, 2022 - forward, Car-T Cell

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
C9739	Cystourethroscopy, with insertion of trans-prostatic implant; one to three implants (Urolift System)	EFFECTIVE 04/01/2025 PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	EFFECTIVE 04/01/2025 PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0534 Treatments for Benigh Prostatic Hypertrophy (BPH)	
C9740	Cystourethroscopy, with insertion of trans-prostatic implant; four or more implants (Urolift System)	EFFECTIVE 04/01/2025 PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	EFFECTIVE 04/01/2025 PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0534 Treatments for Benigh Prostatic Hypertrophy (BPH)	
C9759	Transcatheter intraoperative blood vessel microinfusion(s) (e.g., intraluminal, vascular wall and/or perivascular) therapy, any vessel, including radiological supervision and interpretation, when performed	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C9764	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed (Shockwave Medical Intravascular Lithotripsy [IVL]	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C9765	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed (Shockwave Medical	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C9766	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed (Shockwave Medical Intravascular	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C9767	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
C9772	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed (Shockwave Medical Intravascular Lithotripsy [IVL] System)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C9773	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed (Shockwave Medical Intravascular	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C9774	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed (Shockwave Medical Intravascular Lithotripsy [IVL]	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C9775	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
C9777	Esophageal mucosal integrity testing by electrical impedance, transoral (list separately in addition to code for primary procedure) (e.g., MiVU™)	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 debridement (e.g., limited or extensive), subacromial decompression, acromioplasty, and biceps tenodesis when performed	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
CLINICAL TRIALS	Clinical Trials prior authorization and notification	See NOTES	See NOTES --Paramount does not require prior authorization for participation in a Medicare-qualified clinical trial. - MEDICAL POLICY	PG0446 Clinical Trials	See details related to Clinical Trials Prior Authorization and Notification, Out-Patient services, procedures at Medical Policy PG0446. Effective 7/1/2022 no prior authorization/notification required

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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-archived 120124	
E0217	Water circulating heat pad with pump	NON-COVERED	NON-COVERED	PG0043 Experimental/Investigational Procedures/Services	Active or passive cooling devices (with or without pneumatic compression, continuous or intermittent), as well as devices that combine compression, vibration, or heat therapy in the same device, are considered experimental/investigational and not medically necessary for all uses, including but not limited to recovery after orthopedic surgery or trauma. The following heat and cold therapy devices (with or without pneumatic compression) are considered investigational and not medically necessary for all uses, not an all-inclusive listing:
E0218	Water circulating cold pad with pump	NON-COVERED	NON-COVERED	PG0043 Experimental/Investigational Procedures/Services	Active or passive cooling devices (with or without pneumatic compression, continuous or intermittent), as well as devices that combine compression, vibration, or heat therapy in the same device, are considered experimental/investigational and not medically necessary for all uses, including but not limited to recovery after orthopedic surgery or trauma. The following heat and cold therapy devices (with or without pneumatic compression) are considered investigational and not medically necessary for all uses, not an all-inclusive listing:
E0236	Pump for water circulating pad	NON-COVERED	NON-COVERED	PG0043 Experimental/Investigational Procedures/Services	Active or passive cooling devices (with or without pneumatic compression, continuous or intermittent), as well as devices that combine compression, vibration, or heat therapy in the same device, are considered experimental/investigational and not medically necessary for all uses, including but not limited to recovery after orthopedic surgery or trauma. The following heat and cold therapy devices (with or without pneumatic compression) are considered investigational and not medically necessary for all uses, not an all-inclusive listing:
E0277	Powered pressure-reducing air mattress	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0245 Hospital Beds and Accessories	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 mattress	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0245 Hospital Beds and Accessories	
E0446	Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories	NON-COVERED	NON-COVERED	PG0205 Hyperbaric Oxygen Therapy (HBOT)	
E0469	Lung expansion airway clearance, continuous high frequency oscillation, and nebulization device	NON-COVERED	NON-COVERED	PG0227 Airway Clearance Devices	
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 device with continuous positive airway pressure device)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0247 Testing and Management of Obstructive Sleep Apnea	Exception: Prior Notification see medical policy details. Sleep Study Validation Form must be completed, https://www.paramounthealthcare.com/services/providers/tools-and-resources/documents-and-forms, along with The Durable Medical Equipment Referral Worksheet. https://www.paramounthealthcare.com/assets/documents/provider/fax-request-form-dme.pdf **Effective 02/01/2025 the Sleep Study Validation Form will not be needed, and the Prior Authorization will follow InterQual coverage criteria.**
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 continuous positive airway pressure device)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0247 Testing and Management of Obstructive Sleep Apnea	Exception: Prior Notification see medical policy details. Sleep Study Validation Form must be completed, https://www.paramounthealthcare.com/services/providers/tools-and-resources/documents-and-forms, along with The Durable Medical Equipment Referral Worksheet. https://www.paramounthealthcare.com/assets/documents/provider/fax-request-form-dme.pdf **Effective 02/01/2025 the Sleep Study Validation Form will not be needed, and the Prior Authorization will**

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
E0472	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, eg, tracheostomy tube (intermittent assist device with continuous positive airway pressure device)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY **Effective 01/01/2025 no prior authroization required**	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY - See Details **Effective 01/01/2025 no prior authroization required**	PG0247 Testing and Management of Obstructive Sleep Apnea	Exception: Prior Notification see medical policy details. Sleep Study Validation Form must be completed, https://www.paramounthealthcare.com/services/providers/tools-and-resources/documents-and-forms, along with The Durable Medical Equipment Referral Worksheet. https://www.paramounthealthcare.com/assets/documents/provider/fax-request-form-dme.pdf **Effective 02/01/2025 the Sleep Study Validation Form will not be needed, and the Prior Authorization will follow InterQual coverage criteria. And Effective 01/01/2025 no prior authroization required for E0472**
E0480	Percussor, electric or pneumatic, home model	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0227 Airway Clearance Devices	
E0482	Cough stimulating device, alternating positive and negative airway pressure	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	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	
E0485	Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, prefabricated, includes fitting and adjustment	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		prior authorization per InterQual coverage criteria
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- Archived 120124. Maintain prior authorization per InterQual coverage criteria	prior authorization per InterQual coverage criteria

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
E0490	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by hardware remote	NON-COVERED	NON-COVERED	PG0247 Testing and Management of Obstructive Sleep Apnea; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
E0491	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by hardware remote, 90-day supply	NON-COVERED	NON-COVERED	PG0247 Testing & Management of Obstructive Sleep Apnea; PG0043 Experimental/Investigational Procedures/Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
E0492	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application	NON-COVERED	NON-COVERED	PG0043 Experimental/Investigational Procedures/Services	
E0493	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by phone application, 90-day supply	NON-COVERED	NON-COVERED	PG0043 Experimental/Investigational Procedures/Services	
E0601	Continuous airway pressure (CPAP) device	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0247 Testing and Management of Obstructive Sleep Apnea	Exception: Prior Notification see medical policy details. Sleep Study Validation Form must be completed, https://www.paramounthealthcare.com/services/providers/tools-and-resources/documents-and-forms, along with The Durable Medical Equipment Referral Worksheet. https://www.paramounthealthcare.com/assets/documents/provider/fax-request-form-dme.pdf **Effective 02/01/2025 the Sleep Study Validation Form will not be needed, and the Prior Authorization will follow InterQual coverage criteria**
E0604	Breast pump, hospital grade, electric (AC and/or DC), any type	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0137 Preventive Services. PG0201 Breast Pump Equipment/Supplies and Counseling,archived 120124.	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-archived-converted to RM032 Glucose Testing Supplies.100124	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-archived-converted to RM032 Glucose Testing Supplies.100124

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
E0691	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area 2sq ft or less	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0383 Home Phototherapy for Dermatologic Conditions-archived-combined with medical policy PG0162 Phototherapy, PUVA, UV-A, UV-B and Targeted for Dermatologic Conditions, Office & Home. PG0348 Acne Surgery, Dermabrasion and Chemical Peels	
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-archived-combined with medical policy PG0162 Phototherapy, PUVA, UV-A, UV-B and Targeted for Dermatologic Conditions, Office & Home. PG0348 Acne Surgery, Dermabrasion and Chemical Peels	
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-archived-combined with medical policy PG0162 Phototherapy, PUVA, UV-A, UV-B and Targeted for Dermatologic Conditions, Office & Home. PG0348 Acne Surgery, Dermabrasion and Chemical Peels	
E0694	Ultraviolet multidirectional light therapy system in six foot cabinet, includes bulbs/lamps, timer, and eye protection	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0383 Home Phototherapy for Dermatologic Conditions-archived-combined with medical policy PG0162 Phototherapy, PUVA, UV-A, UV-B and Targeted for Dermatologic Conditions, Office & Home	
E0715	Intravaginal device intended to strengthen pelvic floor muscles during kegel exercises	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	
E0716	Supplies and accessories for intravaginal device intended to strengthen pelvic floor muscles during kegel exercises	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	
E0732	Cranial electrotherapy stimulation (CES) system, any type	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
E0733	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	
E0734	External upper limb tremor stimulator of the peripheral nerves of the wrist	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		
E0740	Non-implanted pelvic floor electrical stimulator, complete system	NON-COVERED	~~NON-COVERED~~ PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0043 Experimental Investigational Procedures Services: PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments and Devices-achived 120124.	Effective 12/01/2024 procedure E0740 changed from noncovered to covered with a prior authorization, for the Medicare Plans, per NCD, per InterQual
E0743	External lower extremity nerve stimulator for restless legs syndrome, each	NON-COVERED	NON-COVERED		Nidra Tonic Motor Activation (TOMAC) system -Noctrix - Non-covered
E0745	Neuromuscular stimulator, electronic shock unit (FES, NMES, TES)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0228 Neuromuscular, Functional, & Neuromuscular, Functional, & Therapeutic Electrical Stimulation Therapy	
E0746	Electromyography (EMG), biofeedback device	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	The use of home biofeedback devices is considered not medically necessary and not covered for all conditions. As they are considered experimental, investigational or unproven and are non-covered:
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)-Archived	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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)-Archived	
E0749	Osteogenesis stimulator, electrical, surgically implanted	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	NON-COVERED	PG0232 Bone Growth Stimulating Services-Devices (Osteogenic Stimulators)-Archived	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)-Archived	
E0764	Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program (FES)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0228 Neuromuscular, Functional, & Neuromuscular, Functional, & Therapeutic Electrical Stimulation Therapy	
E0766	Electrical stimulation device used for cancer treatment, includes all accessories, any type	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	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 Stimulation Therapy	
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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	
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 CRITERIA	PG0284 Manual, Powered, and Motorized Wheeled Mobility Devices	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	
E1392	Portable oxygen concentrator, rental	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0234 Home Oxygen Therapy-archived 120124	
E1399	Durable medical equipment, miscellaneous	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0227 Airway Clearance Devices; **PG0139 Bedwetting Alarms for Nocturnal Enuresis-Archived 4/8/2025**	Bedwetting alarms are non-covered for Elite(Medicare Advantage) Plans
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 and/or fecal management system (i.e. PureWick)	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-archived-converted to RM032 Glucose Testing Supplies.100124	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-archived-converted to RM032 Glucose Testing Supplies.100124

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
E2101	Blood glucose monitor with integrated lancing/blood sample	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0155 Glucose Testing Suppliesarchived-converted to RM032 Glucose Testing Supplies.100124	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 Suppliesarchived-converted to RM032 Glucose Testing Supplies.100124
E2102	Adjunctive, nonimplantable continuous glucose monitor (CGM) or receiver (Effective 04/01/2022)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION NOT 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.
E2103	Nonadjunctive, nonimplanted continuous glucose monitor (CGM) or receiver (Effective 01/01/2023)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION NOT 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.
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 function selection switch, and fixed mounting hardware	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, mechanical function selection switch, and fixed mounting hardware	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	Elite Medicare Advantage	Policy	DETAILS/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	
E2402	Negative pressure wound therapy electrical pump, stationary or portable	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		Effective 02/01/2025 procedure E2402 will require a prior authorization for all product lines, per the InterQual coverage criteria.
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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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		
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		

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 with the prior authorization excel spreadsheet and not the medical policy.
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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
G0282	Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281	NON-COVERED	NON-COVERED	PG0271 Electrical Stimulation and Electromagnetic Therapy for Wound Healing - **Archived 5/1/2025**	
G0295	Electromagnetic therapy, to one or more areas, for wound care other than described in G0329 or for other uses	NON-COVERED	NON-COVERED	PG0271 Electrical Stimulation and Electromagnetic Therapy for Wound Healing - **Archived 5/1/2025**	
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 sedation (monitored anesthesia care) and use of an operating room	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
G0341	Percutaneous islet cell transplant, includes portal vein catheterization and infusion	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0415 Pancreatic Islet Cell Transplantation	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
G0342	Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0415 Pancreatic Islet Cell Transplantation	
G0343	Laparotomy for islet cell transplant, includes portal vein catheterization and infusion	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0415 Pancreatic Islet Cell Transplantation	
G0389	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY - See Details	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY - See Details	PG0207 Sleep Study Testing-archived 120124. PG0247 Testing and Management of Obstructive Sleep Apnea	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 ONLY required for additional repeat unattended (unsupervised) adult home sleep study testing. Pediatric home sleep study testing (95800, 95801, 95806, G0398, G0399, and G0400) is non-covered.**
G0399	Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY - See Details	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY - See Details	PG0207 Sleep Study Testing-archived 120124. PG0247 Testing and Management of Obstructive Sleep Apnea	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 ONLY required for additional repeat unattended (unsupervised) adult home sleep study testing. Pediatric home sleep study testing (95800, 95801, 95806, G0398, G0399, and G0400) is non-covered.**
G0400	Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY - See Details	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY - See Details	PG0207 Sleep Study Testing-archived 120124. PG0247 Testing and Management of Obstructive Sleep Apnea	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 ONLY required for additional repeat unattended (unsupervised) adult home sleep study testing. Pediatric home sleep study testing (95800, 95801, 95806, G0398, G0399, and G0400) is non-covered.**
G0422	Intensive cardiac rehabilitation, with or without continuous ECG monitoring with exercise, per session	PRIOR AUTHORIZATION NOT REQUIRES - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA -SEE NOTES		The number of Phase II cardiac rehabilitation sessions is limited to a maximum of 2 1-hour sessions per day, utilizing any combination of the CPT or HCPCS codes (93798, 93797 or G0422, G0423), for up to 36 sessions or as the members benefit contract limitation indicates, over up to 36 weeks. The following are considered not medically necessary and are therefore non-covered: Outpatient phase II cardiac rehabilitation for any indications other than

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
G0423	Intensive cardiac rehabilitation, with or without continuous ECG monitoring without exercise, per session	PRIOR AUTHORIZATION NOT REQUIRES - SEE NOTES	PRIOR AUTHORIZATION NOT REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA -SEE NOTES		The number of Phase II cardiac rehabilitation sessions is limited to a maximum of 2 1-hour sessions per day, utilizing any combination of the CPT or HCPCS codes (93798, 93797 or G0422, G0423), for up to 36 sessions or as the members benefit contract limitation indicates, over up to 36 weeks. The following are considered not medically necessary and are therefore non-covered: · Outpatient phase II cardiac rehabilitation for any indications other than those listed above; and · Phase III cardiac rehabilitation programs, or self-directed, self-controlled, or monitored exercise programs; and · Phase IV cardiac rehabilitation programs or maintenance therapy that may be safely conducted without medical supervision; and · Cardiac rehabilitation when used in a preventive or prophylactic way, such as for angina, hypertension, or diabetes; and Any cardiac rehabilitation services that are considered primarily educational or training in nature.
G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (lds) (e.g., as a result of highly active antiretroviral therapy)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0104 Cosmetic and Reconstructive Surgery	
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 phlebotomy, centrifugation, and all other preparatory procedures, administration and dressings, per treatment	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0293 Platelet Rich Plasma-Archived; PG0043 Experimental Investigational Procedures Services	
G0465	Autologous platelet rich plasma (PRP) for diabetic chronic wounds/ulcers, using an FDA-cleared device (includes administration, dressings, phlebotomy, centrifugation, and all other preparatory procedures, per treatment)	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0293 Platelet Rich Plasma-Archived; PG0043 Experimental Investigational Procedures Services	
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 cervical cancer screening, must be performed in addition to pap test	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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
G0480	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - See Details/Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - See Details/Notes	PG0069 Drug Testing	Effective 01/01/2024: Presumptive drug screening (CPT code 80305, 80306 or 80307) and Definitive drug testing (HCPCs code G0480, G0481, G0482, G0483, or G0659) ARE ONLY REIMBURSABLE 45 times total every 365 days [any combination of procedures 80305, 80306, 80307, G0480, G0481, G0483, or G0659], when the coverage criteria, Medical Policy PG0069 Drug Testing, are met.
G0481	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - See Details/Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - See Details/Notes	PG0069 Drug Testing	Effective 01/01/2024: Presumptive drug screening (CPT code 80305, 80306 or 80307) and Definitive drug testing (HCPCs code G0480, G0481, G0482, G0483, or G0659) ARE ONLY REIMBURSABLE 45 times total every 365 days [any combination of procedures 80305, 80306, 80307, G0480, G0481, G0483, or G0659], when the coverage criteria, Medical Policy PG0069 Drug Testing, are met.
G0482	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - See Details/Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - See Details/Notes	PG0069 Drug Testing	Effective 01/01/2024: Presumptive drug screening (CPT code 80305, 80306 or 80307) and Definitive drug testing (HCPCs code G0480, G0481, G0482, G0483, or G0659) ARE ONLY REIMBURSABLE 45 times total every 365 days [any combination of procedures 80305, 80306, 80307, G0480, G0481, G0483, or G0659], when the coverage criteria, Medical Policy PG0069 Drug Testing, are met.
G0483	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - See Details/Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - See Details/Notes	PG0069 Drug Testing	Effective 01/01/2024: Presumptive drug screening (CPT code 80305, 80306 or 80307) and Definitive drug testing (HCPCs code G0480, G0481, G0482, G0483, or G0659) ARE ONLY REIMBURSABLE 45 times total every 365 days [any combination of procedures 80305, 80306, 80307, G0480, G0481, G0483, or G0659], when the coverage criteria, Medical Policy PG0069 Drug Testing, are met.
G0555	Provision of replacement patient electronics system (e.g., system pillow, handheld reader) for home pulmonary artery pressure monitoring	NON-COVERED	NON-COVERED		New code effective 1/1/2025 - CardioMEMS accessory pillow
G0561	Tympanostomy with local or topical anesthesia and insertion of a ventilating tube when performed with tympanostomy tube delivery device, unilateral (list separately in addition to 69433) (do not use in conjunction with 0583T)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Services	New code effective 1/1/2025 - Tympanostomy with local or topical anesthesia and insertion of a ventilating tube when performed with tympanostomy tube delivery device, unilateral (list separately in addition to 69433) (do not use in conjunction with 0583T)
G0564	Creation of subcutaneous pocket with insertion of 365 day implantable interstitial glucose sensor, including system activation and patient training (New 1/12025)	PRIOR AUTHORIZTION REQUIRED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0177 Continuous Blood Glucose Monitoring Systems & Insulin Pumps	**CMS cancelled code 03/31/2025**

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
G0565	Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new 365 day implantable sensor, including system activation (New 1/1/2025)	PRIOR AUTHORIZTION REQUIRED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0177 Continuous Blood Glucose Monitoring Systems & Insulin Pumps	**CMS cancelled code 03/31/2025**
G0659	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type	PRIOR AUTHORIZATION REQUIRED - INTERQUAL - See Details/Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA - See Details/Notes	PG0069 Drug Testing	Effective 01/01/2024: Presumptive drug screening (CPT code 80305, 80306 or 80307) and Definitive drug testing (HCPCs code G0480, G0481, G0482, G0483, or G0659) ARE ONLY REIMBURSABLE 45 times total every 365 days [any combination of procedures 80305, 80306, 80307, G0480, G0481, G0483, or G0659], when the coverage criteria, Medical Policy PG0069 Drug Testing, are met.
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 care professional and provision of up to 56 mg of esketamine nasal self-administration, includes 2 hours	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 requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self-administration, includes	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0409 Ketamine and Esketamine for Treatment of Psychiatric Disorders and Pain Management	
G2171	Percutaneous arteriovenous fistula creation (avf), direct, any site, using magnetic-guided arterial and venous catheters and radiofrequency energy, including flow-directing procedures (e.g., vascular coil embolization with radiologic supervision 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)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION **NOT** REQUIRED		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
H0035	Mental Health Partial Hospitalization Treatment <24 Hours	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0531 Behavioral Health Partial Hospitalization Program	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 Prime Therapeutics Management LLC by either post service claim editing or prior authorization. Refer to ~~https://specialtydrug.magellanprovider.com/medication-center/policies-and-guidelines/paramount.aspx~~ http://www.primetherapeutics.com for current policies.
J1411	Injection, etranacogene dezaparvovec-drib, per therapeutic dose	SEE NOTES	SEE NOTES	PG0519 Hemgenix (etranacogene dezaparvovec)-Archived 110124	Codes J1411, J3490, J3590, J9999 [when specified as etranacogene dezaparvovec-drlb (Hemgenix)] requires prior authorization, via Prime Therapeutics Management LLC https://www.primetherapeutics.com/
J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	SEE NOTES	SEE NOTES	PG0520 Luxturna ((voretigene neparvovec-rzyl)-Archived 110124	Code J3398 requires a prior authorization with Prime Therapeutics Management LLC https://www.primetherapeutics.com/

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
J3398	Not otherwise classified, antineoplastic drugs [when specified as betibeglogene autotemcel (Zynteglo)]	SEE NOTES	SEE NOTES	PG0523 Zynteglo (betibeglogene autotemcel)-Archived 110124	Zynteglo (betibeglogene autotemcel) requires a prior authorization with Prime Therapeutics Management LLC https://www.primetherapeutics.com/
J3399	Injection, Onasemnogene abeparvovec-xioi, per treatment, up to 5x1015 vector genomes	SEE NOTES	SEE NOTES	PG0522 Zolgensma (onasemnogene abeparvovec)-Archived 110124	Maintain Prior Authorization; Zolgensma (onasemnogene abeparvovec) requires a prior authorization with Prime Therapeutics Management LLC https://www.primetherapeutics.com/
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)-Archived 110124	Maintain Prior Authorization: Codes J9029, J3490, J3590, J9999 [when specified as nadofaragene firadenovecvncg (Adstiladrin)] requires a prior authorization, via Prime Therapeutics Management LLC https://www.primetherapeutics.com/
J3490	Unclassified drugs [when specified as etranacogene dezaparvovec-drlb (Hemgenix)]	SEE NOTES	SEE NOTES	PG0519 Hemgenix (etranacogene dezaparvovec)-Archived 110124	Codes J1411, J3490, J3590, J9999 [when specified as etranacogene dezaparvovec-drlb (Hemgenix)] requires prior authorization, via Prime Therapeutics Management LLC https://www.primetherapeutics.com/
J3490	Unclassified drugs [when specified as elivaldogene autotemcel (Skysona)]	SEE NOTES	SEE NOTES	PG0521 Skysona (elivaldogene autotemcel)-Archived 110124	Maintain Prior Authorization: Codes J3490, J3590, J9999 [when specified as elivaldogene autotemcel (Skysona)] requires a prior authorization with Prime Therapeutics Management LLC https://www.primetherapeutics.com/
J3590	Unclassified biologics [when specified as nadofaragene firadenovecvncg (Adstiladrin)]	SEE NOTES	SEE NOTES	PG0518 Adstiladrin (nadofaragene firadenovecvncg)-Archived 110124	Maintain Prior Authorization: Codes J9029, J3490, J3590, J9999 [when specified as nadofaragene firadenovecvncg (Adstiladrin)] requires a prior authorization, via Prime Therapeutics Management LLC https://www.primetherapeutics.com/

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
J3590	Unclassified biologics [when specified as etranacogene dezaparvovec-drlb (Hemgenix)]	SEE NOTES	SEE NOTES	PG0519 Hemgenix (etranacogene dezaparvovec)-Archived 110124	Codes J1411, J3490, J3590, J9999 [when specified as etranacogene dezaparvovec-drlb (Hemgenix)] requires prior authorization, via Prime Therapeutics Management LLC https://www.primetherapeutics.com/
J3590	Unclassified biologics [when specified as elivaldogene autotemcel (Skysona)]	SEE NOTES	SEE NOTES	PG0521 Skysona (elivaldogene autotemcel)-Archived 110124	Maintain Prior Authorization: Codes J3490, J3590, J9999 [when specified as elivaldogene autotemcel (Skysona)] requires a prior authorization with Prime Therapeutics Management LLC https://www.primetherapeutics.com/
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 Prime Therapeutics Management LLC by either post service claim editing or prior authorization. Refer to ~~https://specialtydrug.magellanprovider.com/medication-center/policies-and-guidelines/paramount.aspx~~ https://www.primetherapeutics.com/ for current policies.
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 Prime Therapeutics Management LLC Management by either post service claim editing or prior authorization. Refer to ~~https://specialtydrug.magellanprovider.com/medication-center/policies-and-guidelines/paramount.aspx~~ https://www.primetherapeutics.com/ for current policies.
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 Prime Therapeutics Management LLC Management by either post service claim editing or prior authorization. Refer to ~~https://specialtydrug.magellanprovider.com/medication-center/policies-and-guidelines/paramount.aspx~~ https://www.primetherapeutics.com/ for current policies.
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 Prime Therapeutics Management LLC Management by either post service claim editing or prior authorization. Refer to ~~https://specialtydrug.magellanprovider.com/medication-center/policies-and-guidelines/paramount.aspx~~ https://www.primetherapeutics.com/ for current policies.
J7318	Hyaluronan or derivative, durolane, for intra-articular injection, 1 mg	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	Prior Authorization required, with an exception: oPreferred products may not require authorization. oContact Prime Therapeutics Management LLC to advise on whether prior authorization is needed. Refer to the Prime Therapeutics Management LLC Prescription Drug Benefits/Prior Authorizations. The Viscosupplementations will continue to be billed to the medical benefit. Refer to Prescription Drug Benefits/Prior Authorizations ~~https://www.paramounthealthcare.com/services/providers/prior-authorization-criteria/magellan-mrx~~ https://www.primetherapeutics.com/ [Euflexxa, Synvisc, and Synvisc-One are the preferred products and do not require Prior Authorization.]

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J7320	Hyaluronan or derivitive, genvisc 850, for intra-articular injection, 1 mg	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	Prior Authorization required, with an exception: oPreferred products may not require authorization. oContact Prime Therapeutics Management LLC to advise on whether prior authorization is needed. Refer to the Prime Therapeutics Management LLC Prescription Drug Benefits/Prior Authorizations. The Viscosupplementations will continue to be billed to the medical benefit. Refer to Prescription Drug Benefits/Prior Authorizations ~~https://www.paramounthealthcare.com/services/providers/prior-authorization-criteria/magellan-mrx~~ https://www.primetherapeutics.com/ [Euflexxa, Synvisc, and Synvisc-One are the preferred products and do not require Prior Authorization.]
J7321	Hyaluronan or derivative, hyalgan, supartz or visco-3, for intra-articular injection, per dose	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	Prior Authorization required, with an exception: oPreferred products may not require authorization. oContact Prime Therapeutics Management LLC to advise on whether prior authorization is needed. Refer to the Prime Therapeutics Management LLC Prescription Drug Benefits/Prior Authorizations. The Viscosupplementations will continue to be billed to the medical benefit. Refer to Prescription Drug Benefits/Prior Authorizations ~~https://www.paramounthealthcare.com/services/providers/prior-authorization-criteria/magellan-mrx~~ https://www.primetherapeutics.com/ [Euflexxa, Synvisc, and Synvisc-One are the preferred products and do
J7322	Hyaluronan or derivative, hymovis, for intra-articular injection, 1 mg	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	Prior Authorization required, with an exception: oPreferred products may not require authorization. oContact Prime Therapeutics Management LLC to advise on whether prior authorization is needed. Refer to the Prime Therapeutics Management LLC Prescription Drug Benefits/Prior Authorizations. The Viscosupplementations will continue to be billed to the medical benefit. Refer to Prescription Drug Benefits/Prior Authorizations
J7323	Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	Prior Authorization required, with an exception: oPreferred products may not require authorization. oContact Prime Therapeutics Management LLC to advise on whether prior authorization is needed. Refer to the Prime Therapeutics Management LLC Prescription Drug Benefits/Prior Authorizations. The Viscosupplementations will continue to be billed to the medical benefit. Refer to Prescription Drug Benefits/Prior Authorizations
J7324	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	Prior Authorization required, with an exception: oPreferred products may not require authorization. oContact Prime Therapeutics Management LLC to advise on whether prior authorization is needed. Refer to the Prime Therapeutics Management LLC Prescription Drug Benefits/Prior Authorizations. The Viscosupplementations will continue to be billed to the medical benefit. Refer to Prescription Drug Benefits/Prior Authorizations
J7325	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	Prior Authorization required, with an exception: oPreferred products may not require authorization. oContact Prime Therapeutics Management LLC to advise on whether prior authorization is needed. Refer to the Prime Therapeutics Management LLC Prescription Drug Benefits/Prior Authorizations. The Viscosupplementations will continue to be billed to the medical benefit. Refer to Prescription Drug Benefits/Prior Authorizations

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J7326	Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	Prior Authorization required, with an exception: oPreferred products may not require authorization. oContact Prime Therapeutics Management LLC to advise on whether prior authorization is needed. Refer to the Prime Therapeutics Management LLC Prescription Drug Benefits/Prior Authorizations. The Viscosupplementations will continue to be billed to the medical benefit. Refer to Prescription Drug Benefits/Prior Authorizations.
J7327	Hyaluronan or derivative, monovisc, for intra-articular injection, per dose	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	Prior Authorization required, with an exception: oPreferred products may not require authorization. oContact Prime Therapeutics Management LLC to advise on whether prior authorization is needed. Refer to the Prime Therapeutics Management LLC Prescription Drug Benefits/Prior Authorizations. The Viscosupplementations will continue to be billed to the medical benefit. Refer to Prescription Drug Benefits/Prior Authorizations.
J7328	Hyaluronan or derivative, Gel-Syn, for intra-articular injection, 0.1 mg	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	Prior Authorization required, with an exception: oPreferred products may not require authorization. oContact Prime Therapeutics Management LLC to advise on whether prior authorization is needed. Refer to the Prime Therapeutics Management LLC Prescription Drug Benefits/Prior Authorizations. The Viscosupplementations will continue to be billed to the medical benefit. Refer to Prescription Drug Benefits/Prior Authorizations.
J7329	Hyaluronan or derivative, trivisc, for intra-articular injection, 1 mg	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	Prior Authorization required, with an exception: oPreferred products may not require authorization. oContact Prime Therapeutics Management LLC to advise on whether prior authorization is needed. Refer to the Prime Therapeutics Management LLC Prescription Drug Benefits/Prior Authorizations. The Viscosupplementations will continue to be billed to the medical benefit. Refer to Prescription Drug Benefits/Prior Authorizations.
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	Prior Authorization required, with an exception: oPreferred products may not require authorization. oContact Prime Therapeutics Management LLC to advise on whether prior authorization is needed. Refer to the Prime Therapeutics Management LLC Prescription Drug Benefits/Prior Authorizations. The Viscosupplementations will continue to be billed to the medical benefit. Refer to Prescription Drug Benefits/Prior Authorizations.
J7332	Hyaluronan or derivative, Triluron, for intra-articular injection, 1 mg	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	Prior Authorization required, with an exception: oPreferred products may not require authorization. oContact Prime Therapeutics Management LLC to advise on whether prior authorization is needed. Refer to the Prime Therapeutics Management LLC Prescription Drug Benefits/Prior Authorizations. The Viscosupplementations will continue to be billed to the medical benefit. Refer to Prescription Drug Benefits/Prior Authorizations.

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J7333	Hyaluronan or derivative, Visco-3, for intra-articular injection, per dose	SEE NOTES	SEE NOTES	PG0204 Viscosupplementation for Osteoarthritis	Prior Authorization required, with an exception: oPreferred products may not require authorization. oContact Prime Therapeutics Management LLC to advise on whether prior authorization is needed. Refer to the Prime Therapeutics Management LLC Prescription Drug Benefits/Prior Authorizations. The Viscosupplementations will continue to be billed to the medical benefit. Refer to Prescription Drug Benefits/Prior Authorizations
J9029	Injection, Nadofaragene Firadenovec-Vncg, per therapeutic dose	SEE NOTES	SEE NOTES	PG0518 Adstiladrin (nadofaragene firadenovecvncg)-Archived 110124	Maintain Prior Authorization: Codes J9029, J3490, J3590, J9999 [when specified as nadofaragene firadenovecvncg (Adstiladrin)] requires a prior authorization, via Prime Therapeutics Management LLC
G9143	Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)	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-archived 120124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
J9999	Not otherwise classified, antineoplastic drugs [when specified as nadofaragene firadenovecvncg (Adstiladrin)]	SEE NOTES	SEE NOTES	PG0518 Adstiladrin (nadofaragene firadenovecvncg)-Archived 110124	Maintain Prior Authorization: Codes J9029, J3490, J3590, J9999 [when specified as nadofaragene firadenovecvncg (Adstiladrin)] requires a prior authorization, via Prime Therapeutics Management LLC
J9999	Not otherwise classified, antineoplastic drugs [when specified as etranacogene dezaparvovec-drlb (Hemgenix)]	SEE NOTES	SEE NOTES	PG0519 Hemgenix (etranacogene dezaparvovec)-Archived 110124	Codes J1411, J3490, J3590, J9999 [when specified as etranacogene dezaparvovec-drlb (Hemgenix)] requires prior authorization, via Prime Therapeutics Management LLC
J9999	Not otherwise classified, antineoplastic drugs [when specified as elivaldogene autotemcel (Skysona)]	SEE NOTES	SEE NOTES	PG0521 Skysona (elivaldogene autotemcel)-Archived 110124	Maintain Prior Authorization: Codes J3490, J3590, J9999 [when specified as elivaldogene autotemcel (Skysona)] requires a prior authorization with Prime Therapeutics Management LLC

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 for speed adjustment, tremor dampening, acceleration control and braking	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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0224 Cardioverter Defibrillators-archived 120124	
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	
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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
K0812	Power operated vehicle, not otherwise classified	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	
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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
K0839	Power wheelchair, group 2 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	
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	
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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	
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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	
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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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-archived 120124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL. Procedure code deleted 01/01/2024
K1004	Low frequency ultrasonic diathermy treatment device for home use, includes all components and accessories (PainShield®)	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 upright(s), knee joints any type, with or without ankle joints any type, includes all components and accessories, motors, microprocessors, sensors	NON-COVERED	NON-COVERED	PG0425 Powered Robotic Lower Body Exoskeleton Devices-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
K1009	Speech volume modulation system, any type, including all components and accessories (SpeechVive Device)	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 Etns)	NON-COVERED	NON-COVERED	PG0244 Electrical Nerve Stimulators-archived 120124. PG0361 Alternative Radiofrequency Methods of Denervation; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL. Procedure code deleted 01/01/2024

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
K1017	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve (Monarch Etns) Monthly supplies for use of device coded at K1016 (Monarch Etns)	NON-COVERED	NON-COVERED	PG0244 Electrical Nerve Stimulators-archived 120124. PG0361 Alternative Radiofrequency Methods of Denervation; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL. Procedure code deleted 01/01/2024
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-archived 120124. PG0361 Alternative Radiofrequency Methods of Denervation; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL. Procedure code deleted 01/01/2024
K1019	Monthly supplies for use of device coded at K1018 (e.g., Cala Trio™)	NON-COVERED	NON-COVERED	PG0244 Electrical Nerve Stimulators-archived 120124. PG0361 Alternative Radiofrequency Methods of Denervation; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL. Procedure code deleted 01/01/2024
K1023	Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm	NON-COVERED	NON-COVERED	PG0244 Electrical Nerve Stimulators-archived 120124. PG0361 Alternative Radiofrequency Methods of Denervation; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL. Procedure code deleted 01/01/2024
K1026	Mechanical allergen particle barrier/inhalation filter, cream, nasal, topical (Alzair™).	NON-COVERED	NON-COVERED	PG0188 Allergy Testing and Treatments; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
K1027	Oral device/appliance used to reduce upper airway collapsibility, without fixed mechanical hinge, custom fabricated, includes fitting and adjustment	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0131 Custom Oral Appliances for Obstructive Sleep Apnea-archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
K1030	External recharging system for battery (internal) for use with implanted cardiac contractility modulation generator, replacement only	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
K1036	Supplies and accessories (e.g., transducer) for low frequency ultrasonic diathermy treatment device, per month	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-arcived 121124, maintain PA per InterQual coverage criteria	
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-arcived 121124, maintain PA per InterQual coverage criteria	
L1810	Knee orthosis, elastic with joints, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise	PRIOR AUTHORIZATION REQUIRED - INTERQUAL. See Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA. See Notes	PG0480 Knee Orthosis-archived 120124	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. See Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA. See Notes	PG0480 Knee Orthosis-archived 120124	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. See Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA. See Notes	PG0480 Knee Orthosis-archived 120124	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. See Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA. See Notes	PG0480 Knee Orthosis-archived 120124	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
L1831	Knee orthotic, locking knee joint(s), positional orthotic, prefabricated, includes fitting and adjustment	PRIOR AUTHORIZATION REQUIRED - INTERQUAL. See Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA. See Notes	PG0480 Knee Orthosis-archived 120124	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, assembled, or otherwise customized to fit a specific patient by an individual with expertise	PRIOR AUTHORIZATION REQUIRED - INTERQUAL. See Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA. See Notes	PG0480 Knee Orthosis-archived 120124	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. See Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA. See Notes	PG0480 Knee Orthosis-archived 120124	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. See Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA. See Notes	PG0480 Knee Orthosis-archived 120124	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
L1836	Knee orthosis, rigid, without joint(s), includes soft interface material, prefabricated, off-the-shelf	PRIOR AUTHORIZATION REQUIRED - INTERQUAL. See Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA. See Notes	PG0480 Knee Orthosis-archived 120124	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. See Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA. See Notes	PG0480 Knee Orthosis-archived 120124	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 varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled	PRIOR AUTHORIZATION REQUIRED - INTERQUAL. See Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA. See Notes	PG0480 Knee Orthosis-archived 120124	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 without varus/valgus adjustment, custom fabricated	PRIOR AUTHORIZATION REQUIRED - INTERQUAL. See Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA. See Notes	PG0480 Knee Orthosis-archived 120124	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 without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled	PRIOR AUTHORIZATION REQUIRED - INTERQUAL. See Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA. See Notes	PG0480 Knee Orthosis-archived 120124	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 varus/valgus adjustment, custom fabricated	PRIOR AUTHORIZATION REQUIRED - INTERQUAL. See Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA. See Notes	PG0480 Knee Orthosis-archived 120124	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 item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise	NON-COVERED	NON-COVERED	PG0480 Knee Orthosis-archived 120124	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, off-the-shelf	NON-COVERED	NON-COVERED	PG0480 Knee Orthosis-archived 120124	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. See Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA. See Notes	PG0480 Knee Orthosis-archived 120124	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 without varus/valgus adjustment, prefabricated, off-the-shelf	PRIOR AUTHORIZATION REQUIRED - INTERQUAL. See Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA. See Notes	PG0480 Knee Orthosis-archived 120124	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
L1852	Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf	PRIOR AUTHORIZATION REQUIRED - INTERQUAL. See Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA. See Notes	PG0480 Knee Orthosis-archived 120124	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. See Notes	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA. See Notes	PG0480 Knee Orthosis-archived 120124	Prior Authorization will be required for Knee Orthosis with a charged amount greater than $500.00.
~~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 07/01/2024, Medical Policy Archived	
~~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 07/01/2024, Medical Policy Archived	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
~~L5673~~	Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism	~~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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
L6026	Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes, and cables, two batteries, charger, myoelectric control of terminal device, excludes terminal device(s)	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 friction control, for use with body powered or external powered system	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	
L6700	Upper extremity addition, external powered feature, myoelectronic control module, additional EMG inputs, pattern-recognition decoding intent movement	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 motor(s)	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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, Otto Bock or equal, switch, cables, two batteries and one charger, switch control of terminal device	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, Otto Bock or equal, electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6930	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	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, myoelectronic control of terminal device	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 locking hinges, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
L6945	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm; Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	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 elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
L6955	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	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 bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	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 bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal	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 bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	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 bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
L7700	Gasket or seal, for use with prosthetic socket insert, any type, each	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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	
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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
L7400	Addition to upper extremity prosthesis, below elbow/wrist 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	
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 thoracic, ultra-light material (titanium, carbon fiber or equal)	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 thoracic, acrylic material	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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
L8010	Breast prosthesis, mastectomy sleeve	NON-COVERED	NoN-COVERED		
L8031	Breast prosthesis, silicone or equal, with integral adhesive	NON-COVERED	NoN-COVERED		
L8035	Custom breast prosthesis, post mastectomy, molded to patient model	NON-COVERED	NoN-COVERED		
L8600	Implantable breast prosthesis, silicone or equal	PRIOR AUTHORIZATION REQUIRED - INTERQUAL **(See Notes)**	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY **(See Notes)**	PG0144 Breast Reconstruction Services. PG0104 Cosmetic and Reconstructive Surgery	**Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications.** Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery
L8605	Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal	NON-COVERED	PRIOR **NOT** AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0260 Injectable Bulking Agents for Fecal Incontinence	Elite Medicare Advantage Plans - Prior Authorization NOT required, effective 3/1/2025 (to align with Medical Mutual)
L8607	Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping and necessary supplies	NON-COVERED	NoN-COVERED	PG0104 Cosmetic and Reconstructive Surgery	
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 spreadsheet..

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 spreadsheet.
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 spreadsheet.
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 spreadsheet.
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 spreadsheet.
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 spreadsheet.
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 spreadsheet.
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 spreadsheet.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 spreadsheet.
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 spreadsheet.
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 spreadsheet. 08/12/2024 procedure L8625 does not require a prior authorizaton.
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 spreadsheet.
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 spreadsheet.
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 spreadsheet. 08/12/2024 procedure L8629 does not require a prior authorizaton.
L8680	Implantable neurostimulator electrode, each	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED	PG0537 Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED	PG0537 Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea	
L8688	Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED	PG0537 Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea	
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-Archived 11/01/2024	
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-Archived 11/01/2024	
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-Archived 11/01/2024	
L8693	Auditory osseointegrated device abutment, any length, replacement only	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0218 Implantable Bone Conduction and Bone-Anchored Hearing Aids-Archived 11/01/2024	
L8694	Auditory osseointegrated device, transducer/actuator, replacement only, each	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	Prior Authorization required effective 01/01/2025, all product lines	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
L8701	Powered upper extremity range of motion assist device, elbow, wrist, hand with single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated	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 upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0428 Myoelectric Upper Extremity Prosthetic Devices	
P9020	Platelet rich plasma, each unit	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0043 Experimental Investigational Procedures Services	
M0076	Prolotherapy	NON-COVERED	NON-COVERED	PG0170 Prolotherapy; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
NEW TECHNOLOGY	New technology (medical & behavioral health procedures, diagnostics, durable medical equipment)	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		
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		

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
P2031	Hair analysis (excluding arsenic)	NON-COVERED	NON-COVERED	PG0069 Drug Testing. PG0188 Allergy Testing and Treatments. PG0043 Experimental Investigational Procedures Services	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	
Q2026	Injection, radiesse, 0.1 ml	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0104 Cosmetic and Reconstructive Surgery	
Q2028	Injection, culptra, 0.5 mg	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0104 Cosmetic and Reconstructive Surgery	
Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-CD19 CAR positive T cells, including leukapheresis and dose preparation procedures, per therapeutic dose. (Yescarta)	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 Benefits/Prior Authorizations. https://www.paramounthealthcare.com/services/providers/prescription-drug-benefits/

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-CD19 CAR positive T cells, including leukapheresis and dose preparation procedures, per therapeutic dose. (Yescarta)	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 every request of intravenous infusion of Chimeric Antigen Receptor (CAR)-T Cell Therapy [including, but not limited to, tisagenlecleucel (Kymriah), axicabtagene ciloleucel (Yescarta), lisocabtagene maraleucel (Breyanzi), brexucabtagene autoleucel (Tecartus), and idecabtagene vicleucel (Abecma)]. Effectlve March 1. 2022 - forward, Car-T Cell Therapy Prior-Authorization and Notification Process is to be initiated with Paramount's Healthcare Transplant Team. Refer to Medical Policy PG0460
Q2042	Tisagenlecleucel, up to 600 million CAR-positive viable T cells, including leukapheresis and dose preparation procedures, per therapeutic dose. (Kymriah)	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 every request of intravenous infusion of Chimeric Antigen Receptor (CAR)-T Cell Therapy [including, but not limited to, tisagenlecleucel (Kymriah), axicabtagene ciloleucel (Yescarta), lisocabtagene maraleucel (Breyanzi), brexucabtagene autoleucel (Tecartus), and idecabtagene vicleucel (Abecma)]. Effectlve March 1. 2022 - forward, Car-T Cell Therapy Prior-Authorization and Notification Process is to be initiated with Paramount's Healthcare Transplant Team. Refer to Medical Policy PG0460
Q2053	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Tecartus)	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 every request of intravenous infusion of Chimeric Antigen Receptor (CAR)-T Cell Therapy [including, but not limited to, tisagenlecleucel (Kymriah), axicabtagene ciloleucel (Yescarta), lisocabtagene maraleucel (Breyanzi), brexucabtagene autoleucel (Tecartus), and idecabtagene vicleucel (Abecma)]. Effectlve March 1. 2022 - forward, Car-T Cell Therapy Prior-Authorization and Notification Process is to be initiated with Paramount's Healthcare Transplant Team. Refer to Medical Policy PG0460
Q2054	Lisocabtagene maraleucel, up to 110 million autologous anti-CD19 CAR-positive viable T cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Breyanzi)	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 every request of intravenous infusion of Chimeric Antigen Receptor (CAR)-T Cell Therapy [including, but not limited to, tisagenlecleucel (Kymriah), axicabtagene ciloleucel (Yescarta), lisocabtagene maraleucel (Breyanzi), brexucabtagene autoleucel (Tecartus), and idecabtagene vicleucel (Abecma)]. Effectlve March 1. 2022 - forward, Car-T Cell Therapy Prior-Authorization and Notification Process is to be initiated with Paramount's Healthcare Transplant Team. Refer to Medical Policy PG0460

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
Q2055	Idecabtagene vicleucel, up to 460 million autologous b-cell maturation antigen (bcma) directed carpositive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Abecma)	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 every request of intravenous infusion of Chimeric Antigen Receptor (CAR)-T Cell Therapy [including, but not limited to, tisagenlecleucel (Kymriah), axicabtagene ciloleucel (Yescarta), lisocabtagene maraleucel (Breyanzi), brexucabtagene autoleucel (Tecartus), and idecabtagene vicleucel (Abecma)]. Effectlve March 1. 2022 - forward, Car-T Cell Therapy Prior-Authorization and Notification Process is to be initiated with Paramount's Healthcare Transplant Team. Refer to Medical Policy PG0460
Q2056	Ciltacabtagene autoleucel, up to 100 million autologous B-cell maturation antigen (BCMA) directed CAR-positive T cells, including leukapheresis and dose preparation procedures, per therapeutic 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 every request of intravenous infusion of Chimeric Antigen Receptor (CAR)-T Cell Therapy [including, but not limited to, tisagenlecleucel (Kymriah), axicabtagene ciloleucel (Yescarta), lisocabtagene maraleucel (Breyanzi), brexucabtagene autoleucel (Tecartus), and idecabtagene vicleucel (Abecma)]. Effectlve March 1. 2022 - forward, Car-T Cell Therapy Prior-Authorization and Notification Process is to be initiated with Paramount's Healthcare Transplant Team. Refer to Medical Policy PG0460
Q4100	Skin substitute, nos	PRIOR AUTHORIZATION REQUIRED - INTERQUAL	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0203 Bioengineered Skin and Tissue Substitutes	
	Consultation Codes	NON-COVERED	NON-COVERED	PG0291 Consultation Services	Effective January 1, 2010: Consultation services (99241-99245 and 99251-99255) are non-covered for Elite Medicare Plan. Effective April 1, 2023: Paramount will expand the Non-covered Consultation Services Payment Policy to include its Commercial products. In doing so, Paramount now more fully aligns itself with the Centers for Medicare & Medicaid Services' (CMS's) standards by no longer recognizing Current Procedural Terminology (CPT) consultation codes (99242, 99243, 99244, 99245, 99252, 99253, 99254, 99255) as being eligible for reimbursement for its commercial and Medicare Advantage membership.
REHAB ADMISSIONS	Rehabilitation admissions	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED		

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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, solitary pancreas transplant, pancreas transplant after a successful kidney transplant, simultaneous pancreas and kidney transplants, intestine transplants (includes small bowel transplants and multi-visceral transplants), bone marrow/stem cell transplants, and donor-leukocyte transplants. Including any additional multiple organ combination transplants See details related to Transplant: Evaluation-Prior Authorization and Notification, Out-Patient services, procedures at Medical Policy PG0461.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
UNLISTED PROCEDURE CODES	Unlisted procedure codes	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0097 Unlisted/Non-specific HCPCS/CPT and Category III 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 any unlisted and miscellaneous service or item being billed. Services must meet benefit coverage along with medical necessity guidelines appropriate to the procedure/service. Some procedures/services that are billed with an unlisted code may require prior authorization for coverage determination and benefit eligibility. Examples of procedures/services requiring prior authorization include (this list may not be all-inclusive): • Experimental/investigational • New technology • Cosmetic • Plastic and reconstructive Reimbursement is based on review of the unlisted code(s) on an individual claim basis. If an unlisted procedure code does not require prior authorization, documentation submitted with the claim is required to justify the use and validity of the unlisted code and to describe the procedure/service rendered to determine the nature and scope of the procedure and to determine whether or not the procedure is covered, was medically necessary, and if separate service is warranted or is a bundled service. Note: procedure E1399 always requires a prior authorization. A provider must refer to the Paramount PRIOR AUTHORIZATION-EXPERIMENTAL/INVESTIGATIONAL-NONCOVERED SERVICES excel spreadsheet listing https://www.paramounthealthcare.com/providers/claims-and-authorizations/outpatient-prior-authorization AND specific medical policy
V2500	Contact lens, PMMA, spherical, per lens	**Effective 04/01/2025**: PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	**Effective 04/01/2025:** PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0403 Therapeutic Contact Lenses	
V2501	Contact lens, PMMA, toric or prism ballast, per lens	**Effective 04/01/2025**: PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	**Effective 04/01/2025:** PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0403 Therapeutic Contact Lenses	
V2511	Contact lens, gas permeable, toric, prism ballast, per lens	**Effective 04/01/2025**: PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	**Effective 04/01/2025:** PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0403 Therapeutic Contact Lenses	
V2513	Contact lens, gas permeable, extended wear, per lens	**Effective 04/01/2025**: PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	**Effective 04/01/2025:** PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	PG0403 Therapeutic Contact Lenses	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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	
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	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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.
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					

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	Abbott Vascular Absorb GT1 cardiac bio absorbable stent	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Alopecia	SEE NOTES	SEE NOTES	PG0514 Alopecia	· Pharmaceutical treatments depend on the members pharmacy coverage benefit. Some treatments may require a prior authorization. · When alopecia is caused by a systemic illness or by a skin disease of the scalp, the treatment of that illness is covered. The treatment of alopecia that is cosmetic (male or female pattern baldness) is not covered. In no case will drugs designed to grow more hair (whether taken by mouth or applied to the scalp), prosthetics, or surgical transplantation be covered. Alopecia areata and scarring alopecia (e.g., discoid lupus, lichen planus) are the only indications for which treatment of hair loss is considered medically appropriate. Coverage may be contract dependent.
	Avise PG and Avise MTX	NON-COVERED	NON-COVERED	PG0362 Biomarker and Disease Activity Testing for Rheumatoid Arthritis; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Amniotic Fluid and/or Placental Tissue Biological Injections Manipulated amniotic and/or placental tissue biologics for injections to treat illness are experimental exosome biologic products that have not been proven to be safe and effective for any	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 oLARIAT Snare Device oTiger Paw	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	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
	AutoMove AM800	NON-COVERED	NON-COVERED		NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL. AutoMove AM800 is considered experimental and investigational for neuromuscular rehabilitation of post-stroke patients because its effectiveness for this indication has not been established. Although triggered by EMG, AutoMove AM800 is a neuromuscular electrical stimulator, it is not biofeedback. Furthermore, available evidence does not support the effectiveness of this modality in treating post-stroke patients
	Benign Prostatic Hyperplasia Treatments that are considered experimental/investigational - noncovered, include but not limited to: • Absolute ethanol injection • Balloon dilation of the prostate • Temporary Prostatic Stent • Transurethral Plasmakinetic Resection of the Prostate (PKRP) • Water-induced thermotherapy • Temporarily Implanted Nitinol Device (iTind™ System)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	The use of a temporarily implanted nitinol device (e.g., iTind) for treatment of lower urinary tract symptoms due to benign prostatic hyperplasia is considered experimental/investigational. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome. Placement of temporary prostatic stents (e.g., SpannerTM) is experimental/investigational for all uses, including, but not limited to BPH, following surgical treatment of BPH, prostate cancer or radiation therapy. They have not been scientifically demonstrated to be as safe and effective as conventional treatment and have not been shown to improve net health outcomes.
	Biofeedback	NON-COVERED. See Notes	NON-COVERED. See Notes	PG0043 Experimental Investigational Procedures Services	Biofeedback is non-covered for the following indications: •Addictions •Allergy •Anger management •Anterior shoulder instability or pain •Anxiety disorders •As a rehabilitation modality for spasmodic torticollis, spinal cord injury, or following knee surgeries •Attention deficit hyperactivity disorder (ADHD) •Autism •Balance training (with tongue-placed electrotactile biofeedback or visual interactive biofeedback) •Bell's palsy (idiopathic facial paralysis) •Cardiovascular diseases (e.g., heart failure) •Childhood apraxia of speech •Chronic abacterial prostatitis •Chronic fatigue syndrome

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	Bio-Engineered Skin and Soft Tissues Substitutes	SEE NOTES	SEE NOTES	PG0203 Bio-Engineered Skin and Soft Tissue Substitutes (Excluding Skin Substitute Grafts for Diabetic Foot Ulcers and Venous Leg Ulcers); PG0043 Experimental Investigational Procedures Services	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
	Bladder/Urothelial Tumor Markers	SEE NOTES	SEE NOTES	PG0043 Experimental Investigational Procedures Services	The following Bladder/Urothelial Tumor Markers are NonCovered, not an all-inclusive listing: BCLA-4 Bladder EpiCheck (Nucleix) BLCA-1 Hyaluronic acid Hyaluronidase Lewis X antigen
	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
	Breath Analyses, Diagnositc	SEE NOTES	SEE NOTES	PG0043 Experimental Investigational Procedures Services	The Following Breath Tests are Excluded from Coverage: Lactulose breath hydrogen for diagnosing small bowel bacterial overgrowth and measuring small bowel transit time, CO2 for diagnosing bile acid malabsorption, and CO2 for diagnosing fat malabsorption.
	Bronchial thermoplasty	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	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)-Archived 090124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Cartiform	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Category III Codes	SEE NOTES	SEE NOTES	PG0097 Unlisted/Non-specific HCPCS/CPT and Category III Codes	ALL Category III CPT Codes are non-covered unless the code is explicitly addressed as a covered service in an active Paramount Medical Policy or indicated as such on the Prior Authorization-Experimental/Investigational-NonCovered spreadsheet. If not otherwise indicated, the code is non-covered. Unless otherwise specified Category III codes are considered experimental/investigational due to insufficient evidence of efficacy. If a Category III code is available, providers must use that code instead of an unlisted or deleted Category I code. A provider must refer to the Paramount PRIOR AUTHORIZATION-EXPERIMENTAL/INVESTIGATIONAL-NONCOVERED SERVICES
	Catheter, balloon dilatation, non-vascular [Relieva Stratus™ MicroFlow spacer]	NON-COVERED	NON-COVERED	PG0384 Drug Eluting Devices for Use Following Endoscopic Sinus Surgery-archived 120124; PG0043 Experimental Investigational Procedures Services	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 -Not Covered, not an all-inclusive listing oActive release technique oActive therapeutic movement (ATM2) oApplied spinal biomechanical engineering oAtlas orthogonal technique oBioEnergetic synchronization	NON-COVERED	NON-COVERED	PG0150 Chiropractic Services & Spinal Manipulation; PG0043 Experimental Investigational Procedures Services	Chiropractic or diagnostic procedures -Not Covered, not an all-inclusive listing oActive release technique oActive therapeutic movement (ATM2) oApplied spinal biomechanical engineering oAtlas orthogonal technique oBioEnergetic synchronization technique oBiogeometric integration oBlair technique oChiropractic biophysics technique

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	Cordella Pulmonary Artery Sensor System (CorPASS)	NON-COVERED	NON-COVERED		NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Cosmetic Services	NON-COVERED	NON-COVERED	PG0104 Cosmetic and Reconstructive Surgery	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 indications support medical necessity. Reconstructive surgery may be eligible for coverage due to congenital defects, developmental abnormalities, trauma, burns, infection, tumors, or disease of the involved part when a functional impairment is present. Cosmetic Services performed solely to improve one's appearance and/or self-esteem are considered not medically necessary and therefore not covered.
	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; PG0043 Experimental Investigational Procedures Services	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: oAll auricular electroacupuncture devices (e.g., P-STIM™ device,) and all other electrical acupuncture, for any indication, including but not limited to, pain and substance use	NON-COVERED	NON-COVERED	PG0244 Electrical Nerve Stimulators-archived 120124; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	Discogenic Pain Treatment	NON-COVERED - SEE NOTES	NON-COVERED - SEE NOTES	PG0043 Experimental Investigational Procedures Services	The following procedures are unproven and not medically necessary due to insufficient evidence of efficacy (this list may not be all-inclusive): •Annulus fibrosus repair following spinal surgery •Percutaneous discectomy and decompression procedures for treating discogenic pain oPercutaneous lumbar discectomy (manual or automated [APLD] and/or MILD oPercutaneous lase discectomy (PLD) oLaser-assisted disc decompression (LADD) oPercutaneous laser disc decompression (PLDD) oPercutaneous nuclectomy oPercutaneous endoscopic discectomy oEndoscopic laser percutaneous discectomy or LASE oIntradiscal glucocorticoid injection for the treatment of low back pain (LBP) oIntradiscal implantation of combined autologous adipose-derived mesenchymal stem cells and hyaluronic acid for the treatment of discogenic LBP oIntradiscal implantation of stromal vascular fraction plus platelet rich plasma for the treatment of degenerative disc disease (DDD) oIntradiscal infiltration with plasma rich in growth factors for the treatment of LBP oIntradiscal injection of autologous bone marrow concentrate for the treatment of DDD oIntradiscal injections of bone marrow aspirate for the treatment for discogenic LBP
	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 (D-POEM) • Zenker peroral endoscopic myotomy (Z-POEM) Gastric peroral endoscopic myotomy (G-POEM)
	Dual x-ray for preventive screen of vertebral fracture	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Ductus Venosus - Doppler studies of ductus venosus and vessels for surveillance of impaired fetal growth	NON-COVERED	NON-COVERED	Doppler studies of ductus venosus and vessels for surveillance of impaired fetal growth are non-covered. Paramount considers Doppler studies of ductus venosus and vessels other than the middle cerebral artery and umbilical artery for fetal surveillance of impaired fetal growth experimental/investigational because their effectiveness for these indications has not	

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	EarPopper® device	NON-COVERED - SEE NOTES	NON-COVERED - SEE NOTES	PG 0423 Eustachian Tube Dilation. PG0043 Experimental Investigational Procedures Services	There is not enough research to show the EarPopper® device improves health outcomes for people with ETD. No clinical guidelines based on research recommend the EarPopper® device for ETD. Therefore, the EarPopper® device is considered investigational for the treatment of any condition, including but not limited to eustachian tube dysfunction.
	Electrothermal therapy (thermal capsulorrhaphy, electrothermal capsulorrhaphy, electrothermallyassisted capsulorrhaphy, thermal shrinkage)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	Electrothermal shrinkage used as a stand-alone treatment or as an adjunct to arthroscopic or open surgery is considered investigational and not medically necessary for all indications, including but not limited to the tightening of joint capsules, ligaments, and tendons. There is insufficient evidence to support the effectiveness of thermal capsulorrhaphy or thermal shrinkage for treatment of any joint. When unlisted procedure – shoulder (23929), unlisted procedure – humerus or elbow (24999), unlisted procedure – forearm or wrist (25999), unlisted procedure – hands or fingers (26989), unlisted procedure – femur or knee (27599), unlisted procedure – leg or ankle (27899) or unlisted procedure – arthroscopy (29999) is determined to be electrothermal therapy and considered not standard of canre and not payable.
	Embolization of the Ovarian & Iliac Veins for Pelvic Congestion Syndrome	NON-COVERED	NON-COVERED		Embolization of the ovarian & iliac veins for pelvic congestion syndrome is experimental/investigational as there is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure. There are no specific CPT codes for ovarian and internal iliac vein embolization. 37241 [Not covered when use for embolization and/or sclerotherapy of the ovarian and internal iliac veins for the treatment of pelvic congestion syndrome]
	Emborrhoid - Transanal hemorrhoidal dearterialization	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	Emborrhoid is a relatively new nonoperative treatment of hemorrhoidal bleeding, based on the same physiopathological principles of hemorrhoidal dearterialization. It consists in embolization with coils or microparticle of terminal branches of the superior and middle rectal arteries via the endovascular route. The procedure is done in an outpatient state of the art center where our interventional radiologist performs the fibroid treatment through a tiny tube called a catheter. This procedure can be performed by either placing the catheter in an artery at the top of the leg (called a femoral approach) or by placing it into an artery in the lower arm (called a radial approach). Not Covered - Hemorrhoidal embolization (HydroPearl microspheres) AND Coil embolization of hemorrhoids (Emborrhoid technique) embolization of the hemorrhoidal arteries. No Specific Code 37241, 37244
	Extracorporeal Magnetic Stimulation for Treatment of Urinary Incontinence	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments and Devices. PG0094 Biofeedback and Neurofeedback-archived.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	Eustachian tube dilation procedure	NON-COVERED - SEE NOTES	NON-COVERED - SEE NOTES	PG0423 Eustachian Tube Dilation; PG0043 Experimental Investigational Procedures Services	Eustachian tube dilation procedure oSinus stents or drug-eluting implants The use of implantable sinus stents or drug-eluting implants (C9122, J7401, J7402, S1090, S1091) for maintaining sinus ostial patency following endoscopic sinus surgery or for the treatment of recurrent nasal polyps are non-covered including but not limited to: •Propel family of sinus implants (Propel Steroid-Releasing Sinus Implant, Mometasone furoate sinus implant, 370 micrograms)
	Fecal Analysis in the diagnosis of Intestinal Dysbiosis oFecal analysis of the following components is considered investigational/experimental in the diagnosis or evaluation of intestinal dysbiosis, irritable bowel syndrome (IBS), malabsorption or small	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	G-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 (D-POEM) • Zenker peroral endoscopic myotomy (Z-POEM) Gastric peroral endoscopic myotomy (G-POEM)
	Gastroesophageal Reflux Disease: Endoscopic and Laparoscopic Therapies	NON-COVERED see Notes	NON-COVERED see Notes	Coverage Exception: Transoral incisionless fundoplication (TIF) (e.g., EsophyX™) (43210) for GERD is covered, without a prior authorization, when medically indicated.	Endoscopic procedures that are considered experimental and investigational including but not limited to ALL of the following: -Radiofrequency energy • **Stretta System** -Endoscopic plication or suturing • Medigus Ultrasonic Surgery Endostapler (MUSE) • Bard Endoscopic Suturing System (BESS) – EndoCinch Therapy, Endoluminal Plication • Endoscopic Plication System • Full Thickness Plicator • Syntheon ARD Plicator • Apollo OverStitch endoscopic suturing system • StomaphyX • C-BLART (clip band ligation anti-reflux therapy) -Injection/Implantation of Prosthetic Devices or Bulking Agents • Duraphere (Pyrolytic carbon coated zirconium oxide spheres)/Gatekeeper Reflux Repair System • Plexiglas (polymethylmethacrylate [PMMA]) procedure • Enteryx • LINX Reflux Management System (Laparoscopic or open surgical procedure) • Plicator System Angelchik Anti-Reflux Prosthesis
	Gene/Protein expression profiling for Breast Cancer	NON-COVERED	NON-COVERED	PG0041 Genetic Testing and Genetic Counseling	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, TheraPrint, The 41-gene signature assay, The 76-gene "Rotterdam signature" assay, THEROS Breast Cancer Index

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	Gender Reassignment Surgery	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0311 Gender Reaffirming Surgery	
	Gene or Protein expression profiling for Cancer	NON-COVERED - See Notes	NON-COVERED - SEE NOTES	PG0041 Genetic Testing and Genetic Counseling	PancraGEN (Interpace Diagnostics); miRInform Thyroid (Asuragen Inc.); ThyGeNEXT, ThyroMIR (InterpaceDiagnostics Group Inc.); ChemoFx (Helomics Corp.); MI Profile, MI Tumor Seek (Caris Life Sciences); FoundationOne Heme (Foundation Medicine); CANCERPLEX (KEW Inc.); Tempus xF, Tempus xG, Tempus xT (Tempus Labs Inc.); Colon Cancer Hotspot Panel v2 NGS (Thermo Fisher Scientific); Colvera (ClinicalGenomics); Signatera (Natera Inc.);
	Genetic & Protein Biomarkers for Prostate Cancer Screening and Management	NON-COVERED - See Notes	NON-COVERED - SEE NOTES	PG0041 Genetic Testing and Genetic Counseling	Paramount has determined the following diagnostic testing and genetic & protein biomarkers for prostate cancer screening and management are experimental/investigational because there is insufficient evidence in the peer-reviewed medical literature of the effectiveness of these procedures, but are not limited to: · NeoLAB Prostate Liquid Biopsy (0011M) · TMPRSS fusion genes · percent free PSA · Prostate Health Index (PHI) · CCP Score · DD3 · ArteraAI Prostate Test
	Genicular Artery Embolization (GAE) for the treatment of knee pain	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	
	GI Genius Intelligent Endoscopy Module	NON-COVERED - SEE NOTES	NON-COVERED - SEE NOTES	PG0043 Experimental Investigational Procedures Services	Paramount considers the use of artificial intelligence software and computer-aided colonoscopy procedures/techniques experimental/investigational, including but not all-inclusive, GI Genius Intelligent Endoscopy Module.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	Glenoid resurfacing	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	Galleri Test (Grail Inc.); MyPath Melanoma (Castle Biosciences)
	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 residual disease (MRD) assessment, Guardant Reveal - no specific code
	Haystack Minimal Residual Disease (MRD) testing	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	A review of abstracts suggests that there currently is not enough published peer-reviewed literature to evaluate the evidence related to the Haystack MRD test (Quest Diagnostics) for solid tumors. Based on a review of full-text clinical practice guidelines and position statements, guidance appears to confer weak support against the Haystack MRD test. This level of support reflects: •No guidelines or position statements discussed the Haystack MRD test or personalized minimal residual disease (MRD) assays. Most identified guidelines addressed general circulating tumor DNA (ctDNA) testing for monitoring in colon or breast cancer. •In general, guidelines recommend against using ctDNA to inform treatment decisions, monitor treatment response, or monitor for recurrence; citing insufficient evidence. •Five of the 7 guidelines were evidence based.
	Hearing In Noise Test – HINT, also known as Speech in Noise – SIN (QuickSIN) [92700] Measures a person's ability to hear speech in quiet and in noise.	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	HERmark Assay	NON-COVERED	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA		
	Home biofeedback devices	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	The use of home biofeedback devices is considered not medically necessary and not covered for all conditions. As they are considered experimental, investigational or unproven and are non-covered:

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	High speed laryngoscopy	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Home-based pulmonary rehabilitation programs	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Home Uterine Activity Monitoring (HUAM) with our without Associated Nursing Services	NON-COVERED	NON-COVERED	PG0165 Home Uterin Activity Monitoring-Archived-Archived. PG0043 Experimental Investigational Procedures Services	Paramount has determined that home uterine activity monitoring, with or without nursing contact, is experimental/investigational and therefore non-covered, including use with tocolytic therapy (medications used to slow contractions). Despite numerous scientific studies, there is insufficient evidence to determine the effects of the technology on health outcomes
	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
	Implantable sinus stents or drug-eluting implants for maintaining sinus ostial patency	NON-COVERED -SEE NOTES	NON-COVERED - SEE NOTES		The use of the following sinus devices (not an all-inclusive list) are considered, for maintaining sinus ostial patency following endoscopic sinus surgery, experimental/investigational because their effectiveness has not been established: 1. BISORB Drug-Eluting Sinus Biopolymer Stent; 2. Propel sinus implant (PROPEL, PROPEL Mini, PROPEL contour); 3. Relieva Stratus MicroFlow spacer; 4. Sinu-Foam spacer, 5. Sinuva™ (mometasone furoate) Sinus Implant
	Infertility and Reproductive Services	SEE NOTES	SEE NOTES	PG0098 Infertility and Reproductive Services	Refer to medical policy PG0098 Infertility and Reproductive Services for detais/specifics

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	Intradialytic Parenteral Nutrition (IDPN)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0501 Intradialytic Parenteral Nutrition (IDPN)	No specific procedure codes
	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
	Investigational Spinal Procedures, not all inclusive: See Notes	NON-COVERED SEE NOTES	NON-COVERED SEE NOTES	PG0043 Experimental Investigational Procedures Services	There are many investigational spinal procedures that lack the clinical evidence for efficacy compared to other more standard procedures. Many of these include minimally invasive procedures for spinal fusion, discectomy and disc decompression. They are intended to increase stability of vertebral bones and joints and/or relieve any pressure being applied to the nerves and to thus alleviate chronic numbness, stiffness, and pain of the back. INVESTIGATIONAL SPINAL PROCEDURES = Automated percutaneous lumbar discectomy (APLD) (also known as automated percutaneous mechanical lumbar discectomy) including, but not be limited to: Stryker Dekompressor Lumbar Discectomy Probe, aDISC Nucleoplasty, Nucleoplasty Disc Decompression,Intradiscal Thermal Annuloplasty, Microendoscopic discectomy (MED) procedure for decompression of lumbar spine stenosis, lumbar disc herniation, or other indications, Percutaneous Intradiscal Radiofrequency
	Laser Destruction of Cutaneous Vascular Lesions (17106, 17107, 17108)	NON-COVERED SEE NOTES	NON-COVERED SEE NOTES		Laser destruction (CPT codes 17106, 17107, 17108) of cutaneous vascular lesions is considered cosmetic, experimental/investigational, and not medically necessary for the following: including but not limited to: •When performed primarily to improve appearance •Cutaneous vascular lesions that do not interfere with physical body function or without manifestation of complications •Cutaneous amyloidosis •Cutaneous angiokeratomas
	Laser Vitreolysis	NONCOVERED	NONCOVERED	PG0043 Experimental Investigational Procedures Services	Laser vitreolysis (67031) for treatment of vitreous degeneration and vitreous floaters is NC/EI
	Ketamine for Treatment of Psychiatric Disorders and Pain Management oKetamine (J3490) to treat any psychiatric disorders, chronic pain, or migraine headaches is non-covered	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0409 Ketamine for Treatment of Psychiatric Disorders and Pain Management	oKetamine to treat psychiatric disorders is covered with a prior authorization when the coverage criteria below are met. oKetamine to treat any chronic pain, electroconvulsive therapy or migraine headaches is non-covered. oUse of ketamine for the induction of anesthesia or for conscious sedation for minor surgical procedures that do not require skeletal muscle relaxation is considered medically necessary and does not require a prior authorization.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	miraDry	NON-COVERED	NON-COVERED	PG0466 Hyperhidrosis Treatment (excluding botox); PG0043 Experimental Investigational Procedures Services	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
	Lymphederma Treatments	NON-COVERED - SEE NOTES	NON-COVERED - SEE NOTES	PG0043 Experimental Investigational Procedures Services	The following procedures are considered experimental/investigational because the effectiveness of these approaches have not been established, but may not be limited to: •Acoustic radiation force impulse elastography for measurement of tissue stiffness in limb lymphedema •Acupuncture for the treatment of breast cancer-related lymphedema •Advanced pneumatic compression (e.g., the Flexitouch device) for the treatment of head and neck edema
	Lymphedema: Microsurgical Treatments for Lymphedema-Lymphatic Bypass Procedures	NON-COVERED - SEE NOTES	NON-COVERED - SEE NOTES	PG0043 Experimental Investigational Procedures Services	CPT Codes 15756†, 35206†, 35226†, 35236†, 35266†, 37799†, 38308†, 38790†, 38999†, 49906†, 76499† [†When free muscle or myocutaneous flap with microvascular anastomosis (15756), repair blood vessel, direct; upper extremity (35206), repair blood vessel, direct; lower extremity (35226), repair blood vessel with vein graft; upper extremity (35236), repair blood vessel with graft other than vein; upper extremity (36266), unlisted procedure, vascular surgery (37799), lymphangiotomy or other operations on lymphatic channels (38308), unlisted procedure, hemic or lymphatic system (38999), free omental flap with microvascular anastomosis (49906), or unlisted diagnostic radiographic procedure (76499) is determined to be microsurgical treatment for lymphedema.
	Lymphaticovenous anastomosis	NON-COVERED - SEE NOTES	NON-COVERED - SEE NOTES	PG0043 Experimental Investigational Procedures Services	Lymphaticovenous anastomosis is experimental and investigational and therefore non-covered because there is insufficient evidence in the peer-reviewed medical literature of the effectiveness of this procedure.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	Magnetic Resonance Defecography	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL - MR defecography is unproven and not medically necessary for evaluating constipation and anorectal or pelvic floor disorders. There is insufficient clinical evidence of efficacy in the published peer-reviewed medical literature for the use of MR defecography. The utility of this advanced imaging technology in the evaluation and management of refractory constipation must be better defined in statistically robust, well-designed clinical trials. MR defecography (72195-72197-Not Covered when performed for MR defecography)
	Medial Knee Implanted Shock Absorber (MISHA Knee System)	NON-COVERED	NON-COVERED		The MISHA Knee System (Moximed Inc.) is an implantable shock absorber that is intended to treat knee osteoarthritis. The MISHA consists of an implant that is placed outside of the knee joint, where it is connected to the proximal tibia and distal femur. The implant is designed to offload the medial knee joint while supporting natural movement. CPT Code 27599† HCPCS Code C1776† †When 27599 (unlisted procedure, femur or knee) or C1776 (joint device (implantable)) is found to be medial knee implanted shock absorber.
	Microwave Tumor Ablation (Microwave Thermotherapy)	SEE NOTES	SEE NOTES	Microwave ablation of primary or metastatic tumors other than liver or lung is considered experimental/investigational. There is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with these procedures. See Details/Notes	A. Microwave ablation of primary or metastatic hepatic tumors may be considered medically necessary under the following conditions: 1. The tumor is unresectable due to location of lesion[s] and/or comorbid conditions 2. A single tumor of ≤5 cm or up to 3 nodules <3 cm each B. Microwave ablation of primary or metastatic lung tumors may be considered medically necessary under the following conditions: 1. The tumor is unresectable due to location of lesion and/or comorbid conditions 2. A single tumor of ≤3 cm C. Microwave ablation is not covered for any other indication, including (but not limited to), the following: 1.Microwave ablation for any other tumor type is considered experimental and investigational due to a lack of clinical evidence on its efficacy, including, but not limited to: •Bone cancer; or •Brest cancer; or •Cholangiocarcinoma; or •Pancreatic cancer; or •Prostate cancer •Renal cell cancer 2.Microwave ablation for tumors larger than 5 cm or more than 3 nodules larger than 3 cm is considered experimental and investigational due to a lack of clinical evidence on its efficacy compared to other treatment modalities There are no CPT codes specific to microwave ablation.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	Neutralizing antibody testing in multiple sclerosis patients	NON-COVERED	NON-COVERED	PG0180 Neutralizing Antibody Testing in Multiple Sclerosis Patients	
	Night Balance Sleep Position trainer (used with sleep Apnea)	NON-COVERED	NON-COVERED	PG0247 Management of Obstructive Sleep Apnea; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Non-Medical IV Hydration Therapy Services outside of Standard Medical Practice are non-Covered. Medically Indicated IV Hydration requires a qualified licensed practitioner order, administered at a covered place of service by a licensed provider	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
	Neurofeedback, also known as electroencephalogram (EEG) biofeedback	NON-COVERED - SEE NOTES	NON-COVERED - SEE NOTES		Neurofeedback is experimental/investigational. The evidence is insufficient to determine that the technology results in an improvement in net health outcomes. This includes noncoverage for the following, not an all-inclusive listing: anxiety, asperger syndrom, asthma, attention-deficit hyperactivity disorders, cardiovascular conditions, cigarette cravings, cluster headaches, cognitive impariment, depression, epilepsy, fibromyalgia, headache, insomnia and sleep disordrer, obsessive-compulsive disorder, overweight and obesity, post-traumatic stress
	Obstructive Sleep Apnea Devices - NonCovered	NON-COVERED - SEE NOTES	NON-COVERED - SEE NOTES	PG0247 Management of Obstructive Sleep Apnea; PG0043 Experimental Investigational Procedures Services	"Obstructive Sleep Apnea Devices: not all-inclusive 1. Oral Pressure Therapy (OPT) (e.g., Winx® Sleep Therapy System) is considered experimental/investigational for the treatment of OSA because of insufficient evidence. 2. Oral appliances are considered experimental/investigational for treatment of upper airway resistance syndrome (UARS). 3. Oral appliances for snoring (e.g., Slow Wave DS8, and Snore Guard) are considered not medically necessary treatment of disease, as snoring is not considered a disease. An interface consisting of a boil and bite mouthpiece connected to nasal inserts (e.g., CPAP PRO® [Stevenson Industries, Inc., Simi Valley, CA]) is considered

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	Obstructive Sleep Apnea Procedures - NonCovered	NON-COVERED - SEE NOTES	NON-COVERED - SEE NOTES	PG0043 Experimental/Investigational Procedures/Services	Not an all inclusive listing: 1. Laser-assisted uvulopalatoplasty (LAUP) is not covered, it is not considered effective for OSA. LAUP must not be billed as 42145, Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty). This code is not appropriate for this procedure. If LAUP is billed for denial purposes, it should be coded as 42299, (unlisted procedure, palate, uvula) with "LAUP" in the electronic narrative 2400/SV101-7 equivalent to line 19 of the CMS 1500 form. The claim will be denied as not proven effective. 2. Somnoplasty™ is a trade name for palate reduction with the Somnoplasty™ System of Somnus Medical Systems. This is not a term recognized by Paramount as a covered procedure. Therefore
	Percutaneous discectomy and decompression procedures for treating discogenic pain	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services. PG0026 Discogenic Pain Treatment-Archived 120124.	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Peripheral Nerve Stimulation (Percutaneous or Implanted) and Electrical Stimulation for Chronic Intractable Pain Investigational Procedures and/or Devices: i.e. PENFS, ReActive, StimQ, etc..	SEE NOTES	SEE NOTES	PG0043 Experimental Investigational Procedures Services. PG0406 Implantable Peripheral Nerve Stimulation-Archived 110124	The following electrical stimulation procedures and/or devices are considererd experimental/investigational and not eligible for reimbursement, not all-inclusive: • Peripheral nerve stimulation using the ReActiv8 Implantable Neurostimulation System and the StimQ Peripheral Nerve Stimulator System • Peripheral nerve field stimulation (PNFS) and percutaneous electrical nerve field stimulation (PENFS) (e.g., IB-Stim) • Percutaneous neuromodulation therapy (e.g. Vertis Percutaneous Neuromodulation Therapy) • Interferential therapy (e.g. RS-4i Sequential Stimulator) • Transcutaneous electrical modulation pain reprocessing (e.g., Scrambler therapy)• Microcurrent electrical nerve stimulation (MENS) (e.g. Alpha-Stim 100)
	Peristeen Anal Irrigation System (A4459)	COVERED	NON-COVERED	**PG0413 Peristeen Anal Irrigation System - Archived 6/10/2025**; PG0043 Experimental Investigational Procedures Service	Covered for HMO, PPO, Individual Marketplace. Maintain noncoverage experimental/investigational for Elite Medicare Plan
	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

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	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 Detection System, Insulia, Ieva Pelvic Health System, Nerivio, NightWare, reSET, reSET-O, Somryst, Glooko Mobile Insulin Dosing System, Go Dose System, My Dose Coach, Mahana IBS (formerly Parallel or Regul8), Digital infrared thermal imaging, GammaSense Stimulation System, Prescription digital visual therapy and software.
	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; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Prometheus nswer ADA – Serum adalimumab levels and antibodies (Serum adalimumab (ADA) levels and antibodies to adalimumab (ATA))	NON-COVERED	NON-COVERED	PG0341 Measurement of Serum Antibodies to Infliximab, Adalimumab, & Vedolizumab; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Prometheus nswer IFX – Serum infliximab levels and antibodies (Serum infliximab (IFX) levels and antibodies to infliximab (ATI))	NON-COVERED	NON-COVERED	PG0341 Measurement of Serum Antibodies to Infliximab, Adalimumab, & Vedolizumab; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Prometheus nswer UST – Serum ustekinumab levels and antibodies (Serum ustekinumab (UST) and antibodies to ustekinumab (ATU) levels)	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 antibodies to vedolizumab levels)	NON-COVERED	NON-COVERED	PG0341 Measurement of Serum Antibodies to Infliximab, Adalimumab, & Vedolizumab; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	Pulse Radiofrequency Ablation oNoncovered – pulsed radiofrequency denervation, laser denervation, chemodenervation, water-cooled radiofrequency denervation, and cryodenervation	NON-COVERED	NON-COVERED	PG0361 Alternative Radiofrequency Methods of Denervation; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	PrismRA oMolecular signature test to predict response to TNFi therapies for rheumatoid arthritis (RA) (e.g., PrismRA) is considered experimental/investigational in all situations (including for the monitoring of therapy, assessment	NON-COVERED	NON-COVERED	PG0362 Biomarker and Disease Activity Testing for Rheumatoid Arthritis; PG0043 Experimental Investigational Procedures Services	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 Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	Radiofrequency ablation with genicular nerve block for pain – Coolief. oNoncovered – pulsed radiofrequency denervation, laser denervation, chemodenervation, water-cooled radiofrequency denervation, and cryodenervation	NON-COVERED	NON-COVERED	PG0361 Alternative Radiofrequency Methods of Denervation; PG0043 Experimental Investigational Procedures Services	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
	Salivary Hormone Testing	SEE NOTES	SEE NOTES	PG0184 Salivary Hormone Testing	•Salivary cortisol testing (82530, 82533, 84999) collected in the evening for diagnosis of Cushing's syndrome does not require prior authorization. •All other salivary hormone testing (e.g., thyroid, testosterone, estrogen, sexual dysfunction, parathyroid, growth hormone, infertility, preterm labor, endometriosis, polycystic ovary disease (POS), menopause, seasonal affective disorder, depression, multiple sclerosis, sleep disorders, or diseases related to aging, etc.) is considered experimental/investigational and non-covered.
	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™ Tests are considered experimental/investigational. oMonoclonal antibody drugs, including but not limited to tumor necrosis factor antagonist drugs; or	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	SKIN SUBSTITUTES - Bio-Engineered Skin and Soft Tissue Substitutes (Excluding Skin Substitute Grafts for Diabetic Foot Ulcers and Venous Leg Ulcers) AND Skin Substitute Grafts/Cellular and/or Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers	SEE NOTES	SEE NOTES	PG0203 Bio-Engineered Skin and Soft Tissue Substitutes (Excluding Skin Substitute Grafts for Diabetic Foot Ulcers and Venous Leg Ulcers) AND PG0527 Skin Substitute Grafts/Cellular and/or Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers	Refer to the policies for coverage/noncoverage determination/criteria
	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 undergoing radiotherapy for prostate cancer.	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 tendons	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Temporomandibular Joint Disorders	COVERAGE LIMITATIONS -SEE NOTES	COVERAGE LIMITATIONS-SEE NOTES	PG0432 Temporomandibular Joint Disorders	Refer to medical policy PG0432 Temporomandibular Joint Disorders for Non-Covered-nonsurgical treatments, surgical procedures and diagnostic tests & procedures.

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	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
	Topographic Genotyping	NON-COVERED	NON-COVERED		Topographic genotyping using the PathFinder TG® System (e.g., PancraGEN®/PathfinderTG®, BarreGEN) is considered experimental/investigational and not medically necessary for all indications. The impact of this technology on health outcomes compared with existing alternatives (i.e., incremental value) is not known.
	Transanal radiofrequency therapy for the treatment of fecal incontinence (e.g., Secca procedure)	NON-COVERED	NON-COVERED	PG0057 Transanal Radiofrequency Therapy-Archived; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Treatments for Tendon and Soft Tissue Injuries (Investigational)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	Several investigational procedures exist that are purported to treat pain and injury in various tendons and other soft tissues. One of these is the Tenex percutaneous ultrasonic tenotomy system. The procedure involves percutaneous insertion of the TX1 MicroTip™ through an incision near a tendon or soft tissue injury site (i.e., lateral or medial epicondyle, patellar tendon, rotator cuff, plantar fascia or Achilles tendon) under ultrasonic guidance. The probe ultrasonically emulsifies and removes tendon scar tissue. The Tenjet System is another treatment modality intended to reduce pain and injury in tendons and soft tissues. The system utilizes a needle to deliver high-velocity saline that resects diseased tissue and removes it. CPT Code 20999†, 23929†, 24999†, 27599†, 27899† and 28899† †When unlisted procedure musculoskeletal system, general (20999)
	Unlisted procedure, posterior segment-Transpupillary Thermotherapy (TTT)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0149 Transpupillary Thermotherapy (TTT)	Unlisted procedure code 67299

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	Transrectal Ultrasound is considered experimental when using for a screening test	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Travel Immunizations	SEE NOTES	SEE NOTES	PG0019 Routine and Travel Immunizations	Immunizations that are for the purpose of travel, employment/occupational hazards and risks, camp and attendance at school may be non-covered per the member's benefit contract. Please refer to the applicable benefit plan document to determine benefit availability and the terms and conditions of coverage.
	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
	Urinary Incontinence and Overactive Bladder Treatments	NON-COVERED - SEE NOTES	NON-COVERED - SEE NOTES	PG0043 Experimental Investigational Procedures Services	There are many types of devices, supplies and procedures targeted at treating urinary incontinence and overactive bladder. Extracorporeal magnetic stimulation is pulsed magnetic stimulation of sacral and/or pudendal nerves to facilitate contractions of pelvic floor muscles. Therapy is intended to strengthen pelvic floor musculature, thus reducing urinary incontinence. In addition, numerous Kegel exercise assistance devices are available without a prescription and over the counter (e.g. Flyte). The goal of these devices is to guide the user through pelvic floor muscle contractions with vibrations and/or electrical prompting. NonCovered-CPT 53899† HCPCS Codes E0175, E0716. †When unlisted procedure, urinary system – is determined to be extracorporeal magnetic stimulation for urinary incontinence.
	Uterine Fibroids Treatment	NON-COVERED see Notes	NON-COVERED see Notes	PG0043 Experimental Investigational Procedures Services	Paramount considers the following treatments for uterine fibroids experimental and investigational because their safety and effectiveness have not been established, not all-inclusive listing: •Acupuncture •Bipolar electrodes •Cryomyolysis •Cryoablation of fibroids (eg, Cerene Cryoablation System) •Interstitial thermotherapy,YAG lasers •MRI-guided cryoablation •MRI-guided focused ultrasound ablation (MrgFus)(e.g., ExAblate2000) (0071T, 0072T)

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	Vasectomy The following vasectomy and post-vasectomy procedures (not an all-inclusive list) experimental/investigational because of insufficient evidence of their effectiveness: oImplantable vas deferens ligation clip (Vasclip) oPro-Vas occlusion method oVasal injection (e.g., reversible inhibition of sperm under guidance (RISUG) oVasal occlusion (e.g., Intra Vas Plug) oEndoscopic vasectomy oEpididymectomy oMicro-denervation of the spermatic cord	NON-COVERED	NON-COVERED	**PG0288 Vasectomy Procedures - Archived 6/10/2025**; PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Vertebral Axial Decompression Therapy o97039-Unlisted modality [when specified as vertebral axial decompression] Not Covered oS9090	NON-COVERED	NON-COVERED	PG0036 Vertebral Axial Decompression Therapy.Archived 080124; PG0043 Experimental Investigational Procedures Services	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 spinal column. These devices are promoted as non-invasive, non-surgical procedures that treat low back pain due to conditions such as lumbar disc herniation, degenerative disc disease, posterior facet syndrome, sciatica, or radiculopathy. Paramount has determined that vertebral axial decompression therapy (also referred to as mechanized spinal distraction therapy) is non-covered for any indication including, but
	VeriStrat Testing	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	PG0111 Veristrat Testing	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	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 vestibular disorders or any other indications because its sensitivity, specificity, reproducibility, and clinical utility have not been demonstrated. There is no specific code for the vestibular autorotation test (VAT).
	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) experimental and investigational for the screening or diagnosis of colorectal cancer, inflammatory bowel disease, or other indications because its value for these indications has not been established.	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL
	Viscocanalostomy (including p hacoviscocanalostomy)	NON-COVERED	NON-COVERED	PG0043 Experimental Investigational Procedures Services	NON-COVERED - EXPERIMENTAL, INVESTIGATIONAL (CPT Code 66999 when Unlisted procedure, anterior segment of eye (CPT Code 66999) is determined to be transciliary fistulization or viscocanalostomy.)
	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 (D-POEM) • Zenker peroral endoscopic myotomy (Z-POEM) Gastric peroral endoscopic myotomy (G-POEM)

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
	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.

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 INVASIVE SACROILIAC JOINT

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/ 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, L7008, L7009, L7040, L7045, L7170, L7180, L7181, L7185, L7186, L7190, L7191, L7259, L7400, L7401, L7402, L7403, L7404, L7405, L7499, L8701, and L8702 required PA for ALL product lines.

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

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 patients having frequent and fast changing needs for oxygen", procedure E1395 will NOT require a prior authorization					
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/ 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.					
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/ Medicare Plan and added PA requirement for the new 2022 procedure G0465 effective 1/1/2022 for the Elite/ 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 Authorization is required for PG0354 Interventional Pain Management Injections: Sacroiliac, Epidural Steroid, Facet and Trigger Point. Added prior authorization requirement for procedures S1091 and J7402, effective 6/1/2022, for the Advantage product, PG0384 Drug Eluting Devices for Use Following Endoscopic Sinus Surgery.					

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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/ 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/ 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/ 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-archived-converted to RM032 Glucose Testing Supplies.100124					
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/ 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					
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.					

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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					
11/13/2023 Effective 5/17/2023, code 33289 non-covered for Medicare Advantage Plans					
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 product lines, effective 04/01/2024.					
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. Added codes G0564 and G0565 covered with prior authorization					
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.					

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
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 dNerva Lung Denervation System. Added noncovered procedures/services listed in PG0506 Prescription Digital Therapeutics (PDTs) Health Products. Add procedures G0330 and 00170 indicating prior authorization is required when related to a dental procedure in the faciity setting. Updated the procedures 92517, 92518, 92519 from noncovered to covered without a prior authorization effective 07/01/2024. Added the Vestibular Autorotation Test (VAT) testing as noncovered, from PG0323.					
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 with a prior authorization to noncovered, effective 11/01/2024. Added noncoverage for Guardant Reveal for all product lines. Added 0249U as noncovered to Commercial and Medicare. Added 0045U amd 0153U to covered per InterQual for Commercial. Added a lissting of non-covered Gene/Protein expression Profiling for Breast Cancer. Added noncovered procedures, 83700, 83701, 83704, 83719, 83722, 83876, 84431, 0019M, 0377U, 0415U from medical policy PG0392 Cardiovascular Disease (CVS) Risk Testing.					
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.					
08/15/2024 Changed Column D Elite (Medicare Advantage)Plans when Prior Authorization Required - Interqual to Prior Authorization Required - Follow Medicare Coverage Criteria					
8/15/2024 Added the noncoverage for the Gastroesophageal Reflux Disease: Endoscopic and Laparoscopic Therapies. Added noncovered code 0864T from the archived PG0004. Added noncovered MR defecography from the archived medical policy PG0420. Added noncovered procedure 19105 per medical policy PG0517.					
8/20/2024 Clarified procedures 19303, only requires a prior authorization for a prophylactic mastectomy.					
8/26/2024 Added noncovered procedure 92520, effective 12/01/2024. Added procedure 92066, requiring a prior authorization, for all product lines, effective 12/01/2024.					
8/27/2024 - Added - Home Uterine Activity Monitoring - Paramount has determined that home uterine activity monitoring, with or without nursing contact, is experimental/investigational and therefore non-covered, including use with tocolytic therapy (medications used to slow contractions). Despite numerous scientific studies, there is insufficient evidence to determine the effects of the technology on health outcomes. Added-P9020 noncovered for commercial and covered with a PA for Elite, InterQual, effective 10/01/2024.					
09/02/2024 - Corrected procedure 92459 to indicated to follow the medical policy for coverage approval (removed to follow InterQual), for all plans. Added noncovered procedures 0558T, 0743T, 0749T, 0750T for all product lines. Changed procedures 78350, 78351, 0554T, 0555T, 0556T, 0557T, from noncovered to follow Medicare coverage criteria, prior authorization required, InterQual, for the Elite (Medicare Advantage) Plans, effective 11/01/2024. Added procedures A4633 to require a prior authorization for all product lines. Added that procedure 46948 is covered, without a PA, for all product lines, effective 10/01/2024. Added the noncoverage of Emborrhoid (from the archived medical policy PG0329), maintaining the noncoverage, for all product lines. Changed procedure 93701 from noncovered to covered without a prior authorization for the Elite plans, effective 10/01/2024. Added the following noncoverage from archived medical policy PG0180 to the spreadsheet: Neutralizing antibody testing in multiple sclerosis patients is non-covered for all product lines. Added the noncoverage of procedure 53855 from archived medical policy PG0154, along with documentation of noncovered treatments for benign prostatic hyperplasia. Added documentation listing Investigational Spinal Procedures, not all inclusive-from the archived medical policy PG0416 Lumbar Spine Decompression Surgery. Added Viscocanalostomy (including phacoviscocanalostomy) noncovered from the archived MP PG0195. Added noncoverage for electrothermal therapy, from archived medical					
09/10/2024 - Added the noncoverage for Haystack MRD (Quest Diagnostics), Changed the coverage for procedure G9143 to: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. Added the NonCovered Diagnostic Breath Analyses test-from archived medical policy PG0356.					

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
9/12/2024 Added procedures 22586 and 27278 as noncovered effective 12/01/2024, for all product lines. Added the documentation that PG0383 was archived and combined with PG0162.					
9/16/2024 Added the noncoved codes 0865T and 0866T, new codes effective 01/01/2024, for all product lines. Added procedure 20985 as noncovered for all product lines. Added the noncoverage documentation from MP PG0331 r/t Refraction,92015. Added documentation related to Alopecia, PG0514 to the spreadsheet. Added noncovered indications for Laser destruction of cutaneous vascular lesions (CPT codes 17106, 17107, 17108), from archived medical policy PG0308. Updated documentation related to PG0204, indicating Hyaluronic Acid Derivatives, Viscosupplementation for Osteoarthritis, perferred products do not require a prior authorization. Updated Management of Obstructive Sleep Apnea, PG0247 procedure codes E0470, E0471, E0472, E0601 to indicated Medical Policy (and not InterQual), as presently the Dleep Dtudy Validation Form is required for the prior authorization. Corrected procedure 67911 coverage from Medical Policy to InterQual coverage, MP PG0007 was archived.					
10/1/2024 Added procedure 0398T as covered with a prior authorization for all product lines. Changed procedure 55880 from noncovered to covered with a prior authorization for the Commercial plans, effective 11/01/2024. Corrected the documentation related to Kaemine coverage to match the medical policy PG0409. Added 83037 coverage/noncoverage details.					
10/07/2024 - Added CPT codes 15769, 15771, 19316, 19318, 19325, 19350, 19355, 19357, 19361, 19364, 19367. 19368, 19369, 19380, and 19396 - Prior Authorization is NOT required when reported with the pre-select cancer diagnosis, as listed in Medical Policy PG0144 Breast Reconstruction. Prior authorizationis required for all other indications. Addional coverage reference-PG0104 Cosmetic and Reconstructive Surgery. Added NonCoverage of procedures 0394T & 0395T for the Medicare plans, no InterQual coverage, no NCD or CGS LCD coverage.					
10/10/2024-Added coverage/noncoverage documentation related PG0104 Cosmetic and Reconstructive Surgery. Updated coverage for procedures 81420, 81422, 81507, 0252U, 0327U to require a prior authorization per InterQual, Paramount customization to align with the Medical Policy, for all product lines, medical policy PG0287 Non-Invasive Prenatal Screening (NIPS)/Cell-Free DNA Screening for Fetal Aneuploidy. Added procedure L8694 to require a prior authorization, following InterQual, effectie 01/01/2025. Added procedure 0313U as noncovered. Added the noncoverage for Topographic Genotyping, from deleted MP PG0181. Added noncovered procedures E0217, E0218, E0236, from archived MP PG0220. Added noncovered electrical stimulation procedures and/or devices, from the archived MP PG0406 Implantable Peripheral Nerve Stimulation. Added DME codes L 8010, L 8031 and L 8035 as					
10/26/2024 - Added noncoverage Discogenic Pain Treatment procedures as documented on the archived medical policy PG0026. Added new 2024 procedures A4540, A4541, A4542, E0732, E0733, E0734. Added procedures 65760, 65765, 65771 coverage per InterQual, MP PG0289. Added covered procedures 15847 and 15877 to be covered with a PA per the Medicare InterQual coverage criteria, effective 120124. Added procedures G0341, G0342, G0343, MP PG0415. Added noncovered Biofeedback and Neurofeedback indications from archived MP PG0094. Added E0485 requiring a PA from archived PG0131. Added noncovered procedure codes E0492 and E0493. Added Travel Immunizations, PG0019 documentation. Added procedures 10040, 15780, 15781, 15782, 15783, 15788, 15789, 15792, 15793, 17110, 17111, 17340, 17360, 96567, 96570, 96571, 96573, 96574, 96900, medical policy PG0348 Acne Surgery, Dermabrasion and Chemical Peels. Added noncovered procedures 36468, 36473, 36474, from achived MP PG0091.					
11/13/2024 - Documented that MP PG0234 is being archived, and that procedure E1392 is maintaining prior authorization, per the InterQual criteria. Changed procedure 41512 from covered to noncovered for the Medicare Plans, effective 02/01/2025 (reviewed/archived MP PG0056-120124). Effective 12/01/2024 procedure E0740 changed from noncovered to covered with a prior authorization, for the Medicare Plans, per NCD, per InterQual, archived MP PG0497. Added NonCovered procedure codes E0715 and E0716. Added HCPCS codes A4461, A4463, A6000, A6025, A6413 from archived MP PG0241. Added noncovered Lymphedema Treatments, Lymphedema: Microsurgical Treatments for Lymphedema-Lymphatic Bypass Procedures, Lymphaticovenous anastomosis, from archived MP PG0295. Added noncovered Bladder/Urothelial Tumor Markers, i.e. EpiCheck. Added 0431U as noncovered, all product lines. Added noncoverage for GI Genius Intelligent Endoscopy Module. Added HCPCS code E2402 will require a prior authorization, for all product lines, effective 02/01/2025.					
12/01/2024 - Added the noncoverage for EarPopper® device from MP PG0423. Updated Peripheral arterial disease (PAD) rehabilitation, 93668, prior authorization to follow InterQual for all product lines. Added Effective 02/01/2025 procedures 92548 & 92549 are non-covered for all product lines. Added procedure 22860 as covered with a PA for Commercial Plans, per InterQual coverage criteria and noncovered for Medicare Plans-per MP PG0027. Added procedures 93797, 93798, G0422, G0423 coverage and noncoverage from archived MP PG0124. Added Microwave Tumor ablation (microwave thermotherapy) coverage/noncoverage from archived MP PG0434. Added procedure 0038U is covered without a prior authorization, for all product lines, effective 02/01/2025. Added procedures 80145, 80230, 80280. 0514U, 0515U as covered per MP PG0341, effective 12/01/2024. Changed procedures 64454 and 64624 from following MP PG0471 criteria to following InterQual coverage criteria, prior authorization requirement maintained.					
12/15/2024 - Added PG0184 Salivary Hormone Testing to the document. Added NonCoverage for Genicular Artery Embolization (GAE) for the treatment of knee pain, from archived MP PG0471. Added HCPCS V2500, V2501, V2511, V2513 to require a prior authorization, effective 04/01/2025, for all product lines, PG0403. Added documentation related to noncoverage for medical policy PG0432.					
01/05/2025 - Added procedures 52441, 52442, 53854, C9739, C9740 with a prior authorization effective date of 04/01/2025, MP PG0534 Treatments for Benign Prostatic Hypertrophy (BPH). Added the noncoverage of doppler studies of ductus venosus and vessels for surveillance of impaired fetal, archived MP PG0405. Updated that codes 22532, 22548, 22556, 22590, 22595, 22600 to change from requiring a prior authorization to not requiring a prior authorization, for all product lines, effective 02/01/2025, archived MP PG0463. Corrected procedure 41899 to indicate MP PG0536 for the Commercial plans. Added 2025 new noncovered codes 0906T and 0907T, for Pipeline mtg review/determination. Added 2025 new covered code 96041, PG0041.					

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
01/20/2025 Added Laser vitreolysis (67031) for treatment of vitreous degeneration and vitreous floaters is non-covered/experimental. Added Tenex and Tenjet System as non-covered, experimental/investigational (no specific code). Added Non-covered for Embolization of the Ovarian & Iliac Veins for Pelvic Congestion Syndrome (no specific code). Added non-covered code G0555-accesssory pillow CardioMems. Added E/I Cordella Pulmonary Artery Sensor System, Endotronix.. Added non-covered code 0468U (new code effective 07/01/2024). Added, noncovered/EI the Medial Knee Implanted Shock Absorber (MISHA Knee System). Added Code G0561 non-covered/EI (New Code 1/1/2025). 2/5/2025 Added notation Accelerated repetitive transcranial magnetic stimulation (rTMS), Navigated transcranial magnetic stimulation (nTMS), and Theta burst stimulation (TBS) are non-covered per policy PG0294 Transcranial Magnetic Stimulation (TMS). Added non-covered codes 0889T, 0890T, 0891T, 0892T new codes effective 7/1/2024. 2/20/2025 Added code 95867 non-covered for ≤ 18 years old. Added non-covered codes 0493U, 0508U. 0509U to MP PG0525 Molecular Testing for Solid Organ Allograft Rejection . Added non-covered codes A7021 and E0469 to MP PG0227 Airway Clearance Devices. Added non-covered code 0537U to MP PG0065 Colorectal Cancer Screening, effective 4/1/2025. Added code 87626 and noted deleted code 0500T, effective 1/1/2025. Added code 95941 Non-covered 2/27/2025 Added non-covered codes G0282 and G0295 PG0271 Eletrical Stimulation and Electromagnetic Therapy for Wound Healing. 03/01/2025 Added Non-covered code 0936T Photobiomodulation therapy of retina, single session (New code 01/01/2025) [Valeda Photobiomodulation System(LumaThera)]. Added noncovered code 0511U (PARIS test).					
3/12/225 Added Non-Covered codes 0490), 0491U, and 0492U. Added code 20931 to require a prior authorization, effective 6/1/205. Added Non-covered codes 0454U and 0469U (new codes effective 7/1/2024). 4/8/2025 Added Non-covered code 30469 (ViVaer). Added code 30520, covered with a prior authorization effective 7/1/2025. Added Prior authorization is required for Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea codes 42975, 64582, 64583, 64584, effective 07/01/2025. Added codes 0532U. 0533U, 0534U, 0536U, 0537U, 0538U, 0539U, 0540U, 0543U, 0544U, and 0549U new codes effective 4/1/2025 MolDX: Moleculare Diagnostic Tests (MDT) . Added non-covered codes A4544 and E0743 Nidra Tonic Motor Activation (TOMAC) system -Noctrix - Non-covered. Note CMS Deleted Codes G0564 + G0565 effective 3/31/2025 5/9/2025 PG0122 InVitro Chemoresistance & Chemosensitivity Removed deleted codes 0324U, 0325U, and 0564T. Added new codes 0435U and 0525U .					
06/01/2025 - Added non-covered codes 0443U, 0445U, 0479U, 0503U, and 0551U. Removed deleted code 0346U. 6/10/2025 Add codes L6700 and L7700 to require a prior authorization. Added code 65820 non-covered "when goniotomy is determined to be trabectome (ab interno trabeculectomy)". 6/3/2025 Added non-covered G-POEM (Gastric peroral endoscopic myotomy)					
S-CODES COVERAGE EXCEPTIONS					
S-Codes allowed per Provider Contractual Agreements					
Option Care: S9500, S9501, S9502, S9503, S9504, S9497, S9494. Coram: S9343, S9326, S9327, S9349, S9365, S9366, S9368, B4185. Midwest Breast: S Codes are part of their contract					
B4185	Parenteral nutrition solution, not otherwise sp ecified, 10g lipids			**Coram**	
S9326	Home infusion therapy, continuous (24 hours or more) pain management infusion; administrative services, professional pharmacy services, care coordination and all necessary supplies and euipment (drugs and nursing visits coded separately), per diem			**Coram**	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
S9327	Home infusion therapy, intermittent (less than 24 hours) pain management infusion; administrative services, professional pharmacy services, care coordination and all necessary supplies and euipment (drugs and nursing visits coded separately)			Coram	
S9343	Home therapy; enteral nutrition via bolus; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem			Coram	
S9349	Home infusion therapy, tocolytic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem			Coram	
S9365	Home infusion therapy, total parenteral nutrition (TPN); one liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid			Coram	
S9366	Home infusion therapy, total parenteral nutrition (TPN); more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula			Coram	
S9368	Home infusion therapy, total parenteral nutrition (TPN); more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula			Coram	
S9494	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use			Option Care	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES
S9497	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 3 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem			Option Care	
S9500	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem			Option Care	
S9501	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem			Option Care	
S9502	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 8 hours, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem			Option Care	
S9503	Home infusion therapy, antibiotic, antiviral, or antifungal; once every 6 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem			Option Care	
S9504	Home infusion therapy, antibiotic, antiviral, or antifungal; once every 4 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem			Option Care	

Codes	Code Description	Paramount Commercial	Elite Medicare Advantage	Policy	DETAILS/NOTES