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Refer also to the ***Sendero Preauthorization List and Guidance*** document located on the Authorization tab of the Sendero Health Plans web site Provider pages.

Sendero also publishes an interactive online ***Code lookup Tool*** where specific health care services codes can be searched to find out whether an authorization is required and to learn what criteria is used by Sendero for determining medical necessity and coverage. Find it at www.senderohealth.com/preauthorizationsearch.

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0004M	SCOLIOSIS, DNA ANALYSIS OF 53 SINGLE NUCLEOTIDE POLYMORPHISMS (SNPS), USING SALIVA, PROGNOSTIC ALGORITHM REPORTED AS A RISK SCORE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0005U	ONCOLOGY (PROSTATE) GENE EXPRESSION PROFILE BY REAL-TIME RT-PCR OF 3 GENES (ERG, PCA3, AND SPDEF), URINE, ALGORITHM REPORTED AS RISK SCORE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0009M	FETAL ANEUPLOIDY (TRISOMY 21, AND 18) DNA SEQUENCE ANALYSIS OF SELECTED REGIONS USING MATERNAL PLASMA, ALGORITHM REPORTED AS A RISK SCORE FOR EACH TRISOMY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0011M	ONCOLOGY, PROSTATE CANCER, MRNA EXPRESSION ASSAY OF 12 GENES (10 CONTENT AND 2 HOUSEKEEPING), RT-PCR TEST UTILIZING BLOOD PLASMA AND URINE, ALGORITHMS TO PREDICT HIGH-GRADE PROSTATE CANCER RISK		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0012M	ONCOLOGY (UROTHELIAL), MRNA, GENE EXPRESSION PROFILING BY REAL-TIME QUANTITATIVE PCR OF FIVE GENES (MDK, HOXA13, CDC2 [CDK1], IGFBP5, AND CXCR2), UTILIZING URINE, ALGORITHM REPORTED AS A RISK SCORE FOR HAVING UROTHELIAL CARCINOMA		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0013M	ONCOLOGY (UROTHELIAL), MRNA, GENE EXPRESSION PROFILING BY REAL-TIME 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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 OT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0016M	ONCOLOGY (BLADDER), MRNA, MICROARRAY GENE EXPRESSION PROFILING OF 219 GENES, UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS MOLECULAR SUBTYPE (LUMINAL, LUMINAL INFILTRATED, BASAL, BASAL CLAUDIN-LOW, NEUROENDOCRINE-LIKE)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
00170	ANESTHESIA FOR INTRAORAL PROCEDURES, INCLUDING BIOPSY; NOT OTHERWISE SPECIFIED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0021U	ONCOLOGY (PROSTATE), DETECTION OF 8 AUTOANTIBODIES (ARF 6, NKX3-1, 5'-UTR-BMI1, CEP 164, 3'-UTR-ROPPORIN, DESMOCOLLIN, AURKAIP-1, CSNK2A2), MULTIPLEXED IMMUNOASSAY AND FLOW CYTOMETRY SERUM, ALGORITHM REPORTED AS RISK SCORE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0030U	DRUG METABOLISM (WARFARIN DRUG RESPONSE), TARGETED SEQUENCE ANALYSIS (IE, CYP2C9, CYP4F2, VKORC1, RS12777823)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0031U	CYP1A2 (CYTOCHROME P450 FAMILY 1, SUBFAMILY A, MEMBER 2) (EG, DRUG METABOLISM) GENE ANALYSIS, COMMON VARIANTS (IE, *1F, *1K, *6, *7)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0032U	COMT (CATECHOL-O-METHYLTRANSFERASE) (EG, DRUG METABOLISM) GENE ANALYSIS, C.472G>A (RS4680) VARIANT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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.551-3008C>G])		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0042T	CEREBRAL PERFUSION ANALYSIS USING COMPUTED TOMOGRAPHY WITH CONTRAST ADMINISTRATION, INCLUDING POST-PROCESSING OF PARAMETRIC MAPS WITH DETERMINATION OF CEREBRAL BLOOD FLOW, CEREBRAL BLOOD VOLUME, AND MEAN TRANSIT TIME		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 PARAFF		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0050U	TARGETED GENOMIC SEQUENCE ANALYSIS PANEL, ACUTE MYELOGENOUS LEUKEMIA, DNA ANALYSIS, 194 GENES, INTERROGATION FOR SEQUENCE VARIANTS, COPY NUMBER VARIANTS OR REARRANGEMENTS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0054T	COMPUTER-ASSISTED MUSCULOSKELETAL SURGICAL NAVIGATIONAL ORTHOPEDIC PROCEDURE, WITH IMAGE-GUIDANCE BASED ON FLUOROSCOPIC IMAGES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0055U	CARDIOLOGY (HEART TRANSPLANT), CELL-FREE DNA, PCR ASSAY OF 96 DNA TARGET SEQUENCES (94 SINGLE NUCLEOTIDE POLYMORPHISM TARGETS AND TWO CONTROL TARGETS), PLASMA		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0057U	ONCOLOGY (SOLID ORGAN NEOPLASIA), MRNA, GENE EXPRESSION PROFILING BY MASSIVELY PARALLEL SEQUENCING FOR ANALYSIS OF 51 GENES, UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS A NORMALIZED PERCENTILE RANK		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0058U	ONCOLOGY (MERKEL CELL CARCINOMA), DETECTION OF ANTIBODIES TO THE MERKEL CELL POLYOMA VIRUS ONCOPROTEIN (SMALL T ANTIGEN), SERUM, QUANTITATIVE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0059U	ONCOLOGY (MERKEL CELL CARCINOMA), DETECTION OF ANTIBODIES TO THE MERKEL CELL POLYOMA VIRUS CAPSID PROTEIN (VP1), SERUM, REPORTED AS POSITIVE OR NEGATIVE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0063U	NEUROLOGY (AUTISM), 32 AMINES BY LC-MS/MS, USING PLASMA, ALGORITHM REPORTED AS METABOLIC SIGNATURE ASSOCIATED WITH AUTISM SPECTRUM DISORDER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
00640	ANESTHESIA FOR MANIPULATION OF THE SPINE OR FOR CLOSED PROCEDURES ON THE CERVICAL, THORACIC OR LUMBAR SPINE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0067U	ONCOLOGY (BREAST), IMMUNOHISTOCHEMISTRY, PROTEIN EXPRESSION PROFILING OF 4 BIOMARKERS (MATRIX METALLOPROTEINASE-1 [MMP-1], CARCINOEMBRYONIC ANTIGEN-RELATED CELL ADHESION MOLECULE 6 [CEACAM6], HYALURONOGLUCOSAMINIDASE [HYAL1], HIGHLY EXPRESSED IN CANCER PR		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0069U	ONCOLOGY (COLORECTAL), MICRORNA, RT-PCR EXPRESSION PROFILING OF MIR-31-3P, FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS AN EXPRESSION SCORE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0071T	FOCUSED ULTRASOUND ABLATION OF UTERINE LEIOMYOMATA, INCLUDING MR GUIDANCE; TOTAL LEIOMYOMATA VOLUME LESS THAN 200 CC OF TISSUE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0072T	FOCUSED ULTRASOUND ABLATION OF UTERINE LEIOMYOMATA, INCLUDING MR GUIDANCE; TOTAL LEIOMYOMATA VOLUME GREATER OR EQUAL TO 200 CC OF TISSUE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0075T	TRANSCATHETER PLACEMENT OF EXTRACRANIAL VERTEBRAL ARTERY STENT(S), INCLUDING RADIOLOGIC SUPERVISION AND INTERPRETATION, OPEN OR PERCUTANEOUS; INITIAL VESSEL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0076T	TRANSCATHETER PLACEMENT OF EXTRACRANIAL VERTEBRAL ARTERY STENT(S), INCLUDING RADIOLOGIC SUPERVISION AND INTERPRETATION, OPEN OR PERCUTANEOUS; EACH ADDITIONAL VESSEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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-SPICULATION STATUS AND NODULE LOCATION), UTI		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0087U	CARDIOLOGY (HEART TRANSPLANT), MRNA GENE EXPRESSION PROFILING BY MICROARRAY OF 1283 GENES, TRANSPLANT BIOPSY TISSUE, ALLOGRAFT REJECTION AND INJURY ALGORITHM REPORTED AS A PROBABILITY SCORE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0089U	ONCOLOGY (MELANOMA), GENE EXPRESSION PROFILING BY RTQPCR, PRAME AND LINC00518, SUPERFICIAL COLLECTION USING ADHESIVE PATCH(ES)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0090U	ONCOLOGY (CUTANEOUS MELANOMA), MRNA GENE EXPRESSION PROFILING BY RT-PCR OF 23 GENES (14 CONTENT AND 9 HOUSEKEEPING), UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, ALGORITHM REPORTED AS A CATEGORICAL RESULT (IE, BENIGN, INTERMEDIATE, MALIGNANT)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0092U	ONCOLOGY (LUNG), THREE PROTEIN BIOMARKERS, IMMUNOASSAY USING MAGNETIC NANOSENSOR TECHNOLOGY, PLASMA, ALGORITHM REPORTED AS RISK SCORE FOR LIKELIHOOD OF MALIGNANCY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0094U	GENOME (EG, UNEXPLAINED CONSTITUTIONAL OR HERITABLE DISORDER OR SYNDROME), RAPID SEQUENCE ANALYSIS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0097U	GASTROINTESTINAL PATHOGEN, MULTIPLEX REVERSE TRANSCRIPTION AND MULTIPLEX AMPLIFIED PROBE TECHNIQUE, MULTIPLE TYPES OR SUBTYPES, 22 TARGETS (CAMPYLOBACTER [C. JEJUNI/C. COLI/C. UPSALIENSIS], CLOSTRIDIUM DIFFICILE [C. DIFFICILE] TOXIN A/B, PLESIOMONAS SHIGE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0100	ALL-INCLUSIVE ROOM AND BOARD PLUS ANCILLARY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0100T	PLACEMENT OF A SUBCONJUNCTIVAL RETINAL PROSTHESIS RECEIVER AND PULSE GENERATOR, AND IMPLANTATION OF INTRAOCULAR RETINAL ELECTRODE ARRAY, WITH VITRECTOMY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0101	ALL-INCLUSIVE ROOM AND BOARD		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0101T	EXTRACORPOREAL SHOCK WAVE INVOLVING MUSCULOSKELETAL SYSTEM, NOT OTHERWISE SPECIFIED		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 MRNA ANALYTICS TO RESOLVE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0102T	EXTRACORPOREAL SHOCK WAVE PERFORMED BY A PHYSICIAN, REQUIRING ANESTHESIA OTHER THAN LOCAL, AND INVOLVING THE LATERAL HUMERAL EPICONDYLE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0102U	HEREDITARY BREAST CANCER-RELATED DISORDERS (EG, HEREDITARY BREAST CANCER, HEREDITARY OVARIAN CANCER, HEREDITARY ENDOMETRIAL CANCER), GENOMIC SEQUENCE ANALYSIS PANEL UTILIZING A COMBINATION OF NGS, SANGER, MLPA, AND ARRAY CGH, WITH MRNA ANALYTICS TO RESOLV		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 MRNA ANALYTICS TO RESOLVE VARIANTS OF UNKNOWN SIGNIFICANCE WHEN IND		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0106T	QUANTITATIVE SENSORY TESTING (QST), TESTING AND INTERPRETATION PER EXTREMITY; USING TOUCH PRESSURE STIMULI TO ASSESS LARGE DIAMETER SENSATION		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 13CO2 EXCRETION		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0107T	QUANTITATIVE SENSORY TESTING (QST), TESTING AND INTERPRETATION PER EXTREMITY; USING VIBRATION STIMULI TO ASSESS LARGE DIAMETER FIBER SENSATION		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0108T	QUANTITATIVE SENSORY TESTING (QST), TESTING AND INTERPRETATION PER EXTREMITY; USING COOLING STIMULI TO ASSESS SMALL NERVE FIBER SENSATION AND HYPERALGESIA		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0109T	QUANTITATIVE SENSORY TESTING (QST), TESTING AND INTERPRETATION PER EXTREMITY; USING HEAT-PAIN STIMULI TO ASSESS SMALL NERVE FIBER SENSATION AND HYPERALGESIA		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0110	ROOM & BOARD-PRIVATE (ONE BED)-GENERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0110T	QUANTITATIVE SENSORY TESTING (QST), TESTING AND INTERPRETATION PER EXTREMITY; USING OTHER STIMULI TO ASSESS SENSATION		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0111	ROOM & BOARD-PRIVATE (ONE BED)-MEDICAL/SURGICAL/GYN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0111T	LONG-CHAIN (C20-22) OMEGA-3 FATTY ACIDS IN RED BLOOD CELL (RBC) MEMBRANES		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0112	ROOM & BOARD-PRIVATE (ONE BED)-OB		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0113	ROOM & BOARD-PRIVATE (ONE BED)-PEDIATRIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0114	INPATIENT MENTAL HEALTH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0116	INPATIENT SUBSTANCE ABUSE 1 DAY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0117	ROOM & BOARD-PRIVATE (ONE BED)-ONCOLOGY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0118	ROOM & BOARD-PRIVATE (ONE BED)-REHABILITATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0119	ROOM & BOARD-PRIVATE (ONE BED)-OTHER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0120	ROOM & BOARD-SEMIPRIVATE (TWO-BEDS)-GENERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0120U	ONCOLOGY (B-CELL LYMPHOMA CLASSIFICATION), MRNA, GENE EXPRESSION PROFILING BY FLUORESCENT PROBE HYBRIDIZATION OF 58 GENES (45 CONTENT AND 13 HOUSEKEEPING GENES), FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS LIKELIHOOD FOR PRIMARY MEDIAST		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0121	ROOM & BOARD-SEMIPRIVATE (TWO-BEDS)-MEDICAL/SURGICAL/GYN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0122	ROOM & BOARD-SEMIPRIVATE (TWO-BEDS)-OB		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0123	ROOM & BOARD-SEMIPRIVATE (TWO-BEDS)-PEDIATRIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0124	INPATIENT MENTAL HEALTH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0126	INPATIENT SUBSTANCE ABUSE 1 DAY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0126T	COMMON CAROTID INTIMA-MEDIA THICKNESS (IMT) STUDY FOR EVALUATION OF ATHEROSCLEROTIC BURDEN OR CORONARY HEART DISEASE RISK FACTOR ASSESSMENT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0127	ROOM & BOARD-SEMIPRIVATE (TWO-BEDS)-ONCOLOGY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0128	ROOM & BOARD-SEMIPRIVATE (TWO-BEDS)-REHABILITATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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0129	ROOM & BOARD-SEMIPRIVATE (TWO-BEDS)-OTHER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0130	ROOM & BOARD-THREE AND FOUR BEDS-GENERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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 TP53) (LIST SEPARATELY IN		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0131	ROOM & BOARD-THREE AND FOUR BEDS-MEDICAL/SURGICAL/GYN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0132	ROOM & BOARD-THREE AND FOUR BEDS-OB		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0133	ROOM & BOARD-THREE AND FOUR BEDS-PEDIATRIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0134	INPATIENT MENTAL HEALTH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0136	INPATIENT SUBSTANCE ABUSE 1 DAY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0136U	ATM (ATAXIA TELANGIECTASIA MUTATED) (EG, ATAXIA TELANGIECTASIA) MRNA SEQUENCE ANALYSIS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0137	ROOM & BOARD-THREE AND FOUR BEDS-ONCOLOGY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0137U	PALB2 (PARTNER AND LOCALIZER OF BRCA2) (EG, BREAST AND PANCREATIC CANCER) MRNA SEQUENCE ANALYSIS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0138	ROOM & BOARD-THREE AND FOUR BEDS-REHABILITATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0139	ROOM & BOARD-THREE AND FOUR BEDS-OTHER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0139U	NEUROLOGY (AUTISM SPECTRUM DISORDER [ASD]), QUANTITATIVE MEASUREMENTS OF 6 CENTRAL CARBON METABOLITES (IE, AKETOGLUTARATE, ALANINE, LACTATE, PHENYLALANINE, PYRUVATE, AND SUCCINATE), LC-MS/MS, PLASMA, ALGORITHMIC ANALYSIS WITH RESULT REPORTED AS NEGATIVE O		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0140	ROOM & BOARD-DELUXE PRIVATE-GENERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0141	ROOM & BOARD-DELUXE PRIVATE-MEDICAL/SURGICAL/GYN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0142	ROOM & BOARD-DELUXE PRIVATE-OB		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0143	ROOM & BOARD-DELUXE PRIVATE-PEDIATRIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0144	INPATIENT MENTAL HEALTH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0146	INPATIENT SUBSTANCE ABUSE 1 DAY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0147	ROOM & BOARD-DELUXE PRIVATE-ONCOLOGY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0148	ROOM & BOARD-DELUXE PRIVATE-REHABILITATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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0149	ROOM & BOARD-DELUXE PRIVATE-OTHER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0150	ROOM & BOARD-WARD-GENERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0151	ROOM & BOARD-WARD-MEDICAL/SURGICAL/GYN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0152	ROOM & BOARD-WARD-OB		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0153	ROOM & BOARD-WARD-PEDIATRIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0154	INPATIENT MENTAL HEALTH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0156	INPATIENT SUBSTANCE ABUSE 1 DAY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0156U	COPY NUMBER (EG, INTELLECTUAL DISABILITY, DYSMORPHOLOGY), SEQUENCE ANALYSIS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0157	ROOM & BOARD-WARD-ONCOLOGY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0157U	APC (APC REGULATOR OF WNT SIGNALING PATHWAY) (EG, FAMILIAL ADENOMATOSIS POLYPOSIS [FAP]) MRNA SEQUENCE ANALYSIS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0158	INPATIENT REHABILITATION 1 DAY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0159	ROOM & BOARD-WARD-OTHER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0160	ROOM & BOARD-OTHER-GENERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0162U	HEREDITARY COLON CANCER (LYNCH SYNDROME), TARGETED MRNA SEQUENCE ANALYSIS PANEL (MLH1, MSH2, MSH6, PMS2) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0164	ROOM & BOARD-OTHER-STERILE ENVIRONMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0164T	REMOVAL OF TOTAL DISC ARTHROPLASTY, (ARTIFICIAL DISC), ANTERIOR APPROACH, EACH ADDITIONAL INTERSPACE, LUMBAR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0167	ROOM & BOARD-OTHER-SELF-CARE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0169	ROOM & BOARD-OTHER-OTHER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0170	NURSERY - GENERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0171	NURSERY-NEWBORN-LEVEL I		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0172	NURSERY-NEWBORN-LEVEL II		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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-EMBEDDED T		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	

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0173	NURSERY-NEWBORN-LEVEL III		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0173U	PSYCHIATRY (IE, DEPRESSION, ANXIETY), GENOMIC ANALYSIS PANEL, INCLUDES VARIANT ANALYSIS OF 14 GENES		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0174	NURSERY-NEWBORN-LEVEL IV		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0175U	PSYCHIATRY (EG, DEPRESSION, ANXIETY), GENOMIC ANALYSIS PANEL, VARIANT ANALYSIS OF 15 GENES		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0179	NURSERY-OTHER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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 SIGNIFICAN		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0180	LEAVE OF ABSENCE-GENERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0182	LEAVE OF ABSENCE-PATIENT CONVENIENCE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0183	LEAVE OF ABSENCE-THERAPEUTIC LEAVE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0185	LEAVE OF ABSENCE-NURSING HOME (FOR HOSPITALIZATION)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0189	LEAVE OF ABSENCE-OTHER LEAVE OF ABSENCE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0190	SUBACUTE CARE-GENERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0191	SUBACUTE CARE-LEVEL I		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0192	SUBACUTE CARE-LEVEL II		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0193	SUBACUTE CARE-LEVEL III		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0194	SUBACUTE CARE-LEVEL IV		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0198T	MEASUREMENT OF OCULAR BLOOD FLOW BY REPETITIVE INTRAOCULAR PRESSURE SAMPLING, WITH INTERPRETATION AND REPORT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0199	SUBACUTE CARE-OTHER SUBACUTE CARE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0200	INTENSIVE CARE-GENERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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0200T	PERCUTANEOUS SACRAL AUGMENTATION (SACROPLASTY), UNILATERAL INJECTION(S), INCLUDING THE USE OF A BALLOON OR MECHANICAL DEVICE, WHEN USED, 1 OR MORE NEEDLES, INCLUDES IMAGING GUIDANCE AND BONE BIOPSY, WHEN PERFORMED		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0201	INTENSIVE CARE-SURGICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0202	INTENSIVE CARE-MEDICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0202T	POSTERIOR VERTEBRAL JOINT(S) ARTHROPLASTY (EG, FACET JOINT[S] REPLACEMENT), INCLUDING FACETECTOMY, LAMINECTOMY, FORAMINOTOMY, AND VERTEBRAL COLUMN FIXATION, INJECTION OF BONE CEMENT, WHEN PERFORMED, INCLUDING FLUOROSCOPY, SINGLE LEVEL, LUMBAR SPINE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0203	INTENSIVE CARE-PEDIATRIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0206	INTENSIVE CARE-INTERMEDIATE ICU		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0207	INTENSIVE CARE-BURN CARE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0207T	EVACUATION OF MEIBOMIAN GLANDS, AUTOMATED, USING HEAT AND INTERMITTENT PRESSURE, UNILATERAL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0208	INTENSIVE CARE-TRAUMA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0209	INTENSIVE CARE-OTHER INTENSIVE CARE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0210	CORONARY CARE-GENERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0211	CORONARY CARE-MYOCARDIAL INFARCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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 INSTABILITY, WIT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0212	CORONARY CARE-PULMONARY CARE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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 MAPPABLE REGIONS, BLOOD		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0213	CORONARY CARE-HEART TRANSPLANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0213T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, CERVICAL OR THORACIC; SINGLE LEVEL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0214	CORONARY CARE-INTERMEDIATE CCU		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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0214T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, CERVICAL OR THORACIC; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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 MAPPABLE REGIONS, BLOOD O		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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 MAPPABLE REGIONS, BLOOD O		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0216T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, LUMBAR OR SACRAL; SINGLE LEVEL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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 PROC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0219	CORONARY CARE-OTHER CORONARY CARE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0219T	PLACEMENT OF A POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; CERVICAL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0220T	PLACEMENT OF A POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; THORACIC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0220U	ONCOLOGY (BREAST CANCER), IMAGE ANALYSIS WITH ARTIFICIAL INTELLIGENCE ASSESSMENT OF 12 HISTOLOGIC AND IMMUNOHISTOCHEMICAL FEATURES, REPORTED AS A RECURRENCE SCORE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0221T	PLACEMENT OF A POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; LUMBAR		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0222T	PLACEMENT OF A 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)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0226U	SURROGATE VIRAL NEUTRALIZATION TEST (SVNT), SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2) (CORONAVIRUS DISEASE [COVID-19]), ELISA, PLASMA, SERUM		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0228T	INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH ULTRASOUND GUIDANCE, CERVICAL OR THORACIC; SINGLE LEVEL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0229T	INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH ULTRASOUND GUIDANCE, CERVICAL OR THORACIC; EACH ADDITIONAL LEVEL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0229U	BCAT1 (BRANCHED CHAIN AMINO ACID TRANSAMINASE 1) AND IKZF1 (IKAROS FAMILY ZINC FINGER 1) (EG, COLORECTAL CANCER) PROMOTER METHYLATION ANALYSIS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0230T	INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH ULTRASOUND GUIDANCE, LUMBAR OR SACRAL; SINGLE LEVEL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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) EXPANS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0231T	INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH ULTRASOUND GUIDANCE, LUMBAR OR SACRAL; EACH ADDITIONAL LEVEL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0232T	INJECTION(S), PLATELET RICH PLASMA, ANY SITE, INCLUDING IMAGE GUIDANCE, HARVESTING AND PREPARATION WHEN PERFORMED		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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-UNIQUE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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, DELETIONS, AND MOBILE ELEMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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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, RYR2, AND SCN5A		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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-UNIQUELY MAPPABLE REGIO		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0243U	OBSTETRICS (PREECLAMPSIA), BIOCHEMICAL ASSAY OF PLACENTAL-GROWTH FACTOR, TIME-RESOLVED FLUORESCENCE IMMUNOASSAY, MATERNAL SERUM, PREDICTIVE ALGORITHM REPORTED AS A RISK SCORE FOR PREECLAMPSIA		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 FO		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0248U	ONCOLOGY, SPHEROID CELL CULTURE IN 3D MICROENVIRONMENT, 12-DRUG PANEL, BRAIN- OR BRAIN METASTASIS-RESPONSE PREDICTION FOR EACH DRUG		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0249U	ONCOLOGY (BREAST), SEMIQUANTITATIVE ANALYSIS OF 32 PHOSPHOPROTEINS AND PROTEIN ANALYTES, INCLUDES LASER CAPTURE MICRODISSECTION, WITH ALGORITHMIC ANALYSIS AND INTERPRETATIVE REPORT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 INST		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0251U	HEPCIDIN-25, ENZYME-LINKED IMMUNOSORBENT ASSAY (ELISA), SERUM OR PLASMA		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0252U	FETAL ANEUPLOIDY SHORT TANDEM-REPEAT COMPARATIVE ANALYSIS, FETAL DNA FROM PRODUCTS OF CONCEPTION, REPORTED AS NORMAL (EUPLOIDY), MONOSOMY, TRISOMY, OR PARTIAL DELETION/DUPLICATION, MOSAICISM, AND SEGMENTAL ANEUPLOIDY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0256U	TRIMETHYLAMINE/TRIMETHYLAMINE N-OXIDE (TMA/TMAO) PROFILE, TANDEM MASS SPECTROMETRY (MS/MS), URINE, WITH ALGORITHMIC ANALYSIS AND INTERPRETIVE REPORT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0257U	VERY LONG CHAIN ACYL-COENZYME A (COA) DEHYDROGENASE (VLCAD), LEUKOCYTE ENZYME ACTIVITY, WHOLE BLOOD		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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 ESTIMATED GLOMERULAR FILTRATION R		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0260U	RARE DISEASES (CONSTITUTIONAL/HERITABLE DISORDERS), IDENTIFICATION OF COPY NUMBER VARIATIONS, INVERSIONS, INSERTIONS, TRANSLOCATIONS, AND OTHER STRUCTURAL VARIANTS BY OPTICAL GENOME MAPPING		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 RECURRENCE-RISK SCORE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0263U	NEUROLOGY (AUTISM SPECTRUM DISORDER [ASD]), QUANTITATIVE MEASUREMENTS OF 16 CENTRAL CARBON METABOLITES (IE, Î±-KETOGLUTARATE, ALANINE, LACTATE, PHENYLALANINE, PYRUVATE, SUCCINATE, CARNITINE, CITRATE, FUMARATE, HYPOXANTHINE, INOSINE, MALATE, S-SULFOCYSTEIN		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0264U	RARE DISEASES (CONSTITUTIONAL/HERITABLE DISORDERS), IDENTIFICATION OF COPY NUMBER VARIATIONS, INVERSIONS, INSERTIONS, TRANSLOCATIONS, AND OTHER STRUCTURAL VARIANTS BY OPTICAL GENOME MAPPING		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 MARROW CE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 NUM		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0267T	IMPLANTATION OR REPLACEMENT OF CAROTID SINUS BAROREFLEX ACTIVATION DEVICE; LEAD ONLY, UNILATERAL (INCLUDES INTRA-OPERATIVE INTERROGATION, PROGRAMMING, AND REPOSITIONING, WHEN PERFORMED)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0268T	IMPLANTATION OR REPLACEMENT OF CAROTID SINUS BAROREFLEX ACTIVATION DEVICE; PULSE GENERATOR ONLY (INCLUDES INTRA-OPERATIVE INTERROGATION, PROGRAMMING, AND REPOSITIONING, WHEN PERFORMED)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0268U	HEMATOLOGY (ATYPICAL HEMOLYTIC UREMIC SYNDROME [AHUS]), GENOMIC SEQUENCE ANALYSIS OF 15 GENES, BLOOD, BUCCAL SWAB, OR AMNIOTIC FLUID		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0269U	HEMATOLOGY (AUTOSOMAL DOMINANT CONGENITAL THROMBOCYTOPENIA), GENOMIC SEQUENCE ANALYSIS OF 22 GENES, BLOOD, BUCCAL SWAB, OR AMNIOTIC FLUID		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0270T	REVISION OR REMOVAL OF CAROTID SINUS BAROREFLEX ACTIVATION DEVICE; LEAD ONLY, UNILATERAL (INCLUDES INTRA-OPERATIVE INTERROGATION, PROGRAMMING, AND REPOSITIONING, WHEN PERFORMED)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0270U	HEMATOLOGY (CONGENITAL COAGULATION DISORDERS), GENOMIC SEQUENCE ANALYSIS OF 20 GENES, BLOOD, BUCCAL SWAB, OR AMNIOTIC FLUID		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0271T	REVISION OR REMOVAL OF CAROTID SINUS BAROREFLEX ACTIVATION DEVICE; PULSE GENERATOR ONLY (INCLUDES INTRA-OPERATIVE INTERROGATION, PROGRAMMING, AND REPOSITIONING, WHEN PERFORMED)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0271U	HEMATOLOGY (CONGENITAL NEUTROPENIA), GENOMIC SEQUENCE ANALYSIS OF 24 GENES, BLOOD, BUCCAL SWAB, OR AMNIOTIC FLUID		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 (		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0272U	HEMATOLOGY (GENETIC BLEEDING DISORDERS), GENOMIC SEQUENCE ANALYSIS OF 60 GENES AND DUPLICATION/DELETION OF PLAU, BLOOD, BUCCAL SWAB, OR AMNIOTIC FLUID, COMPREHENSIVE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 (		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0273U	HEMATOLOGY (GENETIC HYPERFIBRINOLYSIS, DELAYED BLEEDING), ANALYSIS OF 9 GENES (F13A1, F13B, FGA, FGB, FGG, SERPINA1, SERPINE1, SERPINF2 BY NEXT-GENERATION SEQUENCING, AND PLAU BY ARRAY COMPARATIVE GENOMIC HYBRIDIZATION), BLOOD, BUCCAL SWAB, OR AMNIOTIC FL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0274T	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), SINGL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0274U	HEMATOLOGY (GENETIC PLATELET DISORDERS), GENOMIC SEQUENCE ANALYSIS OF 62 GENES AND DUPLICATION/DELETION OF PLAU, BLOOD, BUCCAL SWAB, OR AMNIOTIC FLUID		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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), SINGL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0276U	HEMATOLOGY (INHERITED THROMBOCYTOPENIA), GENOMIC SEQUENCE ANALYSIS OF 42 GENES, BLOOD, BUCCAL SWAB, OR AMNIOTIC FLUID		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0277U	HEMATOLOGY (GENETIC PLATELET FUNCTION DISORDER), GENOMIC SEQUENCE ANALYSIS OF 40 GENES AND DUPLICATION/DELETION OF PLAU, BLOOD, BUCCAL SWAB, OR AMNIOTIC FLUID		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0278T	TRANSCUTANEOUS ELECTRICAL MODULATION PAIN REPROCESSING (EG, SCRAMBLER THERAPY), EACH TREATMENT SESSION (INCLUDES PLACEMENT OF ELECTRODES)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0278U	HEMATOLOGY (GENETIC THROMBOSIS), GENOMIC SEQUENCE ANALYSIS OF 14 GENES, BLOOD, BUCCAL SWAB, OR AMNIOTIC FLUID		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0279U	HEMATOLOGY (VON WILLEBRAND DISEASE [VWD]), VON WILLEBRAND FACTOR (VWF) AND COLLAGEN III BINDING BY ENZYME-LINKED IMMUNOSORBENT ASSAYS (ELISA), PLASMA, REPORT OF COLLAGEN III BINDING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0281U	HEMATOLOGY (VON WILLEBRAND DISEASE [VWD]), VON WILLEBRAND PROPEPTIDE, ENZYME-LINKED IMMUNOSORBENT ASSAYS (ELISA), PLASMA, DIAGNOSTIC REPORT OF VON WILLEBRAND FACTOR (VWF) PROPEPTIDE ANTIGEN LEVEL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0282U	RED BLOOD CELL ANTIGEN TYPING, DNA, GENOTYPING OF 12 BLOOD GROUP SYSTEM GENES TO PREDICT 44 RED BLOOD CELL ANTIGEN PHENOTYPES		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0285U	ONCOLOGY, RESPONSE TO RADIATION, CELL-FREE DNA, QUANTITATIVE BRANCHED CHAIN DNA AMPLIFICATION, PLASMA, REPORTED AS A RADIATION TOXICITY SCORE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0286U	CEP72 (CENTROSOMAL PROTEIN, 72-KDA), NUDT15 (NUDIX HYDROLASE 15) AND TPMT (THIOPURINE S-METHYLTRANSFERASE) (EG, DRUG METABOLISM) GENE ANALYSIS, COMMON VARIANTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0287U	ONCOLOGY (THYROID), DNA AND MRNA, NEXT-GENERATION 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, INTERMEDIA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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, ALGORITHMIC INTERPRETATION		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0289U	NEUROLOGY (ALZHEIMER DISEASE), MRNA, GENE EXPRESSION PROFILING BY RNA SEQUENCING OF 24 GENES, WHOLE BLOOD, ALGORITHM REPORTED AS PREDICTIVE RISK SCORE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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0290U	PAIN MANAGEMENT, MRNA, GENE EXPRESSION PROFILING BY RNA SEQUENCING OF 36 GENES, WHOLE BLOOD, ALGORITHM REPORTED AS PREDICTIVE RISK SCORE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0291U	PSYCHIATRY (MOOD DISORDERS), MRNA, GENE EXPRESSION PROFILING BY RNA SEQUENCING OF 144 GENES, WHOLE BLOOD, ALGORITHM REPORTED AS PREDICTIVE RISK SCORE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0292U	PSYCHIATRY (STRESS DISORDERS), MRNA, GENE EXPRESSION PROFILING BY RNA SEQUENCING OF 72 GENES, WHOLE BLOOD, ALGORITHM REPORTED AS PREDICTIVE RISK SCORE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0293U	PSYCHIATRY (SUICIDAL IDEATION), MRNA, GENE EXPRESSION PROFILING BY RNA SEQUENCING OF 54 GENES, WHOLE BLOOD, ALGORITHM REPORTED AS PREDICTIVE RISK SCORE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0294U	LONGEVITY AND MORTALITY RISK, MRNA, GENE EXPRESSION PROFILING BY RNA SEQUENCING OF 18 GENES, WHOLE BLOOD, ALGORITHM REPORTED AS PREDICTIVE RISK SCORE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 P		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0296U	ONCOLOGY (ORAL AND/OR OROPHARYNGEAL CANCER), GENE EXPRESSION PROFILING BY RNA SEQUENCING OF AT LEAST 20 MOLECULAR FEATURES (EG, HUMAN AND/OR MICROBIAL MRNA), SALIVA, ALGORITHM REPORTED AS POSITIVE OR NEGATIVE FOR SIGNATURE ASSOCIATED WITH MALIGNANCY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 ID		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0300I	WHOLE GENOME SEQUENCING AND OPTICAL GENOME MAPPING OF PAIRED MALIGNANT AND NORMAL DNA SPECIMENS IN BLOOD SPECIMEN WITH COMPARATIVE SEQUENCE ANALYSES AND VARIANT IDENTIFICATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0308U	CARDIOLOGY (CORONARY ARTERY DISEASE [CAD]), ANALYSIS OF 3 PROTEINS (HIGH SENSITIVITY [HS] TROPONIN, ADIPONECTIN, AND KIDNEY INJURY MOLECULE-1 [KIM-1]) WITH 3 CLINICAL PARAMETERS (AGE, SEX, HISTORY OF CARDIAC INTERVENTION), PLASMA, ALGORITHM REPORTED AS A		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0310U	PEDIATRICS (VASCULITIS, KAWASAKI DISEASE [KD]), ANALYSIS OF 3 BIOMARKERS (NT-PROBNP, C-REACTIVE PROTEIN, AND T-UPTAKE), PLASMA, ALGORITHM REPORTED AS A RISK SCORE FOR KD		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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, HIG		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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, CLA		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0316U	BORRELIA BURGDORFERI (LYME DISEASE), OSPA PROTEIN EVALUATION, URINE		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0318U	PEDIATRICS (CONGENITAL EPIGENETIC DISORDERS), WHOLE GENOME METHYLATION ANALYSIS BY MICROARRAY FOR 50 OR MORE GENES, BLOOD		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0319U	NEPHROLOGY (RENAL TRANSPLANT), RNA EXPRESSION BY SELECT TRANSCRIPTOME SEQUENCING, USING PRETRANSPLANT PERIPHERAL BLOOD, ALGORITHM REPORTED AS A RISK SCORE FOR EARLY ACUTE REJECTION		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
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		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 RISK OF ME		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0323U	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA AND RNA), CENTRAL NERVOUS SYSTEM PATHOGEN, METAGENOMIC NEXT-GENERATION SEQUENCING, CEREBROSPINAL FLUID (CSF), IDENTIFICATION OF PATHOGENIC BACTERIA, VIRUSES, PARASITES, OR FUNGI		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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, MICROSATELLITE INSTABILITY AND TUMOR MUTATIO		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0328U	DRUG ASSAY, DEFINITIVE, 120 OR MORE DRUGS AND METABOLITES, URINE, QUANTITATIVE LIQUID CHROMATOGRAPHY WITH TANDEM MASS SPECTROMETRY (LC-MS/MS), INCLUDES SPECIMEN VALIDITY AND ALGORITHMIC ANALYSIS DESCRIBING DRUG OR METABOLITE AND PRESENCE OR ABSENCE OF RIS		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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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 FRO		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0330T	TEAR FILM IMAGING, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0331T	MYOCARDIAL SYMPATHETIC INNERVATION IMAGING, PLANAR QUALITATIVE AND QUANTITATIVE ASSESSMENT;		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 ALTERATIONS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0332T	MYOCARDIAL SYMPATHETIC INNERVATION IMAGING, PLANAR QUALITATIVE AND QUANTITATIVE ASSESSMENT; WITH TOMOGRAPHIC SPECT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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-GAMMA-CARBOXY-PROTHROMBIN (DCP), ALG		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0334U	ONCOLOGY (SOLID ORGAN), TARGETED GENOMIC SEQUENCE ANALYSIS, FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TUMOR TISSUE, DNA ANALYSIS, 84 OR MORE GENES, INTERROGATION FOR SEQUENCE VARIANTS, GENE COPY NUMBER AMPLIFICATIONS, GENE REARRANGEMENTS, MICROSATELLITE INS		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0335T	INSERTION OF SINUS TARSI IMPLANT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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, MITOCHONDRIAL		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
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, MITOCHONDRIAL		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
0338T	TRANSCATHETER RENAL SYMPATHETIC DENERVATION, PERCUTANEOUS APPROACH INCLUDING ARTERIAL PUNCTURE, SELECTIVE CATHETER PLACEMENT(S) RENAL ARTERY(IES), FLUOROSCOPY, CONTRAST INJECTION(S), INTRAPROCEDURAL ROADMAPPING AND RADIOLOGICAL SUPERVISION AND INTERPRETAT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0339T	TRANSCATHETER RENAL SYMPATHETIC DENERVATION, PERCUTANEOUS APPROACH INCLUDING ARTERIAL PUNCTURE, SELECTIVE CATHETER PLACEMENT(S) RENAL ARTERY(IES), FLUOROSCOPY, CONTRAST INJECTION(S), INTRAPROCEDURAL ROADMAPPING AND RADIOLOGICAL SUPERVISION AND INTERPRETAT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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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		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
0342T	THERAPEUTIC APHERESIS WITH SELECTIVE HDL DELIPIDATION AND PLASMA REINFUSION		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 REPORTED QUALITATIVELY AS		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 PROSTATE CANCER		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0345U	PSYCHIATRY (EG, DEPRESSION, ANXIETY, ATTENTION DEFICIT HYPERACTIVITY DISORDER [ADHD]), GENOMIC ANALYSIS PANEL, VARIANT ANALYSIS OF 15 GENES, INCLUDING DELETION/DUPLICATION ANALYSIS OF CYP2D6		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
0347T	PLACEMENT OF INTERSTITIAL DEVICE(S) IN BONE FOR RADIOSTEREOMETRIC ANALYSIS (RSA)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0347U	DRUG METABOLISM OR PROCESSING (MULTIPLE CONDITIONS), WHOLE BLOOD OR BUCCAL SPECIMEN, DNA ANALYSIS, 16 GENE REPORT, WITH VARIANT ANALYSIS AND REPORTED PHENOTYPES		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0348T	RADIOLOGIC EXAMINATION, RADIOSTEREOMETRIC ANALYSIS (RSA); SPINE, (INCLUDES CERVICAL, THORACIC AND LUMBOSACRAL, WHEN PERFORMED)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0348U	DRUG METABOLISM OR PROCESSING (MULTIPLE CONDITIONS), WHOLE BLOOD OR BUCCAL SPECIMEN, DNA ANALYSIS, 25 GENE REPORT, WITH VARIANT ANALYSIS AND REPORTED PHENOTYPES		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0349T	RADIOLOGIC EXAMINATION, RADIOSTEREOMETRIC ANALYSIS (RSA); UPPER EXTREMITY(IES), (INCLUDES SHOULDER, ELBOW, AND WRIST, WHEN PERFORMED)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0350T	RADIOLOGIC EXAMINATION, RADIOSTEREOMETRIC ANALYSIS (RSA); LOWER EXTREMITY(IES), (INCLUDES HIP, PROXIMAL FEMUR, KNEE, AND ANKLE, WHEN PERFORMED)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0350U	DRUG METABOLISM OR PROCESSING (MULTIPLE CONDITIONS), WHOLE BLOOD OR BUCCAL SPECIMEN, DNA ANALYSIS, 27 GENE REPORT, WITH VARIANT ANALYSIS AND REPORTED PHENOTYPES		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0351U	INFECTIOUS DISEASE (BACTERIAL OR VIRAL), BIOCHEMICAL ASSAYS, TUMOR NECROSIS FACTOR-RELATED APOPTOSIS-INDUCING LIGAND (TRAIL), INTERFERON GAMMA-INDUCED PROTEIN-10 (IP-10), AND C-REACTIVE PROTEIN, SERUM, OR VENOUS WHOLE BLOOD, ALGORITHM REPORTED AS LIKELIHO		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0355U	APOL1 (APOLIPOPROTEIN L1) (EG, CHRONIC KIDNEY DISEASE), RISK VARIANTS (G1, G2)		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0356U	ONCOLOGY (OROPHARYNGEAL OR ANAL), EVALUATION OF 17 DNA BIOMARKERS USING DROPLET DIGITAL PCR (DDPCR), CELL-FREE DNA, ALGORITHM REPORTED AS A PROGNOSTIC RISK SCORE FOR CANCER RECURRENCE		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0358T	BIOELECTRICAL IMPEDANCE ANALYSIS WHOLE BODY COMPOSITION ASSESSMENT, WITH INTERPRETATION AND REPORT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0358U	NEUROLOGY (MILD COGNITIVE IMPAIRMENT), ANALYSIS OF Î²-AMYLOID 1-42 AND 1-40, CHEMILUMINESCENCE ENZYME IMMUNOASSAY, CEREBRAL SPINAL FLUID, REPORTED AS POSITIVE, LIKELY POSITIVE, OR NEGATIVE		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0359U	ONCOLOGY (PROSTATE CANCER), ANALYSIS OF ALL PROSTATE-SPECIFIC ANTIGEN (PSA) STRUCTURAL ISOFORMS BY PHASE SEPARATION AND IMMUNOASSAY, PLASMA, ALGORITHM REPORTS RISK OF CANCER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0361U	NEUROFILAMENT LIGHT CHAIN, DIGITAL IMMUNOASSAY, PLASMA, QUANTITATIVE		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0362T	BEHAVIOR IDENTIFICATION SUPPORTING ASSESSMENT, EACH 15 MINUTES OF TECHNICIANS' TIME FACE-TO-FACE WITH A PATIENT, REQUIRING THE FOLLOWING COMPONENTS: ADMINISTRATION BY THE PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL WHO IS ON SITE; WITH THE ASSIS		4/15/2020	InterQual® Evidence-Based Criteria & Guidelines	
0362U	ONCOLOGY (PAPILLARY THYROID CANCER), GENE-EXPRESSION PROFILING VIA TARGETED HYBRID CAPTURE-ENRICHMENT RNA SEQUENCING OF 82 CONTENT GENES AND 10 HOUSEKEEPING GENES, FINE NEEDLE ASPIRATE OR FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, ALGORITHM REPORTED		12/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0363U	ONCOLOGY (UROTHELIAL), MRNA, GENE-EXPRESSION PROFILING BY REAL-TIME QUANTITATIVE PCR OF 5 GENES (MDK, HOXA13, CDC2 [CDK1], IGFBP5, AND CXCR2), UTILIZING URINE, ALGORITHM INCORPORATES AGE, SEX, SMOKING HISTORY, AND MACROHEMATURIA FREQUENCY, REPORTED AS A R		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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) WITH QUANTI		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0365U	ONCOLOGY (BLADDER), ANALYSIS OF 10 PROTEIN BIOMARKERS (A1AT, ANG, APOE, CA9, IL8, MMP9, MMP10, PAI1, SDC1, AND VEGFA) BY IMMUNOASSAYS, URINE, ALGORITHM REPORTED AS A PROBABILITY OF BLADDER CANCER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0366U	ONCOLOGY (BLADDER), ANALYSIS OF 10 PROTEIN BIOMARKERS (A1AT, ANG, APOE, CA9, IL8, MMP9, MMP10, PAI1, SDC1, AND VEGFA) BY IMMUNOASSAYS, URINE, ALGORITHM REPORTED AS A PROBABILITY OF RECURRENT BLADDER CANCER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0367U	ONCOLOGY (BLADDER), ANALYSIS OF 10 PROTEIN BIOMARKERS (A1AT, ANG, APOE, CA9, IL8, MMP9, MMP10, PAI1, SDC1, AND VEGFA) BY IMMUNOASSAYS, URINE, DIAGNOSTIC ALGORITHM REPORTED AS A RISK SCORE FOR PROBABILITY OF RAPID RECURRENCE OF RECURRENT OR PERSISTENT CANC		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0368U	ONCOLOGY (COLORECTAL CANCER), EVALUATION FOR MUTATIONS OF APC, BRAF, CTNNB1, KRAS, NRAS, PIK3CA, SMAD4, AND TP53, AND METHYLATION MARKERS (MYO1G, KCNQ5, C9ORF50, FLI1, CLIP4, ZNF132, AND TWIST1), MULTIPLEX QUANTITATIVE POLYMERASE CHAIN REACTION (QPCR), CI		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0369U	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA AND RNA), GASTROINTESTINAL PATHOGENS, 31 BACTERIAL, VIRAL, AND PARASITIC ORGANISMS AND IDENTIFICATION OF 21 ASSOCIATED ANTIBIOTIC-RESISTANCE GENES, MULTIPLEX AMPLIFIED PROBE TECHNIQUE		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0373T	ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION, EACH 15 MINUTES OF TECHNICIANS' TIME FACE-TO-FACE WITH A PATIENT, REQUIRING THE FOLLOWING COMPONENTS: ADMINISTRATION BY THE PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL WHO IS ON SITE; WITH		4/15/2020	InterQual® Evidence-Based Criteria & Guidelines	
0375T	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY WITH END PLATE PREPARATION (INCLUDES OSTEOPHYTECTOMY FOR NERVE ROOT OR SPINAL CORD DECOMPRESSION AND MICRODISSECTION), CERVICAL, THREE OR MORE LEVELS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0375U	ONCOLOGY (OVARIAN), BIOCHEMICAL ASSAYS OF 7 PROTEINS (FOLLICLE STIMULATING HORMONE, HUMAN EPIDIDYMIS PROTEIN 4, APOLIPOPROTEIN A-1, TRANSFERRIN, BETA-2 MACROGLOBULIN, PREALBUMIN [IE, TRANSTHYRETIN], AND CANCER ANTIGEN 125), ALGORITHM REPORTED AS OVARIAN C		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 DEPRIVA		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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)		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0378U	RFC1 (REPLICATION FACTOR C SUBUNIT 1), REPEAT EXPANSION VARIANT ANALYSIS BY TRADITIONAL AND REPEAT-PRIMED PCR, BLOOD, SALIVA, OR BUCCAL SWAB		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 INSTABILITY, AND TU		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0381U	MAPLE SYRUP URINE DISEASE MONITORING BY PATIENT-COLLECTED BLOOD CARD SAMPLE, QUANTITATIVE MEASUREMENT OF ALLO-ISOLEUCINE, LEUCINE, ISOLEUCINE, AND VALINE, LIQUID CHROMATOGRAPHY WITH TANDEM MASS SPECTROMETRY (LC-MS/MS)		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0382U	HYPERPHENYLALANINEMIA MONITORING BY PATIENT-COLLECTED BLOOD CARD SAMPLE, QUANTITATIVE MEASUREMENT OF PHENYLALANINE AND TYROSINE, LIQUID CHROMATOGRAPHY WITH TANDEM MASS SPECTROMETRY (LC-MS/MS)		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0383U	TYROSINEMIA TYPE I MONITORING BY PATIENT-COLLECTED BLOOD CARD SAMPLE, QUANTITATIVE MEASUREMENT OF TYROSINE, PHENYLALANINE, METHIONINE, SUCCINYLACETONE, NITISINONE, LIQUID CHROMATOGRAPHY WITH TANDEM MASS SPECTROMETRY (LC-MS/MS)		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0384U	NEPHROLOGY (CHRONIC KIDNEY DISEASE), CARBOXYMETHYLLYSINE, METHYLGLYOXAL HYDROIMIDAZOLONE, AND CARBOXYETHYL LYSINE BY LIQUID CHROMATOGRAPHY WITH TANDEM MASS SPECTROMETRY (LC-MS/MS) AND HBA1C AND ESTIMATED GLOMERULAR FILTRATION RATE (GFR), WITH RISK SCORE R		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0385U	NEPHROLOGY (CHRONIC KIDNEY DISEASE), APOLIPOPROTEIN A4 (APOA4), CD5 ANTIGEN-LIKE (CD5L), AND INSULIN-LIKE GROWTH FACTOR BINDING PROTEIN 3 (IGFBP3) BY ENZYME-LINKED IMMUNOASSAY (ELISA), PLASMA, ALGORITHM COMBINING RESULTS WITH HDL, ESTIMATED GLOMERULAR FIL		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0387U	ONCOLOGY (MELANOMA), AUTOPHAGY AND BECLIN 1 REGULATOR 1 (AMBRA1) AND LORICRIN (AMLO) BY IMMUNOHISTOCHEMISTRY, FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, REPORT FOR RISK OF PROGRESSION		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 DET		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0389U	PEDIATRIC FEBRILE ILLNESS (KAWASAKI DISEASE [KD]), INTERFERON ALPHA-INDUCIBLE PROTEIN 27 (IFI27) AND MAST CELL-EXPRESSED MEMBRANE PROTEIN 1 (MCEMP1), RNA, USING QUANTITATIVE REVERSE TRANSCRIPTION POLYMERASE CHAIN REACTION (RT-QPCR), BLOOD, REPORTED AS A R		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0390U	OBSTETRICS (PREECLAMPSIA), KINASE INSERT DOMAIN RECEPTOR (KDR), ENDOGLIN (ENG), AND RETINOL-BINDING PROTEIN 4 (RBP4), BY IMMUNOASSAY, SERUM, ALGORITHM REPORTED AS A RISK SCORE		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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, SPLICE-SITE VARIANTS, INSERTIONS/DELETIONS, COPY NUMBER ALTERATIONS		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0393U	NEUROLOGY (EG, PARKINSON DISEASE, DEMENTIA WITH LEWY BODIES), CEREBROSPINAL FLUID (CSF), DETECTION OF MISFOLDED Î±-SYNUCLEIN PROTEIN BY SEED AMPLIFICATION ASSAY, QUALITATIVE		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0394T	HIGH DOSE RATE ELECTRONIC BRACHYTHERAPY, SKIN SURFACE APPLICATION, PER FRACTION, INCLUDES BASIC DOSIMETRY, WHEN PERFORMED		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0394U	PERFLUOROALKYL SUBSTANCES (PFAS) (EG, PERFLUOROOCTANOIC ACID, PERFLUOROOCTANE SULFONIC ACID), 16 PFAS COMPOUNDS BY LIQUID CHROMATOGRAPHY WITH TANDEM MASS SPECTROMETRY (LC-MS/MS), PLASMA OR SERUM, QUANTITATIVE		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0395U	ONCOLOGY (LUNG), MULTI-OMICS (MICROBIAL DNA BY SHOTGUN NEXT-GENERATION SEQUENCING AND CARCINOEMBRYONIC ANTIGEN AND OSTEOPONTIN BY IMMUNOASSAY), PLASMA, ALGORITHM REPORTED AS MALIGNANCY RISK FOR LUNG NODULES IN EARLY-STAGE DISEASE		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0397T	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP), WITH OPTICAL ENDOMICROSCOPY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0398U	GASTROENTEROLOGY (BARRETT'S 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		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0399T	MYOCARDIAL STRAIN IMAGING (QUANTITATIVE ASSESSMENT OF MYOCARDIAL MECHANICS USING IMAGE-BASED ANALYSIS OF LOCAL MYOCARDIAL DYNAMICS)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0400U	OBSTETRICS (EXPANDED CARRIER SCREENING), 145 GENES BY NEXT-GENERATION SEQUENCING, FRAGMENT ANALYSIS AND MULTIPLEX LIGATION-DEPENDENT PROBE AMPLIFICATION, DNA, REPORTED AS CARRIER POSITIVE OR NEGATIVE		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0401U	CARDIOLOGY (CORONARY HEART DISEASE [CHD]), 9 GENES (12 VARIANTS), TARGETED VARIANT GENOTYPING, BLOOD, SALIVA, OR BUCCAL SWAB, ALGORITHM REPORTED AS A GENETIC RISK SCORE FOR A CORONARY EVENT		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0403U	ONCOLOGY (PROSTATE), MRNA, GENE EXPRESSION PROFILING OF 18 GENES, FIRST-CATCH URINE, ALGORITHM REPORTED AS PERCENTAGE OF LIKELIHOOD OF DETECTING CLINICALLY SIGNIFICANT PROSTATE CANCER		12/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0404U	ONCOLOGY (BREAST), SEMIQUANTITATIVE MEASUREMENT OF THYMIDINE KINASE ACTIVITY BY IMMUNOASSAY, SERUM, RESULTS REPORTED AS RISK OF DISEASE PROGRESSION		12/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0405U	ONCOLOGY (PANCREATIC), 59 METHYLATION HAPLOTYPE BLOCK MARKERS, NEXT-GENERATION SEQUENCING, PLASMA, REPORTED AS CANCER SIGNAL DETECTED OR NOT DETECTED		12/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		12/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0407U	NEPHROLOGY (DIABETIC CHRONIC KIDNEY DISEASE [CKD]), MULTIPLEX ELECTROCHEMILUMINESCENT IMMUNOASSAY (ECLIA) OF SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR 1 (STNFR1), SOLUBLE TUMOR NECROSIS RECEPTOR 2 (STNFR2), AND KIDNEY INJURY MOLECULE 1 (KIM-1) COMBINED WITH		12/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0408U	INFECTIOUS AGENT ANTIGEN DETECTION BY BULK ACOUSTIC WAVE BIOSENSOR IMMUNOASSAY, SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2) (CORONAVIRUS DISEASE [COVID-19])		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0409U	ONCOLOGY (SOLID TUMOR), DNA (80 GENES) AND RNA (36 GENES), BY NEXT-GENERATION SEQUENCING FROM PLASMA, INCLUDING SINGLE NUCLEOTIDE VARIANTS, INSERTIONS/DELETIONS, COPY NUMBER ALTERATIONS, MICROSATELLITE INSTABILITY, AND FUSIONS, REPORT SHOWING IDENTIFIED M		12/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0410U	ONCOLOGY (PANCREATIC), DNA, WHOLE GENOME SEQUENCING WITH 5-HYDROXYMETHYLCYTOSINE ENRICHMENT, WHOLE BLOOD OR PLASMA, ALGORITHM REPORTED AS CANCER DETECTED OR NOT DETECTED		12/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0411U	PSYCHIATRY (EG, DEPRESSION, ANXIETY, ATTENTION DEFICIT HYPERACTIVITY DISORDER [ADHD]), GENOMIC ANALYSIS PANEL, VARIANT ANALYSIS OF 15 GENES, INCLUDING DELETION/DUPLICATION ANALYSIS OF CYP2D6		12/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0412U	BETA AMYLOID, Aí²42/40 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 PRESENCE OR ABSENCE O		12/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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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		12/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0414U	ONCOLOGY (LUNG), AUGMENTATIVE ALGORITHMIC ANALYSIS OF DIGITIZED WHOLE SLIDE IMAGING FOR 8 GENES (ALK, BRAF, EGFR, ERBB2, MET, NTRK1-3, RET, ROS1), AND KRAS G12C AND PD-L1, IF PERFORMED, FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, REPORTED AS POSITIVE		12/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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) SCO		12/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 CHANGES, DELETIONS, INSERTIONS,		12/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0418U	ONCOLOGY (BREAST), AUGMENTATIVE ALGORITHMIC ANALYSIS OF DIGITIZED WHOLE SLIDE IMAGING OF 8 HISTOLOGIC AND IMMUNOHISTOCHEMICAL FEATURES, REPORTED AS A RECURRENCE SCORE		12/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0419T	DESTRUCTION OF NEUROFIBROMA, EXTENSIVE (CUTANEOUS, DERMAL EXTENDING INTO SUBCUTANEOUS); FACE, HEAD AND NECK, GREATER THAN 50 NEUROFIBROMAS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0419U	NEUROPSYCHIATRY (EG, DEPRESSION, ANXIETY), GENOMIC SEQUENCE ANALYSIS PANEL, VARIANT ANALYSIS OF 13 GENES, SALIVA OR BUCCAL SWAB, REPORT OF EACH GENE PHENOTYPE		12/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0420T	DESTRUCTION OF NEUROFIBROMA, EXTENSIVE (CUTANEOUS, DERMAL EXTENDING INTO SUBCUTANEOUS); TRUNK AND EXTREMITIES, EXTENSIVE, GREATER THAN 100 NEUROFIBROMAS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0420U	ONCOLOGY (UROTHELIAL), MRNA EXPRESSION PROFILING BY REAL-TIME QUANTITATIVE PCR OF MDK, HOXA13, CDC2, IGFBP5, AND CXCR2 IN COMBINATION WITH DROPLET DIGITAL PCR (DDPCR) ANALYSIS OF 6 SINGLE-NUCLEOTIDE POLYMORPHISMS (SNPS) OF GENES TERT AND FGFR3, URINE, ALG		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 WHEN P		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0421U	ONCOLOGY (COLORECTAL) SCREENING, QUANTITATIVE REAL-TIME TARGET AND SIGNAL AMPLIFICATION OF 8 RNA MARKERS (GAPDH, SMAD4, ACY1, AREG, CDH1, KRAS, TNFRSF10B, EGLN2) AND FECAL HEMOGLOBIN, ALGORITHM REPORTED AS A POSITIVE OR NEGATIVE FOR COLORECTAL CANCER RISK		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0422U	ONCOLOGY (PAN-SOLID TUMOR), ANALYSIS OF DNA BIOMARKER RESPONSE TO ANTI-CANCER THERAPY USING CELL-FREE CIRCULATING DNA, BIOMARKER COMPARISON TO A PREVIOUS BASELINE PRE-TREATMENT CELL-FREE CIRCULATING DNA ANALYSIS USING NEXT-GENERATION SEQUENCING, ALGORITHM		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0423T	SECRETORY TYPE II PHOSPHOLIPASE A2 (SPLA2-IIA)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0424T	COMPLETE SYSTEM (TRANSVENOUS PLACEMENT OF RIGHT OR LEFT STIMULATION LEAD, SENSING LEAD, IMPLANTABLE PULSE GENERATOR)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0424U	ONCOLOGY (PROSTATE), EXOSOME-BASED ANALYSIS OF 53 SMALL NONCODING RNAS (SNCRNAS) BY QUANTITATIVE REVERSE TRANSCRIPTION POLYMERASE CHAIN REACTION (RT-QPCR), URINE, REPORTED AS NO MOLECULAR EVIDENCE, LOW-, MODERATE-, OR ELEVATED-RISK OF PROSTATE CANCER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0425T	INSERTION OR REPLACEMENT OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; SENSING LEAD ONLY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0425U	GENOME (EG, UNEXPLAINED CONSTITUTIONAL OR HERITABLE DISORDER OR SYNDROME), RAPID SEQUENCE ANALYSIS, EACH COMPARATOR GENOME (EG, PARENTS, SIBLINGS)		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
0426T	INSERTION OR REPLACEMENT OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; STIMULATION LEAD ONLY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0426U	GENOME (EG, UNEXPLAINED CONSTITUTIONAL OR HERITABLE DISORDER OR SYNDROME), ULTRA-RAPID SEQUENCE ANALYSIS		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
0427T	INSERTION OR REPLACEMENT OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; PULSE GENERATOR ONLY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0428T	REMOVAL OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; PULSE GENERATOR ONLY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0428U	ONCOLOGY (BREAST), TARGETED HYBRID-CAPTURE GENOMIC SEQUENCE ANALYSIS PANEL, CIRCULATING TUMOR DNA (CTDNA) ANALYSIS OF 56 OR MORE GENES, INTERROGATION FOR SEQUENCE VARIANTS, GENE COPY NUMBER AMPLIFICATIONS, GENE REARRANGEMENTS, MICROSATELLITE INSTABILITY,		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0429T	REMOVAL OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; SENSING LEAD ONLY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0430T	REMOVAL OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; STIMULATION LEAD ONLY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0430U	GASTROENTEROLOGY, MALABSORPTION EVALUATION OF ALPHA-1-ANTITRYPSIN, CALPROTECTIN, PANCREATIC ELASTASE AND REDUCING SUBSTANCES, FECES, QUANTITATIVE		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
0431T	REMOVAL AND REPLACEMENT OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA, PULSE GENERATOR ONLY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0431U	GLYCINE RECEPTOR ALPHA1 IGG, SERUM OR CEREBROSPINAL FLUID (CSF), LIVE CELL-BINDING ASSAY (LCBA), QUALITATIVE		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0432T	REPOSITIONING OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; STIMULATION LEAD ONLY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0432U	KELCH-LIKE PROTEIN 11 (KLHL11) ANTIBODY, SERUM OR CEREBROSPINAL FLUID (CSF), CELL-BINDING ASSAY, QUALITATIVE		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0433T	REPOSITIONING OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; SENSING LEAD ONLY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0433U	ONCOLOGY (PROSTATE), 5 DNA REGULATORY MARKERS BY QUANTITATIVE PCR, WHOLE BLOOD, ALGORITHM, INCLUDING PROSTATE-SPECIFIC ANTIGEN, REPORTED AS LIKELIHOOD OF CANCER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0434T	INTERROGATION DEVICE EVALUATION IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM FOR CENTRAL SLEEP APNEA		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0434U	DRUG METABOLISM (ADVERSE DRUG REACTIONS AND DRUG RESPONSE), GENOMIC ANALYSIS PANEL, VARIANT ANALYSIS OF 25 GENES WITH REPORTED PHENOTYPES		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0435T	PROGRAMMING DEVICE EVALUATION OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM FOR CENTRAL SLEEP APNEA; SINGLE SESSION		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0436T	PROGRAMMING DEVICE EVALUATION OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM FOR CENTRAL SLEEP APNEA; DURING SLEEP STUDY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0436U	ONCOLOGY (LUNG), PLASMA ANALYSIS OF 388 PROTEINS, USING APTAMER-BASED PROTEOMICS TECHNOLOGY, PREDICTIVE ALGORITHM REPORTED AS CLINICAL BENEFIT FROM IMMUNE CHECKPOINT INHIBITOR THERAPY		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0437U	PSYCHIATRY (ANXIETY DISORDERS), MRNA, GENE EXPRESSION PROFILING BY RNA SEQUENCING OF 15 BIOMARKERS, WHOLE BLOOD, ALGORITHM REPORTED AS PREDICTIVE RISK SCORE		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0440U	CARDIOLOGY (CORONARY HEART DISEASE [CHD]), DNA, ANALYSIS OF 10 SINGLE-NUCLEOTIDE POLYMORPHISMS (SNPS) (RS710987 [LINC010019], RS1333048 [CDKN2B-AS1], RS12129789 [KCND3], RS942317 [KTN1-AS1], RS1441433 [PPP3CA], RS2869675 [PREX1], RS4639796 [ZBTB41], RS437		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
0441U	INFECTIOUS DISEASE (BACTERIAL, FUNGAL, OR VIRAL INFECTION), SEMIQUANTITATIVE BIOMECHANICAL ASSESSMENT (VIA DEFORMABILITY CYTOMETRY), WHOLE BLOOD, WITH ALGORITHMIC ANALYSIS AND RESULT REPORTED AS AN INDEX		9/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0442U	INFECTIOUS DISEASE (RESPIRATORY INFECTION), MYXOVIRUS RESISTANCE PROTEIN A (MXA) AND C-REACTIVE PROTEIN (CRP), FINGERSTICK WHOLE BLOOD SPECIMEN, EACH BIOMARKER REPORTED AS PRESENT OR ABSENT		9/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0443U	NEUROFILAMENT LIGHT CHAIN (NFL), ULTRA-SENSITIVE IMMUNOASSAY, SERUM OR CEREBROSPINAL FLUID		9/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0444T	INITIAL PLACEMENT OF A DRUG-ELUTING OCULAR INSERT UNDER ONE OR MORE EYELIDS, INCLUDING FITTING, TRAINING, AND INSERTION, UNILATERAL OR BILATERAL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0444U	ONCOLOGY (SOLID ORGAN NEOPLASIA), TARGETED GENOMIC SEQUENCE ANALYSIS PANEL OF 361 GENES, INTERROGATION FOR GENE FUSIONS, TRANSLOCATIONS, OR OTHER REARRANGEMENTS, USING DNA FROM FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TUMOR TISSUE, REPORT OF CLINICALLY SIG		9/1/2024	OncoHealth Global Medical Necessity Review criteria	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0445U	Î²-AMYLOID (ABETA42) AND PHOSPHO TAU (181P) (PTAU181), ELECTROCHEMILUMINESCENT IMMUNOASSAY (ECLIA), CEREBRAL SPINAL FLUID, RATIO REPORTED AS POSITIVE OR NEGATIVE FOR AMYLOID PATHOLOGY		9/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0450U	ONCOLOGY (MULTIPLE MYELOMA), LIQUID CHROMATOGRAPHY WITH TANDEM MASS SPECTROMETRY (LC-MS/MS), MONOCLONAL PARAPROTEIN SEQUENCING ANALYSIS, SERUM, RESULTS REPORTED AS BASELINE PRESENCE OR ABSENCE OF DETECTABLE CLONOTYPIC PEPTIDES		9/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0451T	COMPLETE SYSTEM (COUNTERPULSATION DEVICE, VASCULAR GRAFT, IMPLANTABLE VASCULAR HEMOSTATIC SEAL, MECHANO-ELECTRICAL SKIN INTERFACE AND SUBCUTANEOUS ELECTRODES)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0451U	ONCOLOGY (MULTIPLE MYELOMA), LC-MS/MS, PEPTIDE ION QUANTIFICATION, SERUM, RESULTS COMPARED WITH BASELINE TO DETERMINE MONOCLONAL PARAPROTEIN ABUNDANCE		9/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0452T	INSERTION OR REPLACEMENT OF A PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM, ENDOVASCULAR APPROACH, AND PROGRAMMING OF SENSING AND THERAPEUTIC PARAMETERS; AORTIC COUNTERPULSATION DEVICE AND VASCULAR HEMOSTATIC SEAL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0452U	ONCOLOGY (BLADDER), METHYLATED PENK DNA DETECTION BY LINEAR TARGET ENRICHMENT-QUANTITATIVE METHYLATION-SPECIFIC REAL-TIME PCR (LTE-QMSP), URINE, REPORTED AS LIKELIHOOD OF BLADDER CANCER		9/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0453T	INSERTION OR REPLACEMENT OF A PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM, ENDOVASCULAR APPROACH, AND PROGRAMMING OF SENSING AND THERAPEUTIC PARAMETERS; MECHANO-ELECTRICAL SKIN INTERFACE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0453U	ONCOLOGY (COLORECTAL CANCER), CELL-FREE DNA (CFDNA), METHYLATION-BASED QUANTITATIVE PCR ASSAY (SEPTIN9, IKZF1, BCAT1, SEPTIN9-2, VAV3, BCAN), PLASMA, REPORTED AS PRESENCE OR ABSENCE OF CIRCULATING TUMOR DNA (CTDNA)		9/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0454T	INSERTION OR REPLACEMENT OF A PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM, ENDOVASCULAR APPROACH, AND PROGRAMMING OF SENSING AND THERAPEUTIC PARAMETERS; SUBCUTANEOUS ELECTRODE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0455T	COMPLETE SYSTEM (AORTIC COUNTERPULSATION DEVICE, VASCULAR HEMOSTATIC SEAL, MECHANO-ELECTRICAL SKIN INTERFACE AND ELECTRODES)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0456T	REMOVAL OF PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM; AORTIC COUNTERPULSATION DEVICE AND VASCULAR HEMOSTATIC SEAL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		9/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0457T	REMOVAL OF PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM; MECHANO-ELECTRICAL SKIN INTERFACE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0458T	REMOVAL OF PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM; SUBCUTANEOUS ELECTRODE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0459T	RELOCATION OF SKIN POCKET WITH REPLACEMENT OF IMPLANTED AORTIC COUNTERPULSATION VENTRICULAR ASSIST DEVICE, MECHANO-ELECTRICAL SKIN INTERFACE AND ELECTRODES		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0460T	REPOSITIONING OF PREVIOUSLY IMPLANTED AORTIC COUNTERPULSATION VENTRICULAR ASSIST DEVICE; SUBCUTANEOUS ELECTRODE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		9/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0461T	REPOSITIONING OF PREVIOUSLY IMPLANTED AORTIC COUNTERPULSATION VENTRICULAR ASSIST DEVICE; AORTIC COUNTERPULSATION DEVICE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		9/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0462T	PROGRAMMING DEVICE EVALUATION (IN PERSON) WITH ITERATIVE ADJUSTMENT OF THE IMPLANTABLE MECHANO-ELECTRICAL SKIN INTERFACE AND/OR EXTERNAL DRIVER TO TEST THE FUNCTION OF THE DEVICE AND SELECT OPTIMAL PERMANENT PROGRAMMED VALUES WITH ANALYSIS, INCLUDING REVI		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0463T	INTERROGATION DEVICE EVALUATION (IN PERSON) WITH ANALYSIS, REVIEW AND REPORT, INCLUDES CONNECTION, RECORDING AND DISCONNECTION PER PATIENT ENCOUNTER, IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM, PER DAY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0463U	ONCOLOGY (CERVIX), MRNA GENE EXPRESSION PROFILING OF 14 BIOMARKERS (E6 AND E7 OF THE HIGHEST-RISK HUMAN PAPILLOMAVIRUS [HPV] TYPES 16, 18, 31, 33, 45, 52, 58), BY REAL-TIME NUCLEIC ACID SEQUENCE-BASED AMPLIFICATION (NASBA), EXO- OR ENDOCERVICAL EPITHELIAL		9/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0464T	VISUAL EVOKED POTENTIAL, TESTING FOR GLAUCOMA, WITH INTERPRETATION AND REPORT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0464U	ONCOLOGY (COLORECTAL) SCREENING, QUANTITATIVE REAL-TIME TARGET AND SIGNAL AMPLIFICATION, METHYLATED DNA MARKERS, INCLUDING LASS4, LRRC4 AND PPP2R5C, A REFERENCE MARKER ZDHHC1, AND A PROTEIN MARKER (FECAL HEMOGLOBIN), UTILIZING STOOL, ALGORITHM REPORTED AS		9/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0465T	SUPRACHOROIDAL INJECTION OF A PHARMACOLOGIC AGENT (DOES NOT INCLUDE SUPPLY OF MEDICATION)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0465U	ONCOLOGY (UROTHELIAL CARCINOMA), DNA, QUANTITATIVE METHYLATION-SPECIFIC PCR OF 2 GENES (ONECUT2, VIM), ALGORITHMIC ANALYSIS REPORTED AS POSITIVE OR NEGATIVE		9/1/2024	OncoHealth Global Medical Necessity Review criteria	InterQual® Evidence-Based Criteria & Guidelines
0467U	ONCOLOGY (BLADDER), DNA, NEXT-GENERATION SEQUENCING (NGS) OF 60 GENES AND WHOLE GENOME ANEUPLOIDY, URINE, ALGORITHMS REPORTED AS MINIMAL RESIDUAL DISEASE (MRD) STATUS POSITIVE OR NEGATIVE AND QUANTITATIVE DISEASE BURDEN		9/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		9/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0469T	RETINAL POLARIZATION SCAN, OCULAR SCREENING WITH ON-SITE AUTOMATED RESULTS, BILATERAL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 PATTERN THAT		9/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0470U	ONCOLOGY (OROPHARYNGEAL), DETECTION OF MINIMAL RESIDUAL DISEASE BY NEXT-GENERATION SEQUENCING (NGS) BASED QUANTITATIVE EVALUATION OF 8 DNA TARGETS, CELL-FREE HPV 16 AND 18 DNA FROM PLASMA		9/1/2024	OncoHealth Global Medical Necessity Review criteria	InterQual® Evidence-Based Criteria & Guidelines
0471U	ONCOLOGY (COLORECTAL CANCER), QUALITATIVE REAL-TIME PCR OF 35 VARIANTS OF KRAS AND NRAS GENES (EXONS 2, 3, 4), FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE), PREDICTIVE, IDENTIFICATION OF DETECTED MUTATIONS		9/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0472T	DEVICE EVALUATION, INTERROGATION, AND INITIAL PROGRAMMING OF INTRAOCULAR RETINAL ELECTRODE ARRAY (EG, RETINAL PROSTHESIS), IN PERSON, WITH ITERATIVE ADJUSTMENT OF THE IMPLANTABLE DEVICE TO TEST FUNCTIONALITY, SELECT OPTIMAL PERMANENT PROGRAMMED VALUES WIT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0473T	DEVICE EVALUATION AND INTERROGATION OF INTRAOCULAR RETINAL ELECTRODE ARRAY (EG, RETINAL PROSTHESIS), IN PERSON, INCLUDING REPROGRAMMING AND VISUAL TRAINING, WHEN PERFORMED, WITH REVIEW AND REPORT BY A QUALIFIED HEALTH CARE PROFESSIONAL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0476U	DRUG METABOLISM, PSYCHIATRY (EG, MAJOR DEPRESSIVE DISORDER, GENERAL ANXIETY DISORDER, ATTENTION DEFICIT HYPERACTIVITY DISORDER [ADHD], SCHIZOPHRENIA), WHOLE BLOOD, BUCCAL SWAB, AND PHARMACOGENOMIC GENOTYPING OF 14 GENES AND CYP2D6 COPY NUMBER VARIANT ANAL		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0477U	DRUG METABOLISM, PSYCHIATRY (EG, MAJOR DEPRESSIVE DISORDER, GENERAL ANXIETY DISORDER, ATTENTION DEFICIT HYPERACTIVITY DISORDER [ADHD], SCHIZOPHRENIA), WHOLE BLOOD, BUCCAL SWAB, AND PHARMACOGENOMIC GENOTYPING OF 14 GENES AND CYP2D6 COPY NUMBER VARIANT ANAL		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0478U	ONCOLOGY (NON-SMALL CELL LUNG CANCER), DNA AND RNA, DIGITAL PCR ANALYSIS OF 9 GENES (EGFR, KRAS, BRAF, ALK, ROS1, RET, NTRK 1/2/3, ERBB2, AND MET) IN FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, INTERROGATION FOR SINGLE-NUCLEOTIDE VARIANTS, INSERTIONS/		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0479U	TAU, PHOSPHORYLATED, PTAU217		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0480U	INFECTIOUS DISEASE (BACTERIA, VIRUSES, FUNGI, AND PARASITES), CEREBROSPINAL FLUID (CSF), METAGENOMIC NEXT-GENERATION SEQUENCING (DNA AND RNA), BIOINFORMATIC ANALYSIS, WITH POSITIVE PATHOGEN IDENTIFICATION		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0481T	INJECTION(S), AUTOLOGOUS WHITE BLOOD CELL CONCENTRATE (AUTOLOGOUS PROTEIN SOLUTION), ANY SITE, INCLUDING IMAGE GUIDANCE, HARVESTING AND PREPARATION, WHEN PERFORMED		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0481U	IDH1 (ISOCITRATE DEHYDROGENASE 1 [NADP+]), IDH2 (ISOCITRATE DEHYDROGENASE 2 [NADP+]), AND TERT (TELOMERASE REVERSE TRANSCRIPTASE) PROMOTER (EG, CENTRAL NERVOUS SYSTEM [CNS] TUMORS), NEXT-GENERATION SEQUENCING (SINGLE-NUCLEOTIDE VARIANTS [SNV], DELETIONS,		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
0482U	OBSTETRICS (PREECLAMPSIA), BIOCHEMICAL ASSAY OF SOLUBLE FMS-LIKE TYROSINE KINASE 1 (SFLT-1) AND PLACENTAL GROWTH FACTOR (PLGF), SERUM, RATIO REPORTED FOR SFLT-1/PLGF, WITH RISK OF PROGRESSION FOR PREECLAMPSIA WITH SEVERE FEATURES WITHIN 2 WEEKS		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0485T	OPTICAL COHERENCE TOMOGRAPHY (OCT) OF MIDDLE EAR, WITH INTERPRETATION AND REPORT; UNILATERAL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0485U	ONCOLOGY (SOLID TUMOR), CELL-FREE DNA AND RNA BY NEXT-GENERATION SEQUENCING, INTERPRETATIVE REPORT FOR GERMLINE MUTATIONS, CLONAL HEMATOPOIESIS OF INDETERMINATE POTENTIAL, AND TUMOR-DERIVED SINGLE-NUCLEOTIDE VARIANTS, SMALL INSERTIONS/DELETIONS, COPY NUMB		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0486T	OPTICAL COHERENCE TOMOGRAPHY (OCT) OF MIDDLE EAR, WITH INTERPRETATION AND REPORT; BILATERAL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0486U	ONCOLOGY (PAN-SOLID TUMOR), NEXT-GENERATION SEQUENCING ANALYSIS OF TUMOR METHYLATION MARKERS PRESENT IN CELL-FREE CIRCULATING TUMOR DNA, ALGORITHM REPORTED AS QUANTITATIVE MEASUREMENT OF METHYLATION AS A CORRELATE OF TUMOR FRACTION		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0487U	ONCOLOGY (SOLID TUMOR), CELL-FREE CIRCULATING DNA, TARGETED GENOMIC SEQUENCE ANALYSIS PANEL OF 84 GENES, INTERROGATION FOR SEQUENCE VARIANTS, ANEUPLOIDY-CORRECTED GENE COPY NUMBER AMPLIFICATIONS AND LOSSES, GENE REARRANGEMENTS, AND MICROSATELLITE INSTABIL		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0488U	OBSTETRICS (FETAL ANTIGEN NONINVASIVE PRENATAL TEST), CELL-FREE DNA SEQUENCE ANALYSIS FOR DETECTION OF FETAL PRESENCE OR ABSENCE OF 1 OR MORE OF THE RH, C, C, D, E, DUFFY (FYA), OR KELL (K) ANTIGEN IN ALLOIMMUNIZED PREGNANCIES, REPORTED AS SELECTED ANTIGE		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0489U	OBSTETRICS (SINGLE-GENE NONINVASIVE PRENATAL TEST), CELL-FREE DNA SEQUENCE ANALYSIS OF 1 OR MORE TARGETS (EG, CFTR, SMN1, HBB, HBA1, HBA2) TO IDENTIFY PATERNALLY INHERITED PATHOGENIC VARIANTS, AND RELATIVE MUTATION-DOSAGE ANALYSIS BASED ON MOLECULAR COUNT		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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, PERIPHERAL BLOOD		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 R		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 PROT		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0494U	RED BLOOD CELL ANTIGEN (FETAL RHD GENE ANALYSIS), NEXT-GENERATION SEQUENCING OF CIRCULATING CELL-FREE DNA (CFDNA) OF BLOOD IN PREGNANT INDIVIDUALS KNOWN TO BE RHD NEGATIVE, REPORTED AS POSITIVE OR NEGATIVE		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0495U	ONCOLOGY (PROSTATE), ANALYSIS OF CIRCULATING PLASMA PROTEINS (TPSA, FPSA, KLK2, PSP94, AND GDF15), GERMLINE POLYGENIC RISK SCORE (60 VARIANTS), CLINICAL INFORMATION (AGE, FAMILY HISTORY OF PROSTATE CANCER, PRIOR NEGATIVE PROSTATE BIOPSY), ALGORITHM REPORT		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0496U	ONCOLOGY (COLORECTAL), CELL-FREE DNA, 8 GENES FOR MUTATIONS, 7 GENES FOR METHYLATION BY REAL-TIME RT-PCR, AND 4 PROTEINS BY ENZYME-LINKED IMMUNOSORBENT ASSAY, BLOOD, REPORTED POSITIVE OR NEGATIVE FOR COLORECTAL CANCER OR ADVANCED ADENOMA RISK		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0497U	ONCOLOGY (PROSTATE), MRNA GENE-EXPRESSION PROFILING BY REAL-TIME RT-PCR OF 6 GENES (FOXM1, MCM3, MTUS1, TTC21B, ALAS1, AND PPP2CA), UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, ALGORITHM REPORTED AS A RISK SCORE FOR PROSTATE CANCER		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0498U	ONCOLOGY (COLORECTAL), NEXT-GENERATION SEQUENCING FOR MUTATION DETECTION IN 43 GENES AND METHYLATION PATTERN IN 45 GENES, BLOOD, AND FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, REPORT OF VARIANTS AND METHYLATION PATTERN WITH INTERPRETATION		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0499T	CYSTOURETHROSCOPY, WITH MECHANICAL DILATION AND URETHRAL THERAPEUTIC DRUG DELIVERY FOR URETHRAL STRICTURE OR STENOSIS, INCLUDING FLUOROSCOPY, WHEN PERFORMED		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0499U	ONCOLOGY (COLORECTAL AND LUNG), DNA FROM FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, NEXT-GENERATION SEQUENCING OF 8 GENES (NRAS, EGFR, CTNNB1, PIK3CA, APC, BRAF, KRAS, AND TP53), MUTATION DETECTION		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0500U	AUTOINFLAMMATORY DISEASE (VEXAS SYNDROME), DNA, UBA1 GENE MUTATIONS, TARGETED VARIANT ANALYSIS (M41T, M41V, M41L, C.118-2A>C, C.118-1G>C, C.118-9_118-2DEL, S56F, S621C)		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
0501U	ONCOLOGY (COLORECTAL), BLOOD, QUANTITATIVE MEASUREMENT OF CELL-FREE DNA (CFDNA)		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0503U	NEUROLOGY (ALZHEIMER DISEASE), BETA AMYLOID (AÎ²40, AÎ²42, AÎ²42/40 RATIO) AND TAU-PROTEIN (PTAU217, NP-TAU217, PTAU217/NP-TAU217 RATIO), BLOOD, IMMUNOPRECIPITATION WITH QUANTITATION BY LIQUID CHROMATOGRAPHY WITH TANDEM MASS SPECTROMETRY (LC-MS/MS), ALGOR		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0504U	INFECTIOUS DISEASE (URINARY TRACT INFECTION), IDENTIFICATION OF 17 PATHOLOGIC ORGANISMS, URINE, REAL-TIME PCR, REPORTED AS POSITIVE OR NEGATIVE FOR EACH ORGANISM		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0505U	INFECTIOUS DISEASE (VAGINAL INFECTION), IDENTIFICATION OF 32 PATHOGENIC ORGANISMS, SWAB, REAL-TIME PCR, REPORTED AS POSITIVE OR NEGATIVE FOR EACH ORGANISM		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0506U	GASTROENTEROLOGY (BARRETT'S ESOPHAGUS), ESOPHAGEAL CELLS, DNA METHYLATION ANALYSIS BY NEXT-GENERATION SEQUENCING OF AT LEAST 89 DIFFERENTIALLY METHYLATED GENOMIC REGIONS, ALGORITHM REPORTED AS LIKELIHOOD FOR BARRETT'S ESOPHAGUS		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0507T	NEAR INFRARED DUAL IMAGING (IE, SIMULTANEOUS REFLECTIVE AND TRANSILLUMINATED LIGHT) OF MEIBOMIAN GLANDS, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0507U	ONCOLOGY (OVARIAN), DNA, WHOLE-GENOME SEQUENCING WITH 5-HYDROXYMETHYLCYTOSINE (5HMC) ENRICHMENT, USING WHOLE BLOOD OR PLASMA, ALGORITHM REPORTED AS CANCER DETECTED OR NOT DETECTED		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0508T	PULSE-ECHO ULTRASOUND BONE DENSITY MEASUREMENT RESULTING IN INDICATOR OF AXIAL BONE MINERAL DENSITY, TIBIA		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0510T	REMOVAL OF SINUS TARSI IMPLANT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0510U	ONCOLOGY (PANCREATIC CANCER), AUGMENTATIVE ALGORITHMIC ANALYSIS OF 16 GENES FROM PREVIOUSLY SEQUENCED RNA WHOLE-TRANSCRIPTOME DATA, REPORTED AS PROBABILITY OF PREDICTED MOLECULAR SUBTYPE		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0511T	REMOVAL AND REINSERTION OF SINUS TARSI IMPLANT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0511U	ONCOLOGY (SOLID TUMOR), TUMOR CELL CULTURE IN 3D MICROENVIRONMENT, 36 OR MORE DRUG PANEL, REPORTED AS TUMOR-RESPONSE PREDICTION FOR EACH DRUG		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0512T	EXTRACORPOREAL SHOCK WAVE FOR INTEGUMENTARY WOUND HEALING, INCLUDING TOPICAL APPLICATION AND DRESSING CARE; INITIAL WOUND		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0512U	ONCOLOGY (PROSTATE), AUGMENTATIVE ALGORITHMIC ANALYSIS OF DIGITIZED WHOLE-SLIDE IMAGING OF HISTOLOGIC FEATURES FOR MICROSATELLITE INSTABILITY (MSI) STATUS, FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, REPORTED AS INCREASED OR DECREASED PROBABILITY OF M		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0513U	ONCOLOGY (PROSTATE), AUGMENTATIVE ALGORITHMIC ANALYSIS OF DIGITIZED WHOLE-SLIDE IMAGING OF HISTOLOGIC FEATURES FOR MICROSATELLITE INSTABILITY (MSI) AND HOMOLOGOUS RECOMBINATION DEFICIENCY (HRD) STATUS, FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, REPOR		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 (ÂµG/ML)		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 BATTERY])		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 (ÂµG/ML)		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0516T	INSERTION OF WIRELESS CARDIAC STIMULATOR FOR LEFT VENTRICULAR PACING, INCLUDING DEVICE INTERROGATION AND PROGRAMMING, AND IMAGING SUPERVISION AND INTERPRETATION, WHEN PERFORMED; ELECTRODE ONLY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0516U	DRUG METABOLISM, WHOLE BLOOD, PHARMACOGENOMIC GENOTYPING OF 40 GENES AND CYP2D6 COPY NUMBER VARIANT ANALYSIS, REPORTED AS METABOLIZER STATUS		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0517T	INSERTION OF WIRELESS CARDIAC STIMULATOR FOR LEFT VENTRICULAR PACING, INCLUDING DEVICE INTERROGATION AND PROGRAMMING, AND IMAGING SUPERVISION AND INTERPRETATION, WHEN PERFORMED; BOTH COMPONENTS OF PULSE GENERATOR (BATTERY AND TRANSMITTER) ONLY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0517U	THERAPEUTIC DRUG MONITORING, 80 OR MORE PSYCHOACTIVE DRUGS OR SUBSTANCES, LC-MS/MS, PLASMA, QUALITATIVE AND QUANTITATIVE THERAPEUTIC MINIMALLY AND MAXIMALLY EFFECTIVE DOSE OF PRESCRIBED AND NON-PRESCRIBED MEDICATIONS		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0518T	REMOVAL OF PULSE GENERATOR FOR WIRELESS CARDIAC STIMULATOR FOR LEFT VENTRICULAR PACING; BATTERY COMPONENT ONLY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0518U	THERAPEUTIC DRUG MONITORING, 90 OR MORE PAIN AND MENTAL HEALTH DRUGS OR SUBSTANCES, LC-MS/MS, PLASMA, QUALITATIVE AND QUANTITATIVE THERAPEUTIC MINIMALLY EFFECTIVE RANGE OF PRESCRIBED AND NON-PRESCRIBED MEDICATIONS		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0519T	REMOVAL AND REPLACEMENT OF PULSE GENERATOR FOR WIRELESS CARDIAC STIMULATOR FOR LEFT VENTRICULAR PACING, INCLUDING DEVICE INTERROGATION AND PROGRAMMING; BOTH COMPONENTS (BATTERY AND TRANSMITTER)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0519U	THERAPEUTIC DRUG MONITORING, MEDICATIONS SPECIFIC TO PAIN, DEPRESSION, AND ANXIETY, LC-MS/MS, PLASMA, 110 OR MORE DRUGS OR SUBSTANCES, QUALITATIVE AND QUANTITATIVE THERAPEUTIC MINIMALLY EFFECTIVE RANGE OF PRESCRIBED, NON-PRESCRIBED, AND ILLICIT MEDICATION		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0520T	REMOVAL AND REPLACEMENT OF PULSE GENERATOR FOR WIRELESS CARDIAC STIMULATOR FOR LEFT VENTRICULAR PACING, INCLUDING DEVICE INTERROGATION AND PROGRAMMING; BATTERY COMPONENT ONLY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0520U	THERAPEUTIC DRUG MONITORING, 200 OR MORE DRUGS OR SUBSTANCES, LC-MS/MS, PLASMA, QUALITATIVE AND QUANTITATIVE THERAPEUTIC MINIMALLY EFFECTIVE RANGE OF PRESCRIBED AND NON-PRESCRIBED MEDICATIONS		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 LEF		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0524T	ENDOVENOUS CATHETER DIRECTED CHEMICAL ABLATION WITH BALLOON ISOLATION OF INCOMPETENT EXTREMITY VEIN, OPEN OR PERCUTANEOUS, INCLUDING ALL VASCULAR ACCESS, CATHETER MANIPULATION, DIAGNOSTIC IMAGING, IMAGING GUIDANCE AND MONITORING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0531U	INFECTIOUS DISEASE (ACID-FAST BACTERIA AND INVASIVE FUNGI), DNA (673 ORGANISMS), NEXT-GENERATION SEQUENCING, PLASMA		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 SAMPLE, R		6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	Evidence of Coverage (EOC, Plan coverage docu ment)
0533T	RADIOSTEREOMETRIC ANALYSIS (RSA) - INCLUDES SET-UP, PATIENT TRAINING, CONFIGURATION OF MONITOR, DATA UPLOAD, ANALYSIS AND INITIAL REPORT CONFIGURATION, DOWNLOAD REVIEW, INTERPRETATION AND REPORT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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), REPORTED AS METABOLIZER STATUS AND TRANSPORTER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0534T	RADIOSTEREOMETRIC ANALYSIS (RSA) -SET-UP, PATIENT TRAINING, CONFIGURATION OF MONITOR		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0534U	ONCOLOGY (PROSTATE), MICRORNA, SINGLE-NUCLEOTIDE POLYMORPHISMS (SNPS) ANALYSIS BY RT-PCR OF 32 VARIANTS, USING BUCCAL SWAB, ALGORITHM REPORTED AS A RISK SCORE		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0535T	RADIOSTEREOMETRIC ANALYSIS (RSA) - -DATA UPLOAD, ANALYSIS AND INITIAL REPORT CONFIGURATION		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0535U	PERFLUOROALKYL SUBSTANCES (PFAS) (EG, PERFLUOROOCTANOIC ACID, PERFLUOROOCTANE SULFONIC ACID), BY LIQUID CHROMATOGRAPHY WITH TANDEM MASS SPECTROMETRY (LC-MS/MS), PLASMA OR SERUM, QUANTITATIVE		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0536T	RADIOSTEREOMETRIC ANALYSIS (RSA) - DOWNLOAD REVIEW, INTERPRETATION AND REPORT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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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		6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	Evidence of Coverage (EOC, Plan coverage docu ment)
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		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 INSTABILITY, USING		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	Evidence of Coverage (EOC, Plan coverage docu ment)
0541U	CARDIOVASCULAR DISEASE (HDL REVERSE CHOLESTEROL TRANSPORT), CHOLESTEROL EFFLUX CAPACITY, LC-MS/MS, QUANTITATIVE MEASUREMENT OF 5 DISTINCT HDL-BOUND APOLIPOPROTEINS (APOLIPOPROTEINS A1, C1, C2, C3, AND C4), SERUM, ALGORITHM REPORTED AS PREDICTION OF CORONA		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0542U	NEPHROLOGY (RENAL TRANSPLANT), URINE, NUCLEAR MAGNETIC RESONANCE (NMR) SPECTROSCOPY MEASUREMENT OF 84 URINARY METABOLITES, COMBINED WITH PATIENT DATA, QUANTIFICATION OF BK VIRUS (HUMAN POLYOMAVIRUS 1) USING REAL-TIME PCR AND SERUM CREATININE, ALGORITHM RE		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 GENES AN		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0546T	RADIOFREQUENCY SPECTROSCOPY, REAL TIME, INTRAOPERATIVE MARGIN ASSESSMENT, AT THE TIME OF PARTIAL MASTECTOMY, WITH REPORT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0546U	LOW-DENSITY LIPOPROTEIN RECEPTOR-RELATED PROTEIN 4 (LRP4), ANTIBODY IDENTIFICATION BY IMMUNOFLUORESCENCE, USING LIVE CELLS, REPORTED AS POSITIVE OR NEGATIVE		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0547T	BONE-MATERIAL QUALITY TESTING BY MICROINDENTATION(S) OF THE TIBIA(S), WITH RESULTS REPORTED AS A SCORE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0547U	NEUROFILAMENT LIGHT CHAIN (NFL), CHEMILUMINESCENT ENZYME IMMUNOASSAY, PLASMA, QUANTITATIVE		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0548U	GLIAL FIBRILLARY ACIDIC PROTEIN (GFAP), CHEMILUMINESCENT ENZYME IMMUNOASSAY, USING PLASMA		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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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)		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0550U	ONCOLOGY (PROSTATE), ENZYME-LINKED IMMUNOSORBENT ASSAYS (ELISA) FOR TOTAL PROSTATE-SPECIFIC ANTIGEN (PSA) AND FREE PSA, SERUM, COMBINED WITH AGE, PREVIOUS NEGATIVE PROSTATE BIOPSY STATUS, DIGITAL RECTAL EXAMINATION FINDINGS, PROSTATE VOLUME, AND IMAGE AND		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0551U	TAU, PHOSPHORYLATED, PTAU217, BY SINGLE-MOLECULE ARRAY (ULTRASENSITIVE DIGITAL PROTEIN DETECTION), USING PLASMA		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0553T	PERCUTANEOUS TRANSCATHETER PLACEMENT OF ILIAC ARTERIOVENOUS ANASTOMOSIS IMPLANT, INCLUSIVE OF ALL RADIOLOGICAL SUPERVISION AND INTERPRETATION, INTRAPROCEDURAL ROADMAPPING, AND IMAGING GUIDANCE NECESSARY TO COMPLETE THE INTERVENTION		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0554T	BONE STRENGTH AND FRACTURE RISK USING FINITE ELEMENT ANALYSIS OF FUNCTIONAL DATA AND BONE-MINERAL DENSITY UTILIZING DATA FROM A COMPUTED TOMOGRAPHY SCAN; RETRIEVAL AND TRANSMISSION OF THE SCAN DATA, ASSESSMENT OF BONE STRENGTH AND FRACTURE RISK AND BONE-M		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0555T	BONE STRENGTH AND FRACTURE RISK USING FINITE ELEMENT ANALYSIS OF FUNCTIONAL DATA AND BONE-MINERAL DENSITY UTILIZING DATA FROM A COMPUTED TOMOGRAPHY SCAN; RETRIEVAL AND TRANSMISSION OF THE SCAN DATA		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0556T	BONE STRENGTH AND FRACTURE RISK USING FINITE ELEMENT ANALYSIS OF FUNCTIONAL DATA AND BONE-MINERAL DENSITY UTILIZING DATA FROM A COMPUTED TOMOGRAPHY SCAN; ASSESSMENT OF BONE STRENGTH AND FRACTURE RISK AND BONE-MINERAL DENSITY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0557T	BONE STRENGTH AND FRACTURE RISK USING FINITE ELEMENT ANALYSIS OF FUNCTIONAL DATA AND BONE-MINERAL DENSITY UTILIZING DATA FROM A COMPUTED TOMOGRAPHY SCAN; INTERPRETATION AND REPORT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0558T	COMPUTED TOMOGRAPHY SCAN TAKEN FOR THE PURPOSE OF BIOMECHANICAL COMPUTED TOMOGRAPHY ANALYSIS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0563T	EVACUATION OF MEIBOMIAN GLANDS, USING HEAT DELIVERED THROUGH WEARABLE, OPEN-EYE EYELID TREATMENT DEVICES AND MANUAL GLAND EXPRESSION, BILATERAL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0567T	PERMANENT FALLOPIAN TUBE OCCLUSION WITH DEGRADABLE BIOPOLYMER IMPLANT, TRANSCERVICAL APPROACH, INCLUDING TRANSVAGINAL ULTRASOUND		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0568T	INTRODUCTION OF MIXTURE OF SALINE AND AIR FOR SONOSALPINGOGRAPHY TO CONFIRM OCCLUSION OF FALLOPIAN TUBES, TRANSCERVICAL APPROACH, INCLUDING TRANSVAGINAL ULTRASOUND AND PELVIC ULTRASOUND		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0609T	MAGNETIC RESONANCE SPECTROSCOPY, DETERMINATION AND LOCALIZATION OF DISCOGENIC PAIN (CERVICAL, THORACIC, OR LUMBAR); ACQUISITION OF SINGLE VOXEL DATA, PER DISC, ON BIOMARKERS (IE, LACTIC ACID, CARBOHYDRATE, ALANINE, LAAL, PROPIONIC ACID, PROTEOGLYCAN, AND		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0610T	MAGNETIC RESONANCE SPECTROSCOPY, DETERMINATION AND LOCALIZATION OF DISCOGENIC PAIN (CERVICAL, THORACIC, OR LUMBAR); TRANSMISSION OF BIOMARKER DATA FOR SOFTWARE ANALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0611T	MAGNETIC RESONANCE SPECTROSCOPY, DETERMINATION AND LOCALIZATION OF DISCOGENIC PAIN (CERVICAL, THORACIC, OR LUMBAR); POSTPROCESSING FOR ALGORITHMIC ANALYSIS OF BIOMARKER DATA FOR DETERMINATION OF RELATIVE CHEMICAL DIFFERENCES BETWEEN DISCS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
0612T	MAGNETIC RESONANCE SPECTROSCOPY, DETERMINATION AND LOCALIZATION OF DISCOGENIC PAIN (CERVICAL, THORACIC, OR LUMBAR); INTERPRETATION AND REPORT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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 REVI		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 ANGIOGRAPH		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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, INTERP		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0627T	PERCUTANEOUS INJECTION OF ALLOGENEIC CELLULAR AND/OR TISSUE-BASED PRODUCT, INTERVERTEBRAL DISC, UNILATERAL OR BILATERAL INJECTION, WITH FLUOROSCOPIC GUIDANCE, LUMBAR; FIRST LEVEL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0627T	PERCUTANEOUS INJECTION OF ALLOGENEIC CELLULAR AND/OR TISSUE-BASED PRODUCT, INTERVERTEBRAL DISC, UNILATERAL OR BILATERAL INJECTION, WITH FLUOROSCOPIC GUIDANCE, LUMBAR; FIRST LEVEL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0629T	PERCUTANEOUS INJECTION OF ALLOGENEIC CELLULAR AND/OR TISSUE-BASED PRODUCT, INTERVERTEBRAL DISC, UNILATERAL OR BILATERAL INJECTION, WITH CT GUIDANCE, LUMBAR; FIRST LEVEL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0629T	PERCUTANEOUS INJECTION OF ALLOGENEIC CELLULAR AND/OR TISSUE-BASED PRODUCT, INTERVERTEBRAL DISC, UNILATERAL OR BILATERAL INJECTION, WITH CT GUIDANCE, LUMBAR; FIRST LEVEL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0631T	TRANSCUTANEOUS VISIBLE LIGHT HYPERSPECTRAL IMAGING MEASUREMENT OF OXYHEMOGLOBIN, DEOXYHEMOGLOBIN, AND TISSUE OXYGENATION, WITH INTERPRETATION AND REPORT, PER EXTREMITY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
0633T	COMPUTED TOMOGRAPHY, BREAST, INCLUDING 3D RENDERING, WHEN PERFORMED, UNILATERAL; WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0634T	COMPUTED TOMOGRAPHY, BREAST, INCLUDING 3D RENDERING, WHEN PERFORMED, UNILATERAL; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0635T	COMPUTED TOMOGRAPHY, BREAST, INCLUDING 3D RENDERING, WHEN PERFORMED, UNILATERAL; WITHOUT CONTRAST, FOLLOWED BY CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0636T	COMPUTED TOMOGRAPHY, BREAST, INCLUDING 3D RENDERING, WHEN PERFORMED, BILATERAL; WITHOUT CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0637T	COMPUTED TOMOGRAPHY, BREAST, INCLUDING 3D RENDERING, WHEN PERFORMED, BILATERAL; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0638T	COMPUTED TOMOGRAPHY, BREAST, INCLUDING 3D RENDERING, WHEN PERFORMED, BILATERAL; WITHOUT CONTRAST, FOLLOWED BY CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0650	HOSPICE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0651	HOSPICE, ROUTINE HOME CARE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0652	HOSPICE, CONTINUOUS HOME CARE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0656T	ANTERIOR LUMBAR OR THORACOLUMBAR VERTEBRAL BODY TETHERING; UP TO 7 VERTEBRAL SEGMENTS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0657T	ANTERIOR LUMBAR OR THORACOLUMBAR VERTEBRAL BODY TETHERING; 8 OR MORE VERTEBRAL SEGMENTS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0660T	IMPLANTATION OF ANTERIOR SEGMENT INTRAOCULAR NONBIODEGRADABLE DRUG-ELUTING SYSTEM, INTERNAL APPROACH		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0661T	REMOVAL AND REIMPLANTATION OF ANTERIOR SEGMENT INTRAOCULAR NONBIODEGRADABLE DRUG-ELUTING IMPLANT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0672T	ENDOVAGINAL CRYOGEN-COOLED, MONOPOLAR RADIOFREQUENCY REMODELING OF THE TISSUES SURROUNDING THE FEMALE BLADDER NECK AND PROXIMAL URETHRA FOR URINARY INCONTINENCE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 LEAD (LIS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 SEP		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0679T	LAPAROSCOPIC REMOVAL OF DIAPHRAGMATIC LEAD(S), PERMANENT IMPLANTABLE SYNCHRONIZED DIAPHRAGMATIC STIMULATION SYSTEM FOR AUGMENTATION OF CARDIAC FUNCTION		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0681T	RELOCATION OF PULSE GENERATOR ONLY, PERMANENT IMPLANTABLE SYNCHRONIZED DIAPHRAGMATIC STIMULATION SYSTEM FOR AUGMENTATION OF CARDIAC FUNCTION, WITH CONNECTION TO EXISTING DUAL LEADS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0682T	REMOVAL OF PULSE GENERATOR ONLY, PERMANENT IMPLANTABLE SYNCHRONIZED DIAPHRAGMATIC STIMULATION SYSTEM FOR AUGMENTATION OF CARDIAC FUNCTION		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 SYN		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 DIAPHRAGMA		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0686T	HISTOTRIPSY (IE, NON-THERMAL ABLATION VIA ACOUSTIC ENERGY DELIVERY) OF MALIGNANT HEPATOCELLULAR TISSUE, INCLUDING IMAGE GUIDANCE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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 ASSESSMENT FO		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0711T	NONINVASIVE ARTERIAL PLAQUE ANALYSIS USING SOFTWARE PROCESSING OF DATA FROM NON-CORONARY COMPUTERIZED TOMOGRAPHY ANGIOGRAPHY; DATA PREPARATION AND TRANSMISSION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
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 ASSESS A		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0713T	NONINVASIVE ARTERIAL PLAQUE ANALYSIS USING SOFTWARE PROCESSING OF DATA FROM NON-CORONARY COMPUTERIZED TOMOGRAPHY ANGIOGRAPHY; DATA REVIEW, INTERPRETATION AND REPORT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0762	CRISIS STABILIZATION BED 23 HOUR - PSYCHIATRIC/SUBSTANCE USE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0784T	INSERTION OR REPLACEMENT OF PERCUTANEOUS ELECTRODE ARRAY, SPINAL, WITH INTEGRATED NEUROSTIMULATOR, INCLUDING IMAGING GUIDANCE, WHEN PERFORMED		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
0785T	REVISION OR REMOVAL OF NEUROSTIMULATOR ELECTRODE ARRAY, SPINAL, WITH INTEGRATED NEUROSTIMULATOR		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
0786T	INSERTION OR REPLACEMENT OF PERCUTANEOUS ELECTRODE ARRAY, SACRAL, WITH INTEGRATED NEUROSTIMULATOR, INCLUDING IMAGING GUIDANCE, WHEN PERFORMED		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
0787T	REVISION OR REMOVAL OF NEUROSTIMULATOR ELECTRODE ARRAY, SACRAL, WITH INTEGRATED NEUROSTIMULATOR		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
0788T	ELECTRONIC ANALYSIS WITH SIMPLE 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 PAR		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
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 PA		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
0790T	REVISION (EG, AUGMENTATION, DIVISION OF TETHER), REPLACEMENT, OR REMOVAL OF THORACOLUMBAR OR LUMBAR VERTEBRAL BODY TETHERING, INCLUDING THORACOSCOPY, WHEN PERFORMED		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0791T	MOTOR-COGNITIVE, SEMI-IMMERSIVE VIRTUAL REALITY-FACILITATED GAIT TRAINING, EACH 15 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0794T	PATIENT-SPECIFIC, ASSISTIVE, RULES-BASED ALGORITHM FOR RANKING PHARMACO-ONCOLOGIC TREATMENT OPTIONS BASED ON THE PATIENT'S TUMOR-SPECIFIC CANCER MARKER INFORMATION OBTAINED FROM PRIOR MOLECULAR PATHOLOGY, IMMUNOHISTOCHEMICAL, OR OTHER PATHOLOGY RESULTS WH		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 PROGRAM		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0796T	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 PROGRAM		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0797T	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 PROGRAM		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 AN		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0799T	TRANSCATHETER REMOVAL OF PERMANENT DUAL-CHAMBER LEADLESS PACEMAKER, INCLUDING IMAGING GUIDANCE (EG, FLUOROSCOPY, VENOUS ULTRASOUND, RIGHT ATRIAL ANGIOGRAPHY, RIGHT VENTRICULOGRAPHY, FEMORAL VENOGRAPHY), WHEN PERFORMED; RIGHT ATRIAL PACEMAKER COMPONENT		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0800T	TRANSCATHETER REMOVAL OF PERMANENT DUAL-CHAMBER LEADLESS PACEMAKER, INCLUDING IMAGING GUIDANCE (EG, FLUOROSCOPY, VENOUS ULTRASOUND, RIGHT ATRIAL ANGIOGRAPHY, RIGHT VENTRICULOGRAPHY, FEMORAL VENOGRAPHY), WHEN PERFORMED; RIGHT VENTRICULAR PACEMAKER COMPONEN		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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, INTERROGAT		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0802T	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, INTERROGAT		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0803T	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, INTERROGAT		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 PR		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0805T	TRANSCATHETER SUPERIOR AND INFERIOR VENA CAVA PROSTHETIC VALVE IMPLANTATION (IE, CAVAL VALVE IMPLANTATION [CAVI]); PERCUTANEOUS FEMORAL VEIN APPROACH		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0806T	TRANSCATHETER SUPERIOR AND INFERIOR VENA CAVA PROSTHETIC VALVE IMPLANTATION (IE, CAVAL VALVE IMPLANTATION [CAVI]); OPEN FEMORAL VEIN APPROACH		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0807T	PULMONARY TISSUE VENTILATION ANALYSIS USING SOFTWARE-BASED PROCESSING OF DATA FROM SEPARATELY CAPTURED CINEFLUOROGRAPH IMAGES; IN COMBINATION WITH PREVIOUSLY ACQUIRED COMPUTED TOMOGRAPHY (CT) IMAGES, INCLUDING DATA PREPARATION AND TRANSMISSION, QUANTIFICA		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0808T	PULMONARY TISSUE VENTILATION ANALYSIS USING SOFTWARE-BASED PROCESSING OF DATA FROM SEPARATELY CAPTURED CINEFLUOROGRAPH IMAGES; IN COMBINATION WITH COMPUTED TOMOGRAPHY (CT) IMAGES TAKEN FOR THE PURPOSE OF PULMONARY TISSUE VENTILATION ANALYSIS, INCLUDING DA		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
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 T		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 T		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0818T	REVISION OR REMOVAL OF INTEGRATED NEUROSTIMULATION SYSTEM FOR BLADDER DYSFUNCTION, INCLUDING ANALYSIS, PROGRAMMING, AND IMAGING, WHEN PERFORMED, POSTERIOR TIBIAL NERVE; SUBCUTANEOUS		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0819T	REVISION OR REMOVAL OF INTEGRATED NEUROSTIMULATION SYSTEM FOR BLADDER DYSFUNCTION, INCLUDING ANALYSIS, PROGRAMMING, AND IMAGING, WHEN PERFORMED, POSTERIOR TIBIAL NERVE; SUBFASCIAL		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0820T	CONTINUOUS IN-PERSON MONITORING AND INTERVENTION (EG, PSYCHOTHERAPY, CRISIS INTERVENTION), AS NEEDED, DURING PSYCHEDELIC MEDICATION THERAPY; FIRST PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, EACH HOUR		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0821T	CONTINUOUS IN-PERSON MONITORING AND INTERVENTION (EG, PSYCHOTHERAPY, CRISIS INTERVENTION), AS NEEDED, DURING PSYCHEDELIC MEDICATION THERAPY; SECOND PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, CONCURRENT WITH FIRST PHYSICIAN OR OTHER QUALIFIED H		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0822T	CONTINUOUS IN-PERSON MONITORING AND INTERVENTION (EG, PSYCHOTHERAPY, CRISIS INTERVENTION), AS NEEDED, DURING PSYCHEDELIC MEDICATION THERAPY; CLINICAL STAFF UNDER THE DIRECTION OF A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, CONCURRENT WITH FIR		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 EVALUA		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0859T	NONCONTACT NEAR-INFRARED SPECTROSCOPY (EG, FOR MEASUREMENT OF DEOXYHEMOGLOBIN, OXYHEMOGLOBIN, AND RATIO OF TISSUE OXYGENATION), OTHER THAN FOR SCREENING FOR PERIPHERAL ARTERIAL DISEASE, IMAGE ACQUISITION, INTERPRETATION, AND REPORT; EACH ADDITIONAL ANATOM		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0860T	NONCONTACT NEAR-INFRARED SPECTROSCOPY (EG, FOR MEASUREMENT OF DEOXYHEMOGLOBIN, OXYHEMOGLOBIN, AND RATIO OF TISSUE OXYGENATION), FOR SCREENING FOR PERIPHERAL ARTERIAL DISEASE, INCLUDING PROVOCATIVE MANEUVERS, IMAGE ACQUISITION, INTERPRETATION, AND REPORT,		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0861T	REMOVAL OF PULSE GENERATOR FOR WIRELESS CARDIAC STIMULATOR FOR LEFT VENTRICULAR PACING; BOTH COMPONENTS (BATTERY AND TRANSMITTER)		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0862T	RELOCATION OF PULSE GENERATOR FOR WIRELESS CARDIAC STIMULATOR FOR LEFT VENTRICULAR PACING, INCLUDING DEVICE INTERROGATION AND PROGRAMMING; BATTERY COMPONENT ONLY		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0863T	RELOCATION OF PULSE GENERATOR FOR WIRELESS CARDIAC STIMULATOR FOR LEFT VENTRICULAR PACING, INCLUDING DEVICE INTERROGATION AND PROGRAMMING; TRANSMITTER COMPONENT ONLY		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0864T	LOW-INTENSITY EXTRACORPOREAL SHOCK WAVE THERAPY INVOLVING CORPUS CAVERNOSUM, LOW ENERGY		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0901T	PLACEMENT OF BONE MARROW SAMPLING PORT, INCLUDING IMAGING GUIDANCE WHEN PERFORMED		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
0905	INTENSIVE OUTPATIENT MENTAL HEALTH PROGRAM 3-4 HOURS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0906	INTENSIVE OUTPATIENT SUBSTANCE ABUSE 3-4 HOURS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 PROCEDURE)		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0908T	OPEN IMPLANTATION OF INTEGRATED NEUROSTIMULATION SYSTEM, VAGUS NERVE, INCLUDING ANALYSIS AND PROGRAMMING, WHEN PERFORMED	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
0910	CRISIS INTERVENTION MENTAL HEALTH SERVICE DAY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0912	PARTIAL HOSPITALIZATION- MENTAL HEALTH/SUBSTANCE ABUSE/EATING DISORDER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0913	PARTIAL HOSPITALIZATION- MENTAL HEALTH/SUBSTANCE ABUSE/EATING DISORDER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
0913T	PERCUTANEOUS TRANSCATHETER THERAPEUTIC DRUG DELIVERY BY INTRACORONARY DRUG-DELIVERY BALLOON (EG, DRUG-COATED, DRUG-ELUTING), INCLUDING MECHANICAL DILATION BY NONDRUG-DELIVERY BALLOON ANGIOPLASTY, ENDOLUMINAL IMAGING USING INTRAVASCULAR ULTRASOUND (IVUS) O		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
0914T	PERCUTANEOUS TRANSCATHETER THERAPEUTIC DRUG DELIVERY BY INTRACORONARY DRUG-DELIVERY BALLOON (EG, DRUG-COATED, DRUG-ELUTING) PERFORMED ON A SEPARATE TARGET LESION FROM THE TARGET LESION TREATED WITH BALLOON ANGIOPLASTY, CORONARY STENT PLACEMENT OR CORONARY		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
0915T	INSERTION OF PERMANENT CARDIAC CONTRACTILITY MODULATION-DEFIBRILLATION SYSTEM COMPONENT(S), INCLUDING FLUOROSCOPIC GUIDANCE, AND EVALUATION AND PROGRAMMING OF SENSING AND THERAPEUTIC PARAMETERS; PULSE GENERATOR AND DUAL TRANSVENOUS ELECTRODES/LEADS (PACIN		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0917T	INSERTION OF PERMANENT CARDIAC CONTRACTILITY MODULATION-DEFIBRILLATION SYSTEM COMPONENT(S), INCLUDING FLUOROSCOPIC GUIDANCE, AND EVALUATION AND PROGRAMMING OF SENSING AND THERAPEUTIC PARAMETERS; SINGLE TRANSVENOUS LEAD (PACING OR DEFIBRILLATION) ONLY		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0919T	REMOVAL OF A PERMANENT CARDIAC CONTRACTILITY MODULATION-DEFIBRILLATION SYSTEM COMPONENT(S); PULSE GENERATOR ONLY		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0921T	REMOVAL OF A PERMANENT CARDIAC CONTRACTILITY MODULATION-DEFIBRILLATION SYSTEM COMPONENT(S); SINGLE TRANSVENOUS DEFIBRILLATION LEAD ONLY		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0922T	REMOVAL OF A PERMANENT CARDIAC CONTRACTILITY MODULATION-DEFIBRILLATION SYSTEM COMPONENT(S); DUAL (PACING AND DEFIBRILLATION) TRANSVENOUS LEADS ONLY		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0923T	REMOVAL AND REPLACEMENT OF PERMANENT CARDIAC CONTRACTILITY MODULATION-DEFIBRILLATION PULSE GENERATOR ONLY		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0924T	REPOSITIONING OF PREVIOUSLY IMPLANTED CARDIAC CONTRACTILITY MODULATION-DEFIBRILLATION TRANSVENOUS ELECTRODE(S)/LEAD(S), INCLUDING FLUOROSCOPIC GUIDANCE AND PROGRAMMING OF SENSING AND THERAPEUTIC PARAMETERS		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0925T	RELOCATION OF SKIN POCKET FOR IMPLANTED CARDIAC CONTRACTILITY MODULATION-DEFIBRILLATION PULSE GENERATOR		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0926T	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 M		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0927T	INTERROGATION DEVICE EVALUATION (IN PERSON) WITH ANALYSIS, REVIEW, AND REPORT, INCLUDING CONNECTION, RECORDING, AND DISCONNECTION, PER PATIENT ENCOUNTER, IMPLANTABLE CARDIAC CONTRACTILITY MODULATION-DEFIBRILLATION SYSTEM		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0928T	INTERROGATION DEVICE EVALUATION (REMOTE), UP TO 90 DAYS, CARDIAC CONTRACTILITY MODULATION-DEFIBRILLATION SYSTEM WITH INTERIM ANALYSIS AND REPORT(S) BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0929T	INTERROGATION DEVICE EVALUATION (REMOTE), UP TO 90 DAYS, CARDIAC CONTRACTILITY MODULATION-DEFIBRILLATION SYSTEM, REMOTE DATA ACQUISITION(S), RECEIPT OF TRANSMISSIONS, TECHNICIAN REVIEW, TECHNICAL SUPPORT, AND DISTRIBUTION OF RESULTS		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0930T	ELECTROPHYSIOLOGIC EVALUATION OF CARDIAC CONTRACTILITY MODULATION-DEFIBRILLATOR LEADS, INCLUDING DEFIBRILLATION-THRESHOLD EVALUATION (INDUCTION OF ARRHYTHMIA, EVALUATION OF SENSING AND THERAPY FOR ARRHYTHMIA TERMINATION), AT TIME OF INITIAL IMPLANTATION O		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0931T	ELECTROPHYSIOLOGIC EVALUATION OF CARDIAC CONTRACTILITY MODULATION-DEFIBRILLATOR LEADS, INCLUDING DEFIBRILLATION-THRESHOLD EVALUATION (INDUCTION OF ARRHYTHMIA, EVALUATION OF SENSING AND THERAPY FOR ARRHYTHMIA TERMINATION), SEPARATE FROM INITIAL IMPLANTATIO		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0932T	NONINVASIVE DETECTION OF HEART FAILURE DERIVED FROM AUGMENTATIVE ANALYSIS OF AN ECHOCARDIOGRAM THAT DEMONSTRATED PRESERVED EJECTION FRACTION, WITH INTERPRETATION AND REPORT BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0933T	TRANSCATHETER IMPLANTATION OF WIRELESS LEFT ATRIAL PRESSURE SENSOR FOR LONG-TERM LEFT ATRIAL PRESSURE MONITORING, INCLUDING SENSOR CALIBRATION AND DEPLOYMENT, RIGHT HEART CATHETERIZATION, TRANSSEPTAL PUNCTURE, IMAGING GUIDANCE, AND RADIOLOGICAL SUPERVISIO		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0934T	REMOTE MONITORING OF A WIRELESS LEFT ATRIAL PRESSURE SENSOR FOR UP TO 30 DAYS, INCLUDING DATA FROM DAILY UPLOADS OF LEFT ATRIAL PRESSURE RECORDINGS, INTERPRETATION(S) AND TREND ANALYSIS, WITH ADJUSTMENTS TO THE DIURETICS PLAN, TREATMENT PARADIGM THRESHOLD		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0935T	CYSTOURETHROSCOPY WITH RENAL PELVIC SYMPATHETIC DENERVATION, RADIOFREQUENCY ABLATION, RETROGRADE URETERAL APPROACH, INCLUDING INSERTION OF GUIDE WIRE, SELECTIVE PLACEMENT OF URETERAL SHEATH(S) AND MULTIPLE CONFORMABLE ELECTRODES, CONTRAST INJECTION(S), AN		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0936T	PHOTOBIOMODULATION THERAPY OF RETINA, SINGLE SESSION		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0937T	EXTERNAL ELECTROCARDIOGRAPHIC RECORDING FOR GREATER THAN 15 DAYS UP TO 30 DAYS BY CONTINUOUS RHYTHM RECORDING AND STORAGE; INCLUDING RECORDING, SCANNING ANALYSIS WITH REPORT, REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSI		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
0938T	EXTERNAL ELECTROCARDIOGRAPHIC RECORDING FOR GREATER THAN 15 DAYS UP TO 30 DAYS BY CONTINUOUS RHYTHM RECORDING AND STORAGE; RECORDING (INCLUDING CONNECTION AND INITIAL RECORDING)		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
0939T	EXTERNAL ELECTROCARDIOGRAPHIC RECORDING FOR GREATER THAN 15 DAYS UP TO 30 DAYS BY CONTINUOUS RHYTHM RECORDING AND STORAGE; SCANNING ANALYSIS WITH REPORT		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
0940T	EXTERNAL ELECTROCARDIOGRAPHIC RECORDING FOR GREATER THAN 15 DAYS UP TO 30 DAYS BY CONTINUOUS RHYTHM RECORDING AND STORAGE; REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
0941T	CYSTOURETHROSCOPY, FLEXIBLE; WITH INSERTION AND EXPANSION OF PROSTATIC URETHRAL SCAFFOLD USING INTEGRATED CYSTOSCOPIC VISUALIZATION		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0942T	CYSTOURETHROSCOPY, FLEXIBLE; WITH REMOVAL AND REPLACEMENT OF PROSTATIC URETHRAL SCAFFOLD		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0943T	CYSTOURETHROSCOPY, FLEXIBLE; WITH REMOVAL OF PROSTATIC URETHRAL SCAFFOLD		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0944T	3D CONTOUR SIMULATION OF TARGET LIVER LESION(S) AND MARGIN(S) FOR IMAGE-GUIDED PERCUTANEOUS MICROWAVE ABLATION		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0947T	MAGNETIC RESONANCE IMAGE GUIDED LOW INTENSITY FOCUSED ULTRASOUND (MRGFUS), STEREOTACTIC BLOOD-BRAIN BARRIER DISRUPTION USING MICROBUBBLE RESONATORS TO INCREASE THE CONCENTRATION OF BLOOD-BASED BIOMARKERS OF TARGET, INTRACRANIAL, INCLUDING STEREOTACTIC NAV		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0950T	ABLATION OF BENIGN PROSTATE TISSUE, TRANSRECTAL, WITH HIGH INTENSITYÂ€“FOCUSED ULTRASOUND (HIFU), INCLUDING ULTRASOUND GUIDANCE		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0951T	TOTALLY IMPLANTABLE ACTIVE MIDDLE EAR HEARING IMPLANT; INITIAL PLACEMENT, INCLUDING MASTOIDECTOMY, PLACEMENT OF AND ATTACHMENT TO SOUND PROCESSOR		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0952T	TOTALLY IMPLANTABLE ACTIVE MIDDLE EAR HEARING IMPLANT; REVISION OR REPLACEMENT, WITH MASTOIDECTOMY AND REPLACEMENT OF SOUND PROCESSOR		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0953T	TOTALLY IMPLANTABLE ACTIVE MIDDLE EAR HEARING IMPLANT; REVISION OR REPLACEMENT, WITHOUT MASTOIDECTOMY AND REPLACEMENT OF SOUND PROCESSOR		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0954T	TOTALLY IMPLANTABLE ACTIVE MIDDLE EAR HEARING IMPLANT; REPLACEMENT OF SOUND PROCESSOR ONLY, WITH ATTACHMENT TO EXISTING TRANSDUCERS		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0955T	TOTALLY IMPLANTABLE ACTIVE MIDDLE EAR HEARING IMPLANT; REMOVAL, INCLUDING REMOVAL OF SOUND PROCESSOR AND ALL IMPLANT COMPONENTS		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0962T	ASSISTIVE ALGORITHMIC ANALYSIS OF ACOUSTIC AND ELECTROCARDIOGRAM RECORDING FOR DETECTION OF CARDIAC DYSFUNCTION (EG, REDUCED EJECTION FRACTION, CARDIAC MURMURS, ATRIAL FIBRILLATION), WITH REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0963T	ANOSCOPY WITH DIRECTED SUBMUCOSAL INJECTION OF BULKING AGENT INTO ANAL CANAL		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0964T	IMPRESSION AND CUSTOM PREPARATION OF JAW EXPANSION ORAL PROSTHESIS FOR OBSTRUCTIVE SLEEP APNEA, INCLUDING INITIAL ADJUSTMENT; SINGLE ARCH, WITHOUT MANDIBULAR ADVANCEMENT MECHANISM		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0965T	IMPRESSION AND CUSTOM PREPARATION OF JAW EXPANSION ORAL PROSTHESIS FOR OBSTRUCTIVE SLEEP APNEA, INCLUDING INITIAL ADJUSTMENT; DUAL ARCH, WITH ADDITIONAL MANDIBULAR ADVANCEMENT, NON-FIXED HINGE MECHANISM		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0966T	IMPRESSION AND CUSTOM PREPARATION OF JAW EXPANSION ORAL PROSTHESIS FOR OBSTRUCTIVE SLEEP APNEA, INCLUDING INITIAL ADJUSTMENT; DUAL ARCH, WITH ADDITIONAL MANDIBULAR ADVANCEMENT, FIXED HINGE MECHANISM		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0967T	TRANSANAL INSERTION OF ENDOLUMINAL TEMPORARY COLORECTAL ANASTOMOSIS PROTECTION DEVICE, INCLUDING VACUUM ANCHORING COMPONENT AND FLEXIBLE SHEATH CONNECTED TO EXTERNAL VACUUM SOURCE AND MONITORING SYSTEM		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0968T	INSERTION OR REPLACEMENT OF EPICRANIAL NEUROSTIMULATOR SYSTEM, INCLUDING ELECTRODE ARRAY AND PULSE GENERATOR, WITH CONNECTION TO ELECTRODE ARRAY		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0969T	REMOVAL OF EPICRANIAL NEUROSTIMULATOR SYSTEM		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0970T	ABLATION, BENIGN BREAST TUMOR (EG, FIBROADENOMA), PERCUTANEOUS, LASER, INCLUDING IMAGING GUIDANCE WHEN PERFORMED, EACH TUMOR		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0971T	ABLATION, MALIGNANT BREAST TUMOR(S), PERCUTANEOUS, LASER, INCLUDING IMAGING GUIDANCE WHEN PERFORMED, UNILATERAL		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0972T	ASSISTIVE ALGORITHMIC CLASSIFICATION OF BURN HEALING (IE, HEALING OR NONHEALING) BY NONINVASIVE MULTISPECTRAL IMAGING, INCLUDING SYSTEM SET-UP AND ACQUISITION, SELECTION, AND TRANSMISSION OF IMAGES, WITH AUTOMATED GENERATION OF REPORT		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0973T	SELECTIVE ENZYMATIC DEBRIDEMENT, PARTIAL-THICKNESS AND/OR FULL-THICKNESS BURN ESCHAR, REQUIRING ANESTHESIA (IE, GENERAL ANESTHESIA, MODERATE SEDATION), INCLUDING PATIENT MONITORING, TRUNK, ARMS, LEGS; FIRST 100 SQ CM		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0974T	SELECTIVE ENZYMATIC DEBRIDEMENT, PARTIAL-THICKNESS AND/OR FULL-THICKNESS BURN ESCHAR, REQUIRING ANESTHESIA (IE, GENERAL ANESTHESIA, MODERATE SEDATION), INCLUDING PATIENT MONITORING, TRUNK, ARMS, LEGS; EACH ADDITIONAL 100 SQ CM (LIST SEPARATELY IN ADDITION		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0975T	SELECTIVE ENZYMATIC DEBRIDEMENT, PARTIAL-THICKNESS AND/OR FULL-THICKNESS BURN ESCHAR, REQUIRING ANESTHESIA (IE, GENERAL ANESTHESIA, MODERATE SEDATION), INCLUDING PATIENT MONITORING, SCALP, NECK, HANDS, FEET, AND/OR MULTIPLE DIGITS; FIRST 100 SQ CM		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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0976T	SELECTIVE ENZYMATIC DEBRIDEMENT, PARTIAL-THICKNESS AND/OR FULL-THICKNESS BURN ESCHAR, REQUIRING ANESTHESIA (IE, GENERAL ANESTHESIA, MODERATE SEDATION), INCLUDING PATIENT MONITORING, SCALP, NECK, HANDS, FEET, AND/OR MULTIPLE DIGITS; EACH ADDITIONAL 100 SQ		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0977T	UPPER GASTROINTESTINAL BLOOD DETECTION, SENSOR CAPSULE, WITH INTERPRETATION AND REPORT		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0978T	SUBMUCOSAL CRYOLYSIS THERAPY; SOFT PALATE, BASE OF TONGUE, AND LINGUAL TONSIL		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0979T	SUBMUCOSAL CRYOLYSIS THERAPY; SOFT PALATE ONLY		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0980T	SUBMUCOSAL CRYOLYSIS THERAPY; BASE OF TONGUE AND LINGUAL TONSIL ONLY		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0981T	TRANSCATHETER IMPLANTATION OF WIRELESS INFERIOR VENA CAVA SENSOR FOR LONG-TERM HEMODYNAMIC MONITORING, INCLUDING DEPLOYMENT OF THE SENSOR, RADIOLOGICAL SUPERVISION AND INTERPRETATION, RIGHT HEART CATHETERIZATION, AND INFERIOR VENA CAVA VENOGRAPHY, WHEN PE		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0982T	REMOTE MONITORING OF IMPLANTABLE INFERIOR VENA CAVA PRESSURE SENSOR, PHYSIOLOGIC PARAMETER(S) (EG, WEIGHT, BLOOD PRESSURE, PULSE OXIMETRY, RESPIRATORY FLOW RATE), INITIAL SET-UP AND PATIENT EDUCATION ON USE OF EQUIPMENT		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0983T	REMOTE MONITORING OF AN IMPLANTED INFERIOR VENA CAVA SENSOR FOR UP TO 30 DAYS, INCLUDING AT LEAST WEEKLY DOWNLOADS OF INFERIOR VENA CAVA AREA RECORDINGS, INTERPRETATION(S), TREND ANALYSIS, AND REPORT(S) BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFES		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0984T	INTRAVASCULAR IMAGING OF EXTRACRANIAL CEREBRAL VESSELS USING OPTICAL COHERENCE TOMOGRAPHY (OCT) DURING DIAGNOSTIC EVALUATION AND/OR THERAPEUTIC INTERVENTION, INCLUDING ALL ASSOCIATED RADIOLOGICAL SUPERVISION, INTERPRETATION, AND REPORT; INITIAL VESSEL (LI		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0985T	INTRAVASCULAR IMAGING OF EXTRACRANIAL CEREBRAL VESSELS USING OPTICAL COHERENCE TOMOGRAPHY (OCT) DURING DIAGNOSTIC EVALUATION AND/OR THERAPEUTIC INTERVENTION, INCLUDING ALL ASSOCIATED RADIOLOGICAL SUPERVISION, INTERPRETATION, AND REPORT; EACH ADDITIONAL VE		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0986T	INTRAVASCULAR IMAGING OF INTRACRANIAL CEREBRAL VESSELS USING OPTICAL COHERENCE TOMOGRAPHY (OCT) DURING DIAGNOSTIC EVALUATION AND/OR THERAPEUTIC INTERVENTION, INCLUDING ALL ASSOCIATED RADIOLOGICAL SUPERVISION, INTERPRETATION, AND REPORT; INITIAL VESSEL (LI		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
0987T	INTRAVASCULAR IMAGING OF INTRACRANIAL CEREBRAL VESSELS USING OPTICAL COHERENCE TOMOGRAPHY (OCT) DURING DIAGNOSTIC EVALUATION AND/OR THERAPEUTIC INTERVENTION, INCLUDING ALL ASSOCIATED RADIOLOGICAL SUPERVISION, INTERPRETATION, AND REPORT; EACH ADDITIONAL VE		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
1001	BEHAVIORAL HEALTH SERVICES; SHORT-TERM RESIDENTIAL; HOSPITAL/NON-HOSPITAL, PER DIEM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
1002	ACUTE/SUB-ACUTE DETOXIFICATION; RESIDENTIAL ADDICTION PROGRAM INPATIENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
10040	ACNE SURGERY (EG, MARSUPIALIZATION, OPENING OR REMOVAL OF MULTIPLE MILIA, COMEDONES, CYSTS, PUSTULES)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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11300	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS; LESION DIAMETER 0.5 CM OR LESS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11301	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS; LESION DIAMETER 0.6 TO 1.0 CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11302	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS; LESION DIAMETER 1.1 TO 2.0 CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11303	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS; LESION DIAMETER OVER 2.0 CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11305	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.5 CM OR LESS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11306	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.6 TO 1.0 CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11307	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 1.1 TO 2.0 CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11308	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER OVER 2.0 CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11310	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 0.5 CM OR LESS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11311	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 0.6 TO 1.0 CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11312	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 1.1 TO 2.0 CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11313	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER OVER 2.0 CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11400	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; EXCISED DIAMETER 0.5 CM OR LESS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11401	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; EXCISED DIAMETER 0.6 TO 1.0 CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11402	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; EXCISED DIAMETER 1.1 TO 2.0 CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11403	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; EXCISED DIAMETER 2.1 TO 3.0 CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11404	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; EXCISED DIAMETER 3.1 TO 4.0 CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11406	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; EXCISED DIAMETER OVER 4.0 CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11920	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN, INCLUDING MICROPIGMENTATION; 6.0 SQ CM OR LESS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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11921	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN, INCLUDING MICROPIGMENTATION; 6.1 TO 20.0 SQ CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11922	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN, INCLUDING MICROPIGMENTATION; EACH ADDITIONAL 20.0 SQ CM, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11970	REPLACEMENT OF TISSUE EXPANDER WITH PERMANENT IMPLANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
11971	REMOVAL OF TISSUE EXPANDER WITHOUT INSERTION OF IMPLANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
12011	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 2.5 CM OR LESS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
12051	REPAIR, INTERMEDIATE, WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 2.5 CM OR LESS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
13131	REPAIR, COMPLEX, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/OR FEET; 1.1 CM TO 2.5 CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
13132	REPAIR, COMPLEX, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/OR FEET; 2.6 CM TO 7.5 CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
13133	REPAIR, COMPLEX, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/OR FEET; EACH ADDITIONAL 5 CM OR LESS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
14021	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, SCALP, ARMS AND/OR LEGS; DEFECT 10.1 SQ CM TO 30.0 SQ CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
14040	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/OR FEET; DEFECT 10 SQ CM OR LESS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
14041	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/OR FEET; DEFECT 10.1 SQ CM TO 30.0 SQ CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
14301	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, ANY AREA; DEFECT 30.1 SQ CM TO 60.0 SQ CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
14302	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, ANY AREA; EACH ADDITIONAL 30.0 SQ CM, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15011	HARVEST OF SKIN FOR SKIN CELL SUSPENSION AUTOGRAFT; FIRST 25 SQ CM OR LESS		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
15012	HARVEST OF SKIN FOR SKIN CELL SUSPENSION AUTOGRAFT; EACH ADDITIONAL 25 SQ CM OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
15013	PREPARATION OF SKIN CELL SUSPENSION AUTOGRAFT, REQUIRING ENZYMATIC PROCESSING, MANUAL MECHANICAL DISAGGREGATION OF SKIN CELLS, AND FILTRATION; FIRST 25 SQ CM OR LESS OF HARVESTED SKIN		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
15014	PREPARATION OF SKIN CELL SUSPENSION AUTOGRAFT, REQUIRING ENZYMATIC PROCESSING, MANUAL MECHANICAL DISAGGREGATION OF SKIN CELLS, AND FILTRATION; EACH ADDITIONAL 25 SQ CM OF HARVESTED SKIN OR PART THEREOF		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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15015	APPLICATION OF SKIN CELL SUSPENSION AUTOGRAFT TO WOUND AND DONOR SITES, INCLUDING APPLICATION OF PRIMARY DRESSING, TRUNK, ARMS, LEGS; FIRST 480 SQ CM OR LESS		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
15016	APPLICATION OF SKIN CELL SUSPENSION AUTOGRAFT TO WOUND AND DONOR SITES, INCLUDING APPLICATION OF PRIMARY DRESSING, TRUNK, ARMS, LEGS; EACH ADDITIONAL 480 SQ CM OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
15017	APPLICATION OF SKIN CELL SUSPENSION AUTOGRAFT TO WOUND AND DONOR SITES, INCLUDING APPLICATION OF PRIMARY DRESSING, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; FIRST 480 SQ CM OR LESS		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
15018	APPLICATION OF SKIN CELL SUSPENSION AUTOGRAFT TO WOUND AND DONOR SITES, INCLUDING APPLICATION OF PRIMARY DRESSING, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; EACH ADDITIONAL 480 SQ CM OR PART THEREOF		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
15100	SPLIT-THICKNESS AUTOGRAFT, TRUNK, ARMS, LEGS; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN (EXCEPT 15050)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15101	SPLIT-THICKNESS AUTOGRAFT, TRUNK, ARMS, LEGS; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15110	EPIDERMAL AUTOGRAFT, TRUNK, ARMS, LEGS; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15111	EPIDERMAL AUTOGRAFT, TRUNK, ARMS, LEGS; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15115	EPIDERMAL AUTOGRAFT, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15116	EPIDERMAL AUTOGRAFT, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CO		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15120	SPLIT-THICKNESS AUTOGRAFT, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN (EXCEPT 15050)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15200	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, TRUNK; 20 SQ CM OR LESS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15220	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, SCALP, ARMS, AND/OR LEGS; 20 SQ CM OR LESS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15221	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, SCALP, ARMS, AND/OR LEGS; EACH ADDITIONAL 20 SQ CM, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15240	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS, AND/OR FEET; 20 SQ CM OR LESS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15241	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS, AND/OR FEET; EACH ADDITIONAL 20 SQ CM, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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15273	APPLICATION OF SKIN SUBSTITUTE GRAFT TO TRUNK, ARMS, LEGS, TOTAL WOUND SURFACE AREA GREATER THAN OR EQUAL TO 100 SQ CM; FIRST 100 SQ CM WOUND SURFACE AREA, OR 1% OF BODY AREA OF INFANTS AND CHILDREN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15274	APPLICATION OF SKIN SUBSTITUTE GRAFT TO TRUNK, ARMS, LEGS, TOTAL WOUND SURFACE AREA GREATER THAN OR EQUAL TO 100 SQ CM; EACH ADDITIONAL 100 SQ CM WOUND SURFACE AREA, OR PART THEREOF, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15275	APPLICATION OF SKIN SUBSTITUTE GRAFT TO FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS, TOTAL WOUND SURFACE AREA UP TO 100 SQ CM; FIRST 25 SQ CM OR LESS WOUND SURFACE AREA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15277	APPLICATION OF SKIN SUBSTITUTE GRAFT TO FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS, TOTAL WOUND SURFACE AREA GREATER THAN OR EQUAL TO 100 SQ CM; FIRST 100 SQ CM WOUND SURFACE AREA, OR 1% OF BODY AREA OF		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15278	APPLICATION OF SKIN SUBSTITUTE GRAFT TO FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS, TOTAL WOUND SURFACE AREA GREATER THAN OR EQUAL TO 100 SQ CM; EACH ADDITIONAL 100 SQ CM WOUND SURFACE AREA, OR PART THE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15574	FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT TRANSFER; FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS OR FEET		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15734	MUSCLE, MYOCUTANEOUS, OR FASCIOCUTANEOUS FLAP; TRUNK		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15738	MUSCLE, MYOCUTANEOUS, OR FASCIOCUTANEOUS FLAP; LOWER EXTREMITY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15740	FLAP; ISLAND PEDICLE REQUIRING IDENTIFICATION AND DISSECTION OF AN ANATOMICALLY NAMED AXIAL VESSEL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15750	FLAP; NEUROVASCULAR PEDICLE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15757	FREE SKIN FLAP WITH MICROVASCULAR ANASTOMOSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15769	GRAFTING OF AUTOLOGOUS SOFT TISSUE, OTHER, HARVESTED BY DIRECT EXCISION (EG, FAT, DERMIS, FASCIA)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15771	GRAFTING OF AUTOLOGOUS FAT HARVESTED BY LIPOSUCTION TECHNIQUE TO TRUNK, BREASTS, SCALP, ARMS, AND/OR LEGS; 50 CC OR LESS INJECTATE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15772	GRAFTING OF AUTOLOGOUS FAT HARVESTED BY LIPOSUCTION TECHNIQUE TO TRUNK, BREASTS, SCALP, ARMS, AND/OR LEGS; EACH ADDITIONAL 50 CC INJECTATE, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15780	DERMABRASION; TOTAL FACE (EG, FOR ACNE SCARRING, FINE WRINKLING, RHYTIDS, GENERAL KERATOSIS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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15781	DERMABRASION; SEGMENTAL, FACE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15782	DERMABRASION; REGIONAL, OTHER THAN FACE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15783	DERMABRASION; SUPERFICIAL, ANY SITE (EG, TATTOO REMOVAL)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15786	ABRASION; SINGLE LESION (EG, KERATOSIS, SCAR)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15789	CHEMICAL PEEL, FACIAL; DERMAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15793	CHEMICAL PEEL, NONFACIAL; DERMAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15820	BLEPHAROPLASTY, LOWER EYELID;		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15821	BLEPHAROPLASTY, LOWER EYELID; WITH EXTENSIVE HERNIATED FAT PAD		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15822	BLEPHAROPLASTY, UPPER EYELID;		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15823	BLEPHAROPLASTY, UPPER EYELID; WITH EXCESSIVE SKIN WEIGHTING DOWN LID		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15826	RHYTIDECTOMY; GLABELLAR FROWN LINES		8/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
15830	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); ABDOMEN, INFRAUMBILICAL PANNICULECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15840	GRAFT FOR FACIAL NERVE PARALYSIS; FREE FASCIA GRAFT (INCLUDING OBTAINING FASCIA)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15841	GRAFT FOR FACIAL NERVE PARALYSIS; FREE MUSCLE GRAFT (INCLUDING OBTAINING GRAFT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15842	GRAFT FOR FACIAL NERVE PARALYSIS; FREE MUSCLE FLAP BY MICROSURGICAL TECHNIQUE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15845	GRAFT FOR FACIAL NERVE PARALYSIS; REGIONAL MUSCLE TRANSFER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
15877	SUCTION ASSISTED LIPECTOMY; TRUNK		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
17106	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); LESS THAN 10 SQ CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
17107	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); 10.0 TO 50.0 SQ CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
17108	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); OVER 50.0 SQ CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
17111	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY, SURGICAL CURETTEMENT), OF BENIGN LESIONS OTHER THAN SKIN TAGS OR CUTANEOUS VASCULAR PROLIFERATIVE LESIONS; 15 OR MORE LESIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
17340	CRYOTHERAPY (CO2 SLUSH, LIQUID N2) FOR ACNE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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19105	ABLATION, CRYOSURGICAL, OF FIBROADENOMA, INCLUDING ULTRASOUND GUIDANCE, EACH FIBROADENOMA		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
19301	MASTECTOMY, PARTIAL (EG, LUMPECTOMY, TYLECTOMY, QUADRANTECTOMY, SEGMENTECTOMY);		1/1/2023	InterQual® Evidence-Based Criteria & Guidelines	
19303	MASTECTOMY, SIMPLE, COMPLETE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
19305	MASTECTOMY, RADICAL, INCLUDING PECTORAL MUSCLES, AXILLARY LYMPH NODES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
19306	MASTECTOMY, RADICAL, INCLUDING PECTORAL MUSCLES, AXILLARY AND INTERNAL MAMMARY LYMPH NODES (URBAN TYPE OPERATION)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
19307	MASTECTOMY, MODIFIED RADICAL, INCLUDING AXILLARY LYMPH NODES, WITH OR WITHOUT PECTORALIS MINOR MUSCLE, BUT EXCLUDING PECTORALIS MAJOR MUSCLE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
19318	BREAST REDUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
19328	REMOVAL OF INTACT BREAST IMPLANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
19330	REMOVAL OF RUPTURED BREAST IMPLANT, INCLUDING IMPLANT CONTENTS (EG, SALINE, SILICONE GEL)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
19340	INSERTION OF BREAST IMPLANT ON SAME DAY OF MASTECTOMY (IE, IMMEDIATE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
19342	INSERTION OR REPLACEMENT OF BREAST IMPLANT ON SEPARATE DAY FROM MASTECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
19350	NIPPLE/AREOLA RECONSTRUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
19355	CORRECTION OF INVERTED NIPPLES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
19357	TISSUE EXPANDER PLACEMENT IN BREAST RECONSTRUCTION, INCLUDING SUBSEQUENT EXPANSION(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
19361	BREAST RECONSTRUCTION; WITH LATISSIMUS DORSI FLAP		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
19364	BREAST RECONSTRUCTION; WITH FREE FLAP (EG, FTRAM, DIEP, SIEA, GAP FLAP)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
19367	BREAST RECONSTRUCTION; WITH SINGLE-PEDICLED TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS (TRAM) FLAP		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
19368	BREAST RECONSTRUCTION; WITH SINGLE-PEDICLED TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS (TRAM) FLAP, REQUIRING SEPARATE MICROVASCULAR ANASTOMOSIS (SUPERCHARGING)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
19369	BREAST RECONSTRUCTION; WITH BIPEDICLED TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS (TRAM) FLAP		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
19370	REVISION OF PERI-IMPLANT CAPSULE, BREAST, INCLUDING CAPSULOTOMY, CAPSULORRHAPHY, AND/OR PARTIAL CAPSULECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
19371	PERI-IMPLANT CAPSULECTOMY, BREAST, COMPLETE, INCLUDING REMOVAL OF ALL INTRACAPSULAR CONTENTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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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)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
19396	PREPARATION OF MOULAGE FOR CUSTOM BREAST IMPLANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
20250	BIOPSY, VERTEBRAL BODY, OPEN; THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
20251	BIOPSY, VERTEBRAL BODY, OPEN; LUMBAR OR CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
20552	INJECTION(S); SINGLE OR MULTIPLE TRIGGER POINT(S), 1 OR 2 MUSCLE(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
20553	INJECTION(S); SINGLE OR MULTIPLE TRIGGER POINT(S), 3 OR MORE MUSCLES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
20930	ALLOGRAFT, MORSELIZED, OR PLACEMENT OF OSTEOPROMOTIVE MATERIAL, FOR SPINE SURGERY ONLY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
20931	ALLOGRAFT, STRUCTURAL, FOR SPINE SURGERY ONLY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
20936	AUTOGRAFT FOR SPINE SURGERY ONLY (INCLUDES HARVESTING THE GRAFT); LOCAL (EG, RIBS, SPINOUS PROCESS, OR LAMINAR FRAGMENTS) OBTAINED FROM SAME INCISION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
20937	AUTOGRAFT FOR SPINE SURGERY ONLY (INCLUDES HARVESTING THE GRAFT); MORSELIZED (THROUGH SEPARATE SKIN OR FASCIAL INCISION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
20938	AUTOGRAFT FOR SPINE SURGERY ONLY (INCLUDES HARVESTING THE GRAFT); STRUCTURAL, BICORTICAL OR TRICORTICAL (THROUGH SEPARATE SKIN OR FASCIAL INCISION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
20983	ABLATION THERAPY FOR REDUCTION OR ERADICATION OF 1 OR MORE BONE TUMORS (EG, METASTASIS) INCLUDING ADJACENT SOFT TISSUE WHEN INVOLVED BY TUMOR EXTENSION, PERCUTANEOUS, INCLUDING IMAGING GUIDANCE WHEN PERFORMED; CRYOABLATION		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
20985	COMPUTER-ASSISTED SURGICAL NAVIGATIONAL PROCEDURE FOR MUSCULOSKELETAL PROCEDURES, IMAGE-LESS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
21010	ARTHROTOMY, TEMPOROMANDIBULAR JOINT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21050	CONDYLECTOMY, TEMPOROMANDIBULAR JOINT (SEPARATE PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21060	MENISCECTOMY, PARTIAL OR COMPLETE, TEMPOROMANDIBULAR JOINT (SEPARATE PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21070	CORONOIDECTOMY (SEPARATE PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21073	MANIPULATION OF TEMPOROMANDIBULAR JOINT(S) (TMJ), THERAPEUTIC, REQUIRING AN ANESTHESIA SERVICE (IE, GENERAL OR MONITORED ANESTHESIA CARE)		7/1/2019	InterQual® Evidence-Based Criteria & Guidelines	
21076	IMPRESSION AND CUSTOM PREPARATION; SURGICAL OBTURATOR PROSTHESIS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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21077	IMPRESSION AND CUSTOM PREPARATION; ORBITAL PROSTHESIS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21079	IMPRESSION AND CUSTOM PREPARATION; INTERIM OBTURATOR PROSTHESIS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21080	IMPRESSION AND CUSTOM PREPARATION; DEFINITIVE OBTURATOR PROSTHESIS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21082	IMPRESSION AND CUSTOM PREPARATION; PALATAL AUGMENTATION PROSTHESIS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21083	IMPRESSION AND CUSTOM PREPARATION; PALATAL LIFT PROSTHESIS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21084	IMPRESSION AND CUSTOM PREPARATION; SPEECH AID PROSTHESIS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21086	IMPRESSION AND CUSTOM PREPARATION; AURICULAR PROSTHESIS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21087	IMPRESSION AND CUSTOM PREPARATION; NASAL PROSTHESIS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21088	IMPRESSION AND CUSTOM PREPARATION; FACIAL PROSTHESIS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21089	UNLISTED MAXILLOFACIAL PROSTHETIC PROCEDURE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21116	INJECTION PROCEDURE FOR TEMPOROMANDIBULAR JOINT ARTHROGRAPHY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21120	GENIOPLASTY; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, PROSTHETIC MATERIAL)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21121	GENIOPLASTY; SLIDING OSTEOTOMY, SINGLE PIECE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21122	GENIOPLASTY; SLIDING OSTEOTOMIES, 2 OR MORE OSTEOTOMIES (EG, WEDGE EXCISION OR BONE WEDGE REVERSAL FOR ASYMMETRICAL CHIN)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21123	GENIOPLASTY; SLIDING, AUGMENTATION WITH INTERPOSITIONAL BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21125	AUGMENTATION, MANDIBULAR BODY OR ANGLE; PROSTHETIC MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21127	AUGMENTATION, MANDIBULAR BODY OR ANGLE; WITH BONE GRAFT, ONLAY OR INTERPOSITIONAL (INCLUDES OBTAINING AUTOGRAFT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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21142	RECONSTRUCTION MIDFACE, LEFORT I; 2 PIECES, SEGMENT MOVEMENT IN ANY DIRECTION, WITHOUT BONE GRAFT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21143	RECONSTRUCTION MIDFACE, LEFORT I; 3 OR MORE PIECES, SEGMENT MOVEMENT IN ANY DIRECTION, WITHOUT BONE GRAFT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21145	RECONSTRUCTION MIDFACE, LEFORT I; SINGLE PIECE, SEGMENT MOVEMENT IN ANY DIRECTION, REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21146	RECONSTRUCTION MIDFACE, LEFORT I; 2 PIECES, SEGMENT MOVEMENT IN ANY DIRECTION, REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS) (EG, UNGRAFTED UNILATERAL ALVEOLAR CLEFT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21147	RECONSTRUCTION MIDFACE, LEFORT I; 3 OR MORE PIECES, SEGMENT MOVEMENT IN ANY DIRECTION, REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS) (EG, UNGRAFTED BILATERAL ALVEOLAR CLEFT OR MULTIPLE OSTEOTOMIES)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21150	RECONSTRUCTION MIDFACE, LEFORT II; ANTERIOR INTRUSION (EG, TREACHER-COLLINS SYNDROME)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21150	RECONSTRUCTION MIDFACE, LEFORT II; ANTERIOR INTRUSION (EG, TREACHER-COLLINS SYNDROME)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21151	RECONSTRUCTION MIDFACE, LEFORT II; ANY DIRECTION, REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21151	RECONSTRUCTION MIDFACE, LEFORT II; ANY DIRECTION, REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21154	RECONSTRUCTION MIDFACE, LEFORT III (EXTRACRANIAL), ANY TYPE, REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS); WITHOUT LEFORT I		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21155	RECONSTRUCTION MIDFACE, LEFORT III (EXTRACRANIAL), ANY TYPE, REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS); WITH LEFORT I		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21159	RECONSTRUCTION MIDFACE, LEFORT III (EXTRA AND INTRACRANIAL) WITH FOREHEAD ADVANCEMENT (EG, MONO BLOC), REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS); WITHOUT LEFORT I		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21160	RECONSTRUCTION MIDFACE, LEFORT III (EXTRA AND INTRACRANIAL) WITH FOREHEAD ADVANCEMENT (EG, MONO BLOC), REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS); WITH LEFORT I		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21172	RECONSTRUCTION SUPERIOR-LATERAL ORBITAL RIM AND LOWER FOREHEAD, ADVANCEMENT OR ALTERATION, WITH OR WITHOUT GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21175	RECONSTRUCTION, BIFRONTAL, SUPERIOR-LATERAL ORBITAL RIMS AND LOWER FOREHEAD, ADVANCEMENT OR ALTERATION (EG, PLAGIOCEPHALY, TRIGONOCEPHALY, BRACHYCEPHALY), WITH OR WITHOUT GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21179	RECONSTRUCTION, ENTIRE OR MAJORITY OF FOREHEAD AND/OR SUPRAORBITAL RIMS; WITH GRAFTS (ALLOGRAFT OR PROSTHETIC MATERIAL)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21180	RECONSTRUCTION, ENTIRE OR MAJORITY OF FOREHEAD AND/OR SUPRAORBITAL RIMS; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFTS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
21182	RECONSTRUCTION OF ORBITAL WALLS, RIMS, FOREHEAD, NASOETHMOID COMPLEX FOLLOWING INTRA- AND EXTRACRANIAL EXCISION OF BENIGN TUMOR OF CRANIAL BONE (EG, FIBROUS DYSPLASIA), WITH MULTIPLE AUTOGRAFTS (INCLUDES OBTAINING GRAFTS); TOTAL AREA OF BONE GRAFTING LESS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21183	RECONSTRUCTION OF ORBITAL WALLS, RIMS, FOREHEAD, NASOETHMOID COMPLEX FOLLOWING INTRA- AND EXTRACRANIAL EXCISION OF BENIGN TUMOR OF CRANIAL BONE (EG, FIBROUS DYSPLASIA), WITH MULTIPLE AUTOGRAFTS (INCLUDES OBTAINING GRAFTS); TOTAL AREA OF BONE GRAFTING GREA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21184	RECONSTRUCTION OF ORBITAL WALLS, RIMS, FOREHEAD, NASOETHMOID COMPLEX FOLLOWING INTRA- AND EXTRACRANIAL EXCISION OF BENIGN TUMOR OF CRANIAL BONE (EG, FIBROUS DYSPLASIA), WITH MULTIPLE AUTOGRAFTS (INCLUDES OBTAINING GRAFTS); TOTAL AREA OF BONE GRAFTING GREA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21188	RECONSTRUCTION MIDFACE, OSTEOTOMIES (OTHER THAN LEFORT TYPE) AND BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21193	RECONSTRUCTION OF MANDIBULAR RAMI, HORIZONTAL, VERTICAL, C, OR L OSTEOTOMY; WITHOUT BONE GRAFT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21194	RECONSTRUCTION OF MANDIBULAR RAMI, HORIZONTAL, VERTICAL, C, OR L OSTEOTOMY; WITH BONE GRAFT (INCLUDES OBTAINING GRAFT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21195	RECONSTRUCTION OF MANDIBULAR RAMI AND/OR BODY, SAGITTAL SPLIT; WITHOUT INTERNAL RIGID FIXATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21196	RECONSTRUCTION OF MANDIBULAR RAMI AND/OR BODY, SAGITTAL SPLIT; WITH INTERNAL RIGID FIXATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21198	OSTEOTOMY, MANDIBLE, SEGMENTAL;		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21199	OSTEOTOMY, MANDIBLE, SEGMENTAL; WITH GENIOGLOSSUS ADVANCEMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21206	OSTEOTOMY, MAXILLA, SEGMENTAL (EG, WASSMUND OR SCHUCHARD)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21208	OSTEOPLASTY, FACIAL BONES; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, OR PROSTHETIC IMPLANT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21208	OSTEOPLASTY, FACIAL BONES; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, OR PROSTHETIC IMPLANT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21209	OSTEOPLASTY, FACIAL BONES; REDUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21209	OSTEOPLASTY, FACIAL BONES; REDUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21210	GRAFT, BONE; NASAL, MAXILLARY OR MALAR AREAS (INCLUDES OBTAINING GRAFT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21210	GRAFT, BONE; NASAL, MAXILLARY OR MALAR AREAS (INCLUDES OBTAINING GRAFT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21215	GRAFT, BONE; MANDIBLE (INCLUDES OBTAINING GRAFT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21215	GRAFT, BONE; MANDIBLE (INCLUDES OBTAINING GRAFT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21230	GRAFT; RIB CARTILAGE, AUTOGENOUS, TO FACE, CHIN, NOSE OR EAR (INCLUDES OBTAINING GRAFT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21235	GRAFT; EAR CARTILAGE, AUTOGENOUS, TO NOSE OR EAR (INCLUDES OBTAINING GRAFT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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21240	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH OR WITHOUT AUTOGRAFT (INCLUDES OBTAINING GRAFT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21242	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH ALLOGRAFT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21243	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH PROSTHETIC JOINT REPLACEMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21244	RECONSTRUCTION OF MANDIBLE, EXTRAORAL, WITH TRANSOSTEAL BONE PLATE (EG, MANDIBULAR STAPLE BONE PLATE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21245	RECONSTRUCTION OF MANDIBLE OR MAXILLA, SUBPERIOSTEAL IMPLANT; PARTIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21246	RECONSTRUCTION OF MANDIBLE OR MAXILLA, SUBPERIOSTEAL IMPLANT; COMPLETE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21247	RECONSTRUCTION OF MANDIBULAR CONDYLE WITH BONE AND CARTILAGE AUTOGRAFTS (INCLUDES OBTAINING GRAFTS) (EG, FOR HEMIFACIAL MICROSOMIA)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21248	RECONSTRUCTION OF MANDIBLE OR MAXILLA, ENDOSTEAL IMPLANT (EG, BLADE, CYLINDER); PARTIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21249	RECONSTRUCTION OF MANDIBLE OR MAXILLA, ENDOSTEAL IMPLANT (EG, BLADE, CYLINDER); COMPLETE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21255	RECONSTRUCTION OF ZYGOMATIC ARCH AND GLENOID FOSSA WITH BONE AND CARTILAGE (INCLUDES OBTAINING AUTOGRAFTS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21256	RECONSTRUCTION OF ORBIT WITH OSTEOTOMIES (EXTRACRANIAL) AND WITH BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS) (EG, MICRO-OPHTHALMIA)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21260	PERIORBITAL OSTEOTOMIES FOR ORBITAL HYPERTELORISM, WITH BONE GRAFTS; EXTRACRANIAL APPROACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21261	PERIORBITAL OSTEOTOMIES FOR ORBITAL HYPERTELORISM, WITH BONE GRAFTS; COMBINED INTRA- AND EXTRACRANIAL APPROACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21263	PERIORBITAL OSTEOTOMIES FOR ORBITAL HYPERTELORISM, WITH BONE GRAFTS; WITH FOREHEAD ADVANCEMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21267	ORBITAL REPOSITIONING, PERIORBITAL OSTEOTOMIES, UNILATERAL, WITH BONE GRAFTS; EXTRACRANIAL APPROACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21268	ORBITAL REPOSITIONING, PERIORBITAL OSTEOTOMIES, UNILATERAL, WITH BONE GRAFTS; COMBINED INTRA- AND EXTRACRANIAL APPROACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21275	SECONDARY REVISION OF ORBITOCRANIOFACIAL RECONSTRUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21295	REDUCTION OF MASSETER MUSCLE AND BONE (EG, FOR TREATMENT OF BENIGN MASSETERIC HYPERTROPHY); EXTRAORAL APPROACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21296	REDUCTION OF MASSETER MUSCLE AND BONE (EG, FOR TREATMENT OF BENIGN MASSETERIC HYPERTROPHY); INTRAORAL APPROACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21299	UNLISTED CRANIOFACIAL AND MAXILLOFACIAL PROCEDURE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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21440	CLOSED TREATMENT OF MANDIBULAR OR MAXILLARY ALVEOLAR RIDGE FRACTURE (SEPARATE PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21445	OPEN TREATMENT OF MANDIBULAR OR MAXILLARY ALVEOLAR RIDGE FRACTURE (SEPARATE PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21480	CLOSED TREATMENT OF TEMPOROMANDIBULAR DISLOCATION; INITIAL OR SUBSEQUENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21485	CLOSED TREATMENT OF TEMPOROMANDIBULAR DISLOCATION; COMPLICATED (EG, RECURRENT REQUIRING INTERMAXILLARY FIXATION OR SPLINTING), INITIAL OR SUBSEQUENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21490	OPEN TREATMENT OF TEMPOROMANDIBULAR DISLOCATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21497	INTERDENTAL WIRING, FOR CONDITION OTHER THAN FRACTURE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21740	RECONSTRUCTIVE REPAIR OF PECTUS EXCAVATUM OR CARINATUM; OPEN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21742	RECONSTRUCTIVE REPAIR OF PECTUS EXCAVATUM OR CARINATUM; MINIMALLY INVASIVE APPROACH (NUSS PROCEDURE), WITHOUT THORACOSCOPY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
21743	RECONSTRUCTIVE REPAIR OF PECTUS EXCAVATUM OR CARINATUM; MINIMALLY INVASIVE APPROACH (NUSS PROCEDURE), WITH THORACOSCOPY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22010	INCISION AND DRAINAGE, OPEN, OF DEEP ABSCESS (SUBFASCIAL), POSTERIOR SPINE; CERVICAL, THORACIC, OR CERVICOTHORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22015	INCISION AND DRAINAGE, OPEN, OF DEEP ABSCESS (SUBFASCIAL), POSTERIOR SPINE; LUMBAR, SACRAL, OR LUMBOSACRAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22100	PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG, SPINOUS PROCESS, LAMINA OR FACET) FOR INTRINSIC BONY LESION, SINGLE VERTEBRAL SEGMENT; CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22101	PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG, SPINOUS PROCESS, LAMINA OR FACET) FOR INTRINSIC BONY LESION, SINGLE VERTEBRAL SEGMENT; THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22102	PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG, SPINOUS PROCESS, LAMINA OR FACET) FOR INTRINSIC BONY LESION, SINGLE VERTEBRAL SEGMENT; LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22103	PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG, SPINOUS PROCESS, LAMINA OR FACET) FOR INTRINSIC BONY LESION, SINGLE VERTEBRAL SEGMENT; EACH ADDITIONAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22110	PARTIAL EXCISION OF VERTEBRAL BODY, FOR INTRINSIC BONY LESION, WITHOUT DECOMPRESSION OF SPINAL CORD OR NERVE ROOT(S), SINGLE VERTEBRAL SEGMENT; CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22112	PARTIAL EXCISION OF VERTEBRAL BODY, FOR INTRINSIC BONY LESION, WITHOUT DECOMPRESSION OF SPINAL CORD OR NERVE ROOT(S), SINGLE VERTEBRAL SEGMENT; THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22114	PARTIAL EXCISION OF VERTEBRAL BODY, FOR INTRINSIC BONY LESION, WITHOUT DECOMPRESSION OF SPINAL CORD OR NERVE ROOT(S), SINGLE VERTEBRAL SEGMENT; LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22116	PARTIAL EXCISION OF VERTEBRAL BODY, FOR INTRINSIC BONY LESION, WITHOUT DECOMPRESSION OF SPINAL CORD OR NERVE ROOT(S), SINGLE VERTEBRAL SEGMENT; EACH ADDITIONAL VERTEBRAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
22206	OSTEOTOMY OF SPINE, POSTERIOR OR POSTEROLATERAL APPROACH, 3 COLUMNS, 1 VERTEBRAL SEGMENT (EG, PEDICLE/VERTEBRAL BODY SUBTRACTION); THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22207	OSTEOTOMY OF SPINE, POSTERIOR OR POSTEROLATERAL APPROACH, 3 COLUMNS, 1 VERTEBRAL SEGMENT (EG, PEDICLE/VERTEBRAL BODY SUBTRACTION); LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22208	OSTEOTOMY OF SPINE, POSTERIOR OR POSTEROLATERAL APPROACH, 3 COLUMNS, 1 VERTEBRAL SEGMENT (EG, PEDICLE/VERTEBRAL BODY SUBTRACTION); EACH ADDITIONAL VERTEBRAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22210	OSTEOTOMY OF SPINE, POSTERIOR OR POSTEROLATERAL APPROACH, 1 VERTEBRAL SEGMENT; CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22212	OSTEOTOMY OF SPINE, POSTERIOR OR POSTEROLATERAL APPROACH, 1 VERTEBRAL SEGMENT; THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22214	OSTEOTOMY OF SPINE, POSTERIOR OR POSTEROLATERAL APPROACH, 1 VERTEBRAL SEGMENT; LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22216	OSTEOTOMY OF SPINE, POSTERIOR OR POSTEROLATERAL APPROACH, 1 VERTEBRAL SEGMENT; EACH ADDITIONAL VERTEBRAL SEGMENT (LIST SEPARATELY IN ADDITION TO PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22220	OSTEOTOMY OF SPINE, INCLUDING DISCECTOMY, ANTERIOR APPROACH, SINGLE VERTEBRAL SEGMENT; CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22222	OSTEOTOMY OF SPINE, INCLUDING DISCECTOMY, ANTERIOR APPROACH, SINGLE VERTEBRAL SEGMENT; THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22224	OSTEOTOMY OF SPINE, INCLUDING DISCECTOMY, ANTERIOR APPROACH, SINGLE VERTEBRAL SEGMENT; LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22226	OSTEOTOMY OF SPINE, INCLUDING DISCECTOMY, ANTERIOR APPROACH, SINGLE VERTEBRAL SEGMENT; EACH ADDITIONAL VERTEBRAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22505	MANIPULATION OF SPINE REQUIRING ANESTHESIA, ANY REGION		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
22510	PERCUTANEOUS VERTEBROPLASTY (BONE BIOPSY INCLUDED WHEN PERFORMED), 1 VERTEBRAL BODY, UNILATERAL OR BILATERAL INJECTION, INCLUSIVE OF ALL IMAGING GUIDANCE; CERVICOTHORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22511	PERCUTANEOUS VERTEBROPLASTY (BONE BIOPSY INCLUDED WHEN PERFORMED), 1 VERTEBRAL BODY, UNILATERAL OR BILATERAL INJECTION, INCLUSIVE OF ALL IMAGING GUIDANCE; LUMBOSACRAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22512	PERCUTANEOUS VERTEBROPLASTY (BONE BIOPSY INCLUDED WHEN PERFORMED), 1 VERTEBRAL BODY, UNILATERAL OR BILATERAL INJECTION, INCLUSIVE OF ALL IMAGING GUIDANCE; EACH ADDITIONAL CERVICOTHORACIC OR LUMBOSACRAL VERTEBRAL BODY (LIST SEPARATELY IN ADDITION TO CODE F		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22513	PERCUTANEOUS VERTEBRAL AUGMENTATION, INCLUDING CAVITY CREATION (FRACTURE REDUCTION AND BONE BIOPSY INCLUDED WHEN PERFORMED) USING MECHANICAL DEVICE (EG, KYPHOPLASTY), 1 VERTEBRAL BODY, UNILATERAL OR BILATERAL CANNULATION, INCLUSIVE OF ALL IMAGING GUIDANCE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22514	PERCUTANEOUS VERTEBRAL AUGMENTATION, INCLUDING CAVITY CREATION (FRACTURE REDUCTION AND BONE BIOPSY INCLUDED WHEN PERFORMED) USING MECHANICAL DEVICE (EG, KYPHOPLASTY), 1 VERTEBRAL BODY, UNILATERAL OR BILATERAL CANNULATION, INCLUSIVE OF ALL IMAGING GUIDANCE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
22515	PERCUTANEOUS VERTEBRAL AUGMENTATION, INCLUDING CAVITY CREATION (FRACTURE REDUCTION AND BONE BIOPSY INCLUDED WHEN PERFORMED) USING MECHANICAL DEVICE (EG, KYPHOPLASTY), 1 VERTEBRAL BODY, UNILATERAL OR BILATERAL CANNULATION, INCLUSIVE OF ALL IMAGING GUIDANCE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22520	PERCUTANEOUS VERTEBROPLASTY, 1 VERTEBRAL BODY, UNILATERAL OR BILATERAL INJECTION; LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22521	PERCUTANEOUS VERTEBROPLASTY, 1 VERTEBRAL BODY, UNILATERAL OR BILATERAL INJECTION; LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22522	PERCUTANEOUS VERTEBROPLASTY, 1 VERTEBRAL BODY, UNILATERAL OR BILATERAL INJECTION; EACH ADDITIONAL THORACIC OR LUMBAR VERTEBRAL BODY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22523	PERCUTANEOUS VERTEBRAL AUGMENTATION, INCLUDING CAVITY CREATION (FRACTURE REDUCTION AND BONE BIOPSY INCLUDED WHEN PERFORMED) USING MECHANICAL DEVICE, 1 VERTEBRAL BODY, UNILATERAL OR BILATERAL CANNULATION (E.G. KYPHOPLASTY); THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22524	PERCUTANEOUS VERTEBRAL AUGMENTATION, INCLUDING CAVITY CREATION (FRACTURE REDUCTION AND BONE BIOPSY INCLUDED WHEN PERFORMED) USING MECHANICAL DEVICE, 1 VERTEBRAL BODY, UNILATERAL OR BILATERAL CANNULATION (E.G. KYPHOPLASTY); LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22525	PERCUTANEOUS VERTEBRAL AUGMENTATION, INCLUDING CAVITY CREATION (FRACTURE REDUCTION AND BONE BIOPSY INCLUDED WHEN PERFORMED) USING MECHANICAL DEVICE, 1 VERTEBRAL BODY, UNILATERAL OR BILATERAL CANNULATION (EG, KYPHOPLASTY); EACH ADDITIONAL THORACIC OR LUMBA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22526	PERCUTANEOUS INTRADISCAL ELECTROTHERMAL ANNULOPLASTY, UNILATERAL OR BILATERAL INCLUDING FLUOROSCOPIC GUIDANCE; SINGLE LEVEL		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
22532	ARTHRODESIS, LATERAL EXTRACAVITARY TECHNIQUE, INCLUDING MINIMAL DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22533	ARTHRODESIS, LATERAL EXTRACAVITARY TECHNIQUE, INCLUDING MINIMAL DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22534	ARTHRODESIS, LATERAL EXTRACAVITARY TECHNIQUE, INCLUDING MINIMAL DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); THORACIC OR LUMBAR, EACH ADDITIONAL VERTEBRAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22548	ARTHRODESIS, ANTERIOR TRANSORAL OR EXTRAORAL TECHNIQUE, CLIVUS-C1-C2 (ATLAS-AXIS), WITH OR WITHOUT EXCISION OF ODONTOID PROCESS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22551	ARTHRODESIS, ANTERIOR INTERBODY, INCLUDING DISC SPACE PREPARATION, DISCECTOMY, OSTEOPHYTECTOMY AND DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOTS; CERVICAL BELOW C2		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22552	ARTHRODESIS, ANTERIOR INTERBODY, INCLUDING DISC SPACE PREPARATION, DISCECTOMY, OSTEOPHYTECTOMY AND DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOTS; CERVICAL BELOW C2, EACH ADDITIONAL INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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22554	ARTHRODESIS, ANTERIOR INTERBODY TECHNIQUE, INCLUDING MINIMAL DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); CERVICAL BELOW C2		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22556	ARTHRODESIS, ANTERIOR INTERBODY TECHNIQUE, INCLUDING MINIMAL DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22558	ARTHRODESIS, ANTERIOR INTERBODY TECHNIQUE, INCLUDING MINIMAL DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22590	ARTHRODESIS, POSTERIOR TECHNIQUE, CRANIOCERVICAL (OCCIPUT-C2)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22595	ARTHRODESIS, POSTERIOR TECHNIQUE, ATLAS-AXIS (C1-C2)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22600	ARTHRODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE, SINGLE INTERSPACE; CERVICAL BELOW C2 SEGMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22610	ARTHRODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE, SINGLE INTERSPACE; THORACIC (WITH LATERAL TRANSVERSE TECHNIQUE, WHEN PERFORMED)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22612	ARTHRODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE, SINGLE INTERSPACE; LUMBAR (WITH LATERAL TRANSVERSE TECHNIQUE, WHEN PERFORMED)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22614	ARTHRODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE, SINGLE INTERSPACE; EACH ADDITIONAL INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22630	ARTHRODESIS, POSTERIOR INTERBODY TECHNIQUE, INCLUDING LAMINECTOMY AND/OR DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE, LUMBAR;		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22632	ARTHRODESIS, POSTERIOR INTERBODY TECHNIQUE, INCLUDING LAMINECTOMY AND/OR DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE, LUMBAR; EACH ADDITIONAL INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22633	ARTHRODESIS, COMBINED POSTERIOR OR POSTEROLATERAL TECHNIQUE WITH POSTERIOR INTERBODY TECHNIQUE INCLUDING LAMINECTOMY AND/OR DISCECTOMY SUFFICIENT TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE, LUMBAR;		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22634	ARTHRODESIS, COMBINED POSTERIOR OR POSTEROLATERAL TECHNIQUE WITH POSTERIOR INTERBODY TECHNIQUE INCLUDING LAMINECTOMY AND/OR DISCECTOMY SUFFICIENT TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE, LUMBAR; EACH ADDITIONAL INTERSPACE (		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22800	ARTHRODESIS, POSTERIOR, FOR SPINAL DEFORMITY, WITH OR WITHOUT CAST; UP TO 6 VERTEBRAL SEGMENTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22802	ARTHRODESIS, POSTERIOR, FOR SPINAL DEFORMITY, WITH OR WITHOUT CAST; 7 TO 12 VERTEBRAL SEGMENTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22804	ARTHRODESIS, POSTERIOR, FOR SPINAL DEFORMITY, WITH OR WITHOUT CAST; 13 OR MORE VERTEBRAL SEGMENTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22808	ARTHRODESIS, ANTERIOR, FOR SPINAL DEFORMITY, WITH OR WITHOUT CAST; 2 TO 3 VERTEBRAL SEGMENTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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22810	ARTHRODESIS, ANTERIOR, FOR SPINAL DEFORMITY, WITH OR WITHOUT CAST; 4 TO 7 VERTEBRAL SEGMENTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22812	ARTHRODESIS, ANTERIOR, FOR SPINAL DEFORMITY, WITH OR WITHOUT CAST; 8 OR MORE VERTEBRAL SEGMENTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22818	KYPHECTOMY, CIRCUMFERENTIAL EXPOSURE OF SPINE AND RESECTION OF VERTEBRAL SEGMENT(S) (INCLUDING BODY AND POSTERIOR ELEMENTS); SINGLE OR 2 SEGMENTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22819	KYPHECTOMY, CIRCUMFERENTIAL EXPOSURE OF SPINE AND RESECTION OF VERTEBRAL SEGMENT(S) (INCLUDING BODY AND POSTERIOR ELEMENTS); 3 OR MORE SEGMENTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22830	EXPLORATION OF SPINAL FUSION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22836	ANTERIOR THORACIC VERTEBRAL BODY TETHERING, INCLUDING THORACOSCOPY, WHEN PERFORMED; UP TO 7 VERTEBRAL SEGMENTS		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
22837	ANTERIOR THORACIC VERTEBRAL BODY TETHERING, INCLUDING THORACOSCOPY, WHEN PERFORMED; 8 OR MORE VERTEBRAL SEGMENTS		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
22838	REVISION (EG, AUGMENTATION, DIVISION OF TETHER), REPLACEMENT, OR REMOVAL OF THORACIC VERTEBRAL BODY TETHERING, INCLUDING THORACOSCOPY, WHEN PERFORMED		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
22840	POSTERIOR NON-SEGMENTAL INSTRUMENTATION (EG, HARRINGTON ROD TECHNIQUE, PEDICLE FIXATION ACROSS 1 INTERSPACE, ATLANTOAXIAL TRANSARTICULAR SCREW FIXATION, SUBLAMINAR WIRING AT C1, FACET SCREW FIXATION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22841	INTERNAL SPINAL FIXATION BY WIRING OF SPINOUS PROCESSES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22842	POSTERIOR SEGMENTAL INSTRUMENTATION (EG, PEDICLE FIXATION, DUAL RODS WITH MULTIPLE HOOKS AND SUBLAMINAR WIRES); 3 TO 6 VERTEBRAL SEGMENTS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22843	POSTERIOR SEGMENTAL INSTRUMENTATION (EG, PEDICLE FIXATION, DUAL RODS WITH MULTIPLE HOOKS AND SUBLAMINAR WIRES); 7 TO 12 VERTEBRAL SEGMENTS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22844	POSTERIOR SEGMENTAL INSTRUMENTATION (EG, PEDICLE FIXATION, DUAL RODS WITH MULTIPLE HOOKS AND SUBLAMINAR WIRES); 13 OR MORE VERTEBRAL SEGMENTS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22845	ANTERIOR INSTRUMENTATION; 2 TO 3 VERTEBRAL SEGMENTS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22846	ANTERIOR INSTRUMENTATION; 4 TO 7 VERTEBRAL SEGMENTS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22847	ANTERIOR INSTRUMENTATION; 8 OR MORE VERTEBRAL SEGMENTS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22848	PELVIC FIXATION (ATTACHMENT OF CAUDAL END OF INSTRUMENTATION TO PELVIC BONY STRUCTURES) OTHER THAN SACRUM (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
22849	REINSERTION OF SPINAL FIXATION DEVICE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22850	REMOVAL OF POSTERIOR NONSEGMENTAL INSTRUMENTATION (EG, HARRINGTON ROD)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22853	INSERTION OF INTERBODY BIOMECHANICAL DEVICE(S) (EG, SYNTHETIC CAGE, MESH) WITH INTEGRAL ANTERIOR INSTRUMENTATION FOR DEVICE ANCHORING (EG, SCREWS, FLANGES), WHEN PERFORMED, TO INTERVERTEBRAL DISC SPACE IN CONJUNCTION WITH INTERBODY ARTHRODESIS, EACH INTER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22854	INSERTION OF INTERVERTEBRAL BIOMECHANICAL DEVICE(S) (EG, SYNTHETIC CAGE, MESH) WITH INTEGRAL ANTERIOR INSTRUMENTATION FOR DEVICE ANCHORING (EG, SCREWS, FLANGES), WHEN PERFORMED, TO VERTEBRAL CORPECTOMY(IES) (VERTEBRAL BODY RESECTION, PARTIAL OR COMPLETE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22855	REMOVAL OF ANTERIOR INSTRUMENTATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22856	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY WITH END PLATE PREPARATION (INCLUDES OSTEOPHYTECTOMY FOR NERVE ROOT OR SPINAL CORD DECOMPRESSION AND MICRODISSECTION); SINGLE INTERSPACE, CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22857	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); SINGLE INTERSPACE, LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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 T		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22859	INSERTION OF INTERVERTEBRAL BIOMECHANICAL DEVICE(S) (EG, SYNTHETIC CAGE, MESH, METHYLMETHACRYLATE) TO INTERVERTEBRAL DISC SPACE OR VERTEBRAL BODY DEFECT WITHOUT INTERBODY ARTHRODESIS, EACH CONTIGUOUS DEFECT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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)		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
22861	REVISION INCLUDING REPLACEMENT OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, SINGLE INTERSPACE; CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22862	REVISION INCLUDING REPLACEMENT OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, SINGLE INTERSPACE; LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22864	REMOVAL OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, SINGLE INTERSPACE; CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22865	REMOVAL OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, SINGLE INTERSPACE; LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22867	INSERTION OF INTERLAMINAR/INTERSPINOUS PROCESS STABILIZATION/DISTRACTION DEVICE, WITHOUT FUSION, INCLUDING IMAGE GUIDANCE WHEN PERFORMED, WITH OPEN DECOMPRESSION, LUMBAR; SINGLE LEVEL		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 PROCEDURE)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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22869	INSERTION OF INTERLAMINAR/INTERSPINOUS PROCESS STABILIZATION/DISTRACTION DEVICE, WITHOUT OPEN DECOMPRESSION OR FUSION, INCLUDING IMAGE GUIDANCE WHEN PERFORMED, LUMBAR; SINGLE LEVEL		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
22890	PERCUTANEOUS INTRADISCAL ELECTROTHERMAL ANNULOPLASTY, UNILATERAL OR BILATERAL INCLUDING FLUOROSCOPIC GUIDANCE; 1 OR MORE ADDITIONAL LEVELS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
22899	UNLISTED PROCEDURE, SPINE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
22999	UNLISTED PROCEDURE, ABDOMEN, MUSCULOSKELETAL SYSTEM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
23440	RESECTION OR TRANSPLANTATION OF LONG TENDON OF BICEPS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
23470	ARTHROPLASTY, GLENOHUMERAL JOINT; HEMIARTHROPLASTY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
23472	ARTHROPLASTY, GLENOHUMERAL JOINT; TOTAL SHOULDER (GLENOID AND PROXIMAL HUMERAL REPLACEMENT (EG, TOTAL SHOULDER))		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
23473	REVISION OF TOTAL SHOULDER ARTHROPLASTY, INCLUDING ALLOGRAFT WHEN PERFORMED; HUMERAL OR GLENOID COMPONENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
23474	REVISION OF TOTAL SHOULDER ARTHROPLASTY, INCLUDING ALLOGRAFT WHEN PERFORMED; HUMERAL AND GLENOID COMPONENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
24363	ARTHROPLASTY, ELBOW; WITH DISTAL HUMERUS AND PROXIMAL ULNAR PROSTHETIC REPLACEMENT (EG, TOTAL ELBOW)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
24370	REVISION OF TOTAL ELBOW ARTHROPLASTY, INCLUDING ALLOGRAFT WHEN PERFORMED; HUMERAL OR ULNAR COMPONENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
24371	REVISION OF TOTAL ELBOW ARTHROPLASTY, INCLUDING ALLOGRAFT WHEN PERFORMED; HUMERAL AND ULNAR COMPONENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
24420	OSTEOPLASTY, HUMERUS (EG, SHORTENING OR LENGTHENING) (EXCLUDING 64876)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
24470	HEMIEPIPHYSEAL ARREST (EG, CUBITUS VARUS OR VALGUS, DISTAL HUMERUS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
25310	TENDON TRANSPLANTATION OR TRANSFER, FLEXOR OR EXTENSOR, FOREARM AND/OR WRIST, SINGLE; EACH TENDON		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
25312	TENDON TRANSPLANTATION OR TRANSFER, FLEXOR OR EXTENSOR, FOREARM AND/OR WRIST, SINGLE; WITH TENDON GRAFT(S) (INCLUDES OBTAINING GRAFT), EACH TENDON		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
25332	ARTHROPLASTY, WRIST, WITH OR WITHOUT INTERPOSITION, WITH OR WITHOUT EXTERNAL OR INTERNAL FIXATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
25390	OSTEOPLASTY, RADIUS OR ULNA; SHORTENING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
25391	OSTEOPLASTY, RADIUS OR ULNA; LENGTHENING WITH AUTOGRAFT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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25392	OSTEOPLASTY, RADIUS AND ULNA; SHORTENING (EXCLUDING 64876)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
25393	OSTEOPLASTY, RADIUS AND ULNA; LENGTHENING WITH AUTOGRAFT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
25394	OSTEOPLASTY, CARPAL BONE, SHORTENING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
25441	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; DISTAL RADIUS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
25442	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; DISTAL ULNA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
25443	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; SCAPHOID CARPAL (NAVICULAR)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
25444	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; LUNATE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
25445	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; TRAPEZIUM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
25446	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; DISTAL RADIUS AND PARTIAL OR ENTIRE CARPUS (TOTAL WRIST)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
25447	ARTHROPLASTY, INTERPOSITION, INTERCARPAL OR CARPOMETACARPAL JOINTS (E.G. TENDON)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
25449	REVISION OF ARTHROPLASTY, INCLUDING REMOVAL OF IMPLANT, WRIST JOINT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
25450	EPIPHYSEAL ARREST BY EPIPHYSIODESIS OR STAPLING; DISTAL RADIUS OR ULNA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
25455	EPIPHYSEAL ARREST BY EPIPHYSIODESIS OR STAPLING; DISTAL RADIUS AND ULNA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
26480	TRANSFER OR TRANSPLANT OF TENDON, CARPOMETACARPAL AREA OR DORSUM OF HAND; WITHOUT FREE GRAFT, EACH TENDON		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
26483	TRANSFER OR TRANSPLANT OF TENDON, CARPOMETACARPAL AREA OR DORSUM OF HAND; WITH FREE TENDON GRAFT (INCLUDES OBTAINING GRAFT), EACH TENDON		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
26485	TRANSFER OR TRANSPLANT OF TENDON, PALMAR; WITHOUT FREE TENDON GRAFT, EACH TENDON		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
26489	TRANSFER OR TRANSPLANT OF TENDON, PALMAR; WITH FREE TENDON GRAFT (INCLUDES OBTAINING GRAFT), EACH TENDON		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27080	COCCYGECTOMY, PRIMARY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27096	INJECTION PROCEDURE FOR SACROILIAC JOINT, ANESTHETIC/STEROID, WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT) INCLUDING ARTHROGRAPHY WHEN PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27125	HEMIARTHROPLASTY, HIP, PARTIAL (EG, FEMORAL STEM PROSTHESIS, BIPOLAR ARTHROPLASTY)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27130	ARTHROPLASTY, ACETABULAR AND PROXIMAL FEMORAL PROSTHETIC REPLACEMENT (TOTAL HIP ARTHROPLASTY), WITH OR WITHOUT AUTOGRAFT OR ALLOGRAFT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27132	CONVERSION OF PREVIOUS HIP SURGERY TO TOTAL HIP ARTHROPLASTY, WITH OR WITHOUT AUTOGRAFT OR ALLOGRAFT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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27134	REVISION OF TOTAL HIP ARTHROPLASTY; BOTH COMPONENTS, WITH OR WITHOUT AUTOGRAFT OR ALLOGRAFT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27137	REVISION OF TOTAL HIP ARTHROPLASTY; ACETABULAR COMPONENT ONLY, WITH OR WITHOUT AUTOGRAFT OR ALLOGRAFT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27138	REVISION OF TOTAL HIP ARTHROPLASTY; FEMORAL COMPONENT ONLY, WITH OR WITHOUT ALLOGRAFT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27278	ARTHRODESIS, SACROILIAC JOINT, PERCUTANEOUS, WITH IMAGE GUIDANCE, INCLUDING PLACEMENT OF INTRA-ARTICULAR IMPLANT(S) (EG, BONE ALLOGRAFT[S], SYNTHETIC DEVICE[S]), WITHOUT PLACEMENT OF TRANSFIXATION DEVICE		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
27279	ARTHRODESIS, SACROILIAC JOINT, PERCUTANEOUS OR MINIMALLY INVASIVE (INDIRECT VISUALIZATION), WITH IMAGE GUIDANCE, INCLUDES OBTAINING BONE GRAFT WHEN PERFORMED, AND PLACEMENT OF TRANSFIXING DEVICE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27280	ARTHRODESIS, SACROILIAC JOINT, OPEN, INCLUDES OBTAINING BONE GRAFT, INCLUDING INSTRUMENTATION, WHEN PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27412	AUTOLOGOUS CHONDROCYTE IMPLANTATION, KNEE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27415	OSTEOCHONDRAL ALLOGRAFT, KNEE, OPEN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27416	OSTEOCHONDRAL AUTOGRAFT(S), KNEE, OPEN (EG, MOSAICPLASTY) (INCLUDES HARVESTING OF AUTOGRAFT[S])		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
27437	ARTHROPLASTY, PATELLA; WITHOUT PROSTHESIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27438	ARTHROPLASTY, PATELLA; WITH PROSTHESIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27440	ARTHROPLASTY, KNEE, TIBIAL PLATEAU;		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27441	ARTHROPLASTY, KNEE, TIBIAL PLATEAU; WITH DEBRIDEMENT AND PARTIAL SYNOVECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27442	ARTHROPLASTY, FEMORAL CONDYLES OR TIBIAL PLATEAU(S), KNEE;		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27443	ARTHROPLASTY, FEMORAL CONDYLES OR TIBIAL PLATEAU(S), KNEE; WITH DEBRIDEMENT AND PARTIAL SYNOVECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27445	ARTHROPLASTY, KNEE, HINGE PROSTHESIS (EG, WALLDIUS TYPE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27446	ARTHROPLASTY, KNEE, CONDYLE AND PLATEAU; MEDIAL OR LATERAL COMPARTMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27447	ARTHROPLASTY, KNEE, CONDYLE AND PLATEAU; MEDIAL AND LATERAL COMPARTMENTS WITH OR WITHOUT PATELLA RESURFACING (TOTAL KNEE ARTHROPLASTY)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27465	OSTEOPLASTY, FEMUR; SHORTENING (EXCLUDING 64876)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27466	OSTEOPLASTY, FEMUR; LENGTHENING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27468	OSTEOPLASTY, FEMUR; COMBINED, LENGTHENING AND SHORTENING WITH FEMORAL SEGMENT TRANSFER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
27486	REVISION OF TOTAL KNEE ARTHROPLASTY, WITH OR WITHOUT ALLOGRAFT; 1 COMPONENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27487	REVISION OF TOTAL KNEE ARTHROPLASTY, WITH OR WITHOUT ALLOGRAFT; FEMORAL AND ENTIRE TIBIAL COMPONENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27488	REMOVAL OF PROSTHESIS, INCLUDING TOTAL KNEE PROSTHESIS, METHYLMETHACRYLATE WITH OR WITHOUT INSERTION OF SPACER, KNEE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27700	ARTHROPLASTY, ANKLE;		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27702	ARTHROPLASTY, ANKLE; WITH IMPLANT (TOTAL ANKLE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27703	ARTHROPLASTY, ANKLE; REVISION, TOTAL ANKLE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
27715	OSTEOPLASTY, TIBIA AND FIBULA, LENGTHENING OR SHORTENING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
28285	CORRECTION, HAMMERTOE (EG, INTERPHALANGEAL FUSION, PARTIAL OR TOTAL PHALANGECTOMY)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
28286	CORRECTION, COCK-UP FIFTH TOE, WITH PLASTIC SKIN CLOSURE (EG, RUIZ-MORA TYPE PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
28292	CORRECTION, HALLUX VALGUS WITH BUNIONECTOMY, WITH SESAMOIDECTOMY WHEN PERFORMED; WITH RESECTION OF PROXIMAL PHALANX BASE, WHEN PERFORMED, ANY METHOD		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
28295	CORRECTION, HALLUX VALGUS WITH BUNIONECTOMY, WITH SESAMOIDECTOMY WHEN PERFORMED; WITH PROXIMAL METATARSAL OSTEOTOMY, ANY METHOD		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
28296	CORRECTION, HALLUX VALGUS WITH BUNIONECTOMY, WITH SESAMOIDECTOMY WHEN PERFORMED; WITH DISTAL METATARSAL OSTEOTOMY, ANY METHOD		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
28297	CORRECTION, HALLUX VALGUS WITH BUNIONECTOMY, WITH SESAMOIDECTOMY WHEN PERFORMED; WITH FIRST METATARSAL AND MEDIAL CUNEIFORM JOINT ARTHRODESIS, ANY METHOD		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
28298	CORRECTION, HALLUX VALGUS WITH BUNIONECTOMY, WITH SESAMOIDECTOMY WHEN PERFORMED; WITH PROXIMAL PHALANX OSTEOTOMY, ANY METHOD		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
28299	CORRECTION, HALLUX VALGUS WITH BUNIONECTOMY, WITH SESAMOIDECTOMY WHEN PERFORMED; WITH DOUBLE OSTEOTOMY, ANY METHOD		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
28344	RECONSTRUCTION, TOE(S); POLYDACTYLY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
28345	RECONSTRUCTION, TOE(S); SYNDACTYLY, WITH OR WITHOUT SKIN GRAFT(S), EACH WEB		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
28890	EXTRACORPOREAL SHOCK WAVE, HIGH ENERGY, PERFORMED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, REQUIRING ANESTHESIA OTHER THAN LOCAL, INCLUDING ULTRASOUND GUIDANCE, INVOLVING THE PLANTAR FASCIA		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
28899	UNLISTED PROCEDURE, FOOT OR TOES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
29800	ARTHROSCOPY, TEMPOROMANDIBULAR JOINT, DIAGNOSTIC, WITH OR WITHOUT SYNOVIAL BIOPSY (SEPARATE PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
29804	ARTHROSCOPY, TEMPOROMANDIBULAR JOINT, SURGICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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29866	ARTHROSCOPY, KNEE, SURGICAL; OSTEOCHONDRAL AUTOGRAFT(S) (EG, MOSAICPLASTY) (INCLUDES HARVESTING OF THE AUTOGRAFT[S])		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
29867	ARTHROSCOPY, KNEE, SURGICAL; OSTEOCHONDRAL ALLOGRAFT (EG, MOSAICPLASTY)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
29868	ARTHROSCOPY, KNEE, SURGICAL; MENISCAL TRANSPLANTATION (INCLUDES ARTHROTOMY FOR MENISCAL INSERTION), MEDIAL OR LATERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
30120	EXCISION OR SURGICAL PLANING OF SKIN OF NOSE FOR RHINOPHYMA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
30130	EXCISION INFERIOR TURBINATE, PARTIAL OR COMPLETE, ANY METHOD		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
30140	SUBMUCOUS RESECTION INFERIOR TURBINATE, PARTIAL OR COMPLETE, ANY METHOD		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
30150	RHINECTOMY; PARTIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
30160	RHINECTOMY; TOTAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
30469	REPAIR OF NASAL VALVE COLLAPSE WITH LOW ENERGY, TEMPERATURE-CONTROLLED (IE, RADIOFREQUENCY) SUBCUTANEOUS/SUBMUCOSAL REMODELING		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
30801	ABLATION, SOFT TISSUE OF INFERIOR TURBINATES, UNILATERAL OR BILATERAL, ANY METHOD (EG, ELECTROCAUTERY, RADIOFREQUENCY ABLATION, OR TISSUE VOLUME REDUCTION); SUPERFICIAL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
30802	ABLATION, SOFT TISSUE OF INFERIOR TURBINATES, UNILATERAL OR BILATERAL, ANY METHOD (EG, ELECTROCAUTERY, RADIOFREQUENCY ABLATION, OR TISSUE VOLUME REDUCTION); INTRAMURAL (IE, SUBMUCOSAL)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
30999	UNLISTED PROCEDURE, NOSE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
31242	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH DESTRUCTION BY RADIOFREQUENCY ABLATION, POSTERIOR NASAL NERVE		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
31243	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH DESTRUCTION BY CRYOABLATION, POSTERIOR NASAL NERVE		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
31660	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH BRONCHIAL THERMOPLASTY, 1 LOBE		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
31661	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH BRONCHIAL THERMOPLASTY, 2 OR MORE LOBES		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
32850	DONOR PNEUMONECTOMY(S) (INCLUDING COLD PRESERVATION), FROM CADAVER DONOR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
32851	LUNG TRANSPLANT, SINGLE; WITHOUT CARDIOPULMONARY BYPASS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
32852	LUNG TRANSPLANT, SINGLE; WITH CARDIOPULMONARY BYPASS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
32853	LUNG TRANSPLANT, DOUBLE (BILATERAL SEQUENTIAL OR EN BLOC); WITHOUT CARDIOPULMONARY BYPASS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
32854	LUNG TRANSPLANT, DOUBLE (BILATERAL SEQUENTIAL OR EN BLOC); WITH CARDIOPULMONARY BYPASS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
32856	BACKBENCH STANDARD PREPARATION OF CADAVER DONOR LUNG ALLOGRAFT PRIOR TO TRANSPLANTATION, INCLUDING DISSECTION OF ALLOGRAFT FROM SURROUNDING SOFT TISSUES TO PREPARE PULMONARY VENOUS/ATRIAL CUFF, PULMONARY ARTERY, AND BRONCHUS; BILATERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
32999	UNLISTED PROCEDURE, LUNGS AND PLEURA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
33265	ENDOSCOPY, SURGICAL; OPERATIVE TISSUE ABLATION AND RECONSTRUCTION OF ATRIA, LIMITED (EG, MODIFIED MAZE PROCEDURE), WITHOUT CARDIOPULMONARY BYPASS		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
33266	ENDOSCOPY, SURGICAL; OPERATIVE TISSUE ABLATION AND RECONSTRUCTION OF ATRIA, EXTENSIVE (EG, MAZE PROCEDURE), WITHOUT CARDIOPULMONARY BYPASS		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
33276	INSERTION OF PHRENIC NERVE STIMULATOR SYSTEM (PULSE GENERATOR AND STIMULATING LEAD[S]), INCLUDING VESSEL CATHETERIZATION, ALL IMAGING GUIDANCE, AND PULSE GENERATOR INITIAL ANALYSIS WITH DIAGNOSTIC MODE ACTIVATION, WHEN PERFORMED		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
33277	INSERTION OF PHRENIC NERVE STIMULATOR TRANSVENOUS SENSING LEAD (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
33278	REMOVAL OF PHRENIC NERVE STIMULATOR, INCLUDING VESSEL CATHETERIZATION, ALL IMAGING GUIDANCE, AND INTERROGATION AND PROGRAMMING, WHEN PERFORMED; SYSTEM, INCLUDING PULSE GENERATOR AND LEAD(S)		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
33279	REMOVAL OF PHRENIC NERVE STIMULATOR, INCLUDING VESSEL CATHETERIZATION, ALL IMAGING GUIDANCE, AND INTERROGATION AND PROGRAMMING, WHEN PERFORMED; TRANSVENOUS STIMULATION OR SENSING LEAD(S) ONLY		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
33280	REMOVAL OF PHRENIC NERVE STIMULATOR, INCLUDING VESSEL CATHETERIZATION, ALL IMAGING GUIDANCE, AND INTERROGATION AND PROGRAMMING, WHEN PERFORMED; PULSE GENERATOR ONLY		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
33281	REPOSITIONING OF PHRENIC NERVE STIMULATOR TRANSVENOUS LEAD(S)		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
33287	REMOVAL AND REPLACEMENT OF PHRENIC NERVE STIMULATOR, INCLUDING VESSEL CATHETERIZATION, ALL IMAGING GUIDANCE, AND INTERROGATION AND PROGRAMMING, WHEN PERFORMED; PULSE GENERATOR		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
33288	REMOVAL AND REPLACEMENT OF PHRENIC NERVE STIMULATOR, INCLUDING VESSEL CATHETERIZATION, ALL IMAGING GUIDANCE, AND INTERROGATION AND PROGRAMMING, WHEN PERFORMED; TRANSVENOUS STIMULATION OR SENSING LEAD(S)		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
33548	SURGICAL VENTRICULAR RESTORATION PROCEDURE, INCLUDES PROSTHETIC PATCH, WHEN PERFORMED (EG, VENTRICULAR REMODELING, SVR, SAVER, DOR PROCEDURES)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
33927	IMPLANTATION OF A TOTAL REPLACEMENT HEART SYSTEM (ARTIFICIAL HEART) WITH RECIPIENT CARDIECTOMY		8/15/2018	InterQual® Evidence-Based Criteria & Guidelines	
33928	REMOVAL AND REPLACEMENT OF TOTAL REPLACEMENT HEART SYSTEM (ARTIFICIAL HEART)		8/15/2018	InterQual® Evidence-Based Criteria & Guidelines	
33929	REMOVAL OF A TOTAL REPLACEMENT HEART SYSTEM (ARTIFICIAL HEART) FOR HEART TRANSPLANTATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		8/15/2018	InterQual® Evidence-Based Criteria & Guidelines	
33930	DONOR CARDIECTOMY-PNEUMONECTOMY (INCLUDING COLD PRESERVATION)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
33933	BACKBENCH STANDARD PREPARATION OF CADAVER DONOR HEART/LUNG ALLOGRAFT PRIOR TO TRANSPLANTATION, INCLUDING DISSECTION OF ALLOGRAFT FROM SURROUNDING SOFT TISSUES TO PREPARE AORTA, SUPERIOR VENA CAVA, INFERIOR VENA CAVA, AND TRACHEA FOR IMPLANTATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
33935	HEART-LUNG TRANSPLANT WITH RECIPIENT CARDIECTOMY-PNEUMONECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
33940	DONOR CARDIECTOMY (INCLUDING COLD PRESERVATION)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
33944	BACKBENCH STANDARD PREPARATION OF CADAVER DONOR HEART ALLOGRAFT PRIOR TO TRANSPLANTATION, INCLUDING DISSECTION OF ALLOGRAFT FROM SURROUNDING SOFT TISSUES TO PREPARE AORTA, SUPERIOR VENA CAVA, INFERIOR VENA CAVA, PULMONARY ARTERY, AND LEFT ATRIUM FOR IMPLA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
33945	HEART TRANSPLANT, WITH OR WITHOUT RECIPIENT CARDIECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
33990	INSERTION OF VENTRICULAR ASSIST DEVICE, PERCUTANEOUS, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; LEFT HEART, ARTERIAL ACCESS ONLY		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
33991	INSERTION OF VENTRICULAR ASSIST DEVICE, PERCUTANEOUS, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; LEFT HEART, BOTH ARTERIAL AND VENOUS ACCESS, WITH TRANSSEPTAL PUNCTURE		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
33992	REMOVAL OF PERCUTANEOUS LEFT HEART VENTRICULAR ASSIST DEVICE, ARTERIAL OR ARTERIAL AND VENOUS CANNULA(S), AT SEPARATE AND DISTINCT SESSION FROM INSERTION		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
33993	REPOSITIONING OF PERCUTANEOUS RIGHT OR LEFT HEART VENTRICULAR ASSIST DEVICE WITH IMAGING GUIDANCE AT SEPARATE AND DISTINCT SESSION FROM INSERTION		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
33999	UNLISTED PROCEDURE, CARDIAC SURGERY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
36465	INJECTION OF NON-COMPOUNDED FOAM SCLEROSANT WITH ULTRASOUND COMPRESSION MANEUVERS TO GUIDE DISPERSION OF THE INJECTATE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING; SINGLE INCOMPETENT EXTREMITY TRUNCAL VEIN (EG, GREAT SAPHENOUS VEIN, ACCESSORY SAPHEN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
36465	INJECTION OF NON-COMPOUNDED FOAM SCLEROSANT WITH ULTRASOUND COMPRESSION MANEUVERS TO GUIDE DISPERSION OF THE INJECTATE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING; SINGLE INCOMPETENT EXTREMITY TRUNCAL VEIN (EG, GREAT SAPHENOUS VEIN, ACCESSORY SAPHEN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
36466	INJECTION OF NON-COMPOUNDED FOAM SCLEROSANT WITH ULTRASOUND COMPRESSION MANEUVERS TO GUIDE DISPERSION OF THE INJECTATE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING; MULTIPLE INCOMPETENT TRUNCAL VEINS (EG, GREAT SAPHENOUS VEIN, ACCESSORY SAPHENOUS VEI		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
36466	INJECTION OF NON-COMPOUNDED FOAM SCLEROSANT WITH ULTRASOUND COMPRESSION MANEUVERS TO GUIDE DISPERSION OF THE INJECTATE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING; MULTIPLE INCOMPETENT TRUNCAL VEINS (EG, GREAT SAPHENOUS VEIN, ACCESSORY SAPHENOUS VEI		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
36470	INJECTION OF SCLEROSANT; SINGLE INCOMPETENT VEIN (OTHER THAN TELANGIECTASIA)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
36470	INJECTION OF SCLEROSANT; SINGLE INCOMPETENT VEIN (OTHER THAN TELANGIECTASIA)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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36471	INJECTION OF SCLEROSANT; MULTIPLE INCOMPETENT VEINS (OTHER THAN TELANGIECTASIA), SAME LEG		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
36471	INJECTION OF SCLEROSANT; MULTIPLE INCOMPETENT VEINS (OTHER THAN TELANGIECTASIA), SAME LEG		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
36473	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, MECHANOCHEMICAL; FIRST VEIN TREATED		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		7/1/2019	InterQual® Evidence-Based Criteria & Guidelines	
36475	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, RADIOFREQUENCY; FIRST VEIN TREATED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
36475	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, RADIOFREQUENCY; FIRST VEIN TREATED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
36476	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, RADIOFREQUENCY; SUBSEQUENT VEIN(S) TREATED IN A SINGLE EXTREMITY, EACH THROUGH SEPARATE ACCESS SITES (LIST SEPARATELY IN ADDITION T		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
36476	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, RADIOFREQUENCY; SUBSEQUENT VEIN(S) TREATED IN A SINGLE EXTREMITY, EACH THROUGH SEPARATE ACCESS SITES (LIST SEPARATELY IN ADDITION T		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
36478	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, LASER; FIRST VEIN TREATED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
36478	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, LASER; FIRST VEIN TREATED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
36479	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, LASER; SUBSEQUENT VEIN(S) TREATED IN A SINGLE EXTREMITY, EACH THROUGH SEPARATE ACCESS SITES (LIST SEPARATELY IN ADDITION TO CODE FO		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
36479	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, LASER; SUBSEQUENT VEIN(S) TREATED IN A SINGLE EXTREMITY, EACH THROUGH SEPARATE ACCESS SITES (LIST SEPARATELY IN ADDITION TO CODE FO		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37500	VASCULAR ENDOSCOPY, SURGICAL, WITH LIGATION OF PERFORATOR VEINS, SUBFASCIAL (SEPS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37500	VASCULAR ENDOSCOPY, SURGICAL, WITH LIGATION OF PERFORATOR VEINS, SUBFASCIAL (SEPS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37700	LIGATION AND DIVISION OF LONG SAPHENOUS VEIN AT SAPHENOFEMORAL JUNCTION, OR DISTAL INTERRUPTIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37700	LIGATION AND DIVISION OF LONG SAPHENOUS VEIN AT SAPHENOFEMORAL JUNCTION, OR DISTAL INTERRUPTIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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37718	LIGATION, DIVISION, AND STRIPPING, SHORT SAPHENOUS VEIN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37718	LIGATION, DIVISION, AND STRIPPING, SHORT SAPHENOUS VEIN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37719	LIGATION, DIVISION, AND STRIPPING, SHORT SAPHENOUS VEIN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37719	LIGATION, DIVISION, AND STRIPPING, SHORT SAPHENOUS VEIN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37722	LIGATION, DIVISION, AND STRIPPING, LONG (GREATER) SAPHENOUS VEINS FROM SAPHENOFEMORAL JUNCTION TO KNEE OR BELOW		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37722	LIGATION, DIVISION, AND STRIPPING, LONG (GREATER) SAPHENOUS VEINS FROM SAPHENOFEMORAL JUNCTION TO KNEE OR BELOW		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37735	LIGATION AND DIVISION AND COMPLETE STRIPPING OF LONG OR SHORT SAPHENOUS VEINS WITH RADICAL EXCISION OF ULCER AND SKIN GRAFT AND/OR INTERRUPTION OF COMMUNICATING VEINS OF LOWER LEG, WITH EXCISION OF DEEP FASCIA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37735	LIGATION AND DIVISION AND COMPLETE STRIPPING OF LONG OR SHORT SAPHENOUS VEINS WITH RADICAL EXCISION OF ULCER AND SKIN GRAFT AND/OR INTERRUPTION OF COMMUNICATING VEINS OF LOWER LEG, WITH EXCISION OF DEEP FASCIA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37760	LIGATION OF PERFORATOR VEINS, SUBFASCIAL, RADICAL (LINTON TYPE), INCLUDING SKIN GRAFT, WHEN PERFORMED, OPEN,1 LEG		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37760	LIGATION OF PERFORATOR VEINS, SUBFASCIAL, RADICAL (LINTON TYPE), INCLUDING SKIN GRAFT, WHEN PERFORMED, OPEN,1 LEG		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37761	LIGATION OF PERFORATOR VEIN(S), SUBFASCIAL, OPEN, INCLUDING ULTRASOUND GUIDANCE, WHEN PERFORMED, 1 LEG		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37761	LIGATION OF PERFORATOR VEIN(S), SUBFASCIAL, OPEN, INCLUDING ULTRASOUND GUIDANCE, WHEN PERFORMED, 1 LEG		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37765	STAB PHLEBECTOMY OF VARICOSE VEINS, 1 EXTREMITY; 10-20 STAB INCISIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37765	STAB PHLEBECTOMY OF VARICOSE VEINS, 1 EXTREMITY; 10-20 STAB INCISIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37766	STAB PHLEBECTOMY OF VARICOSE VEINS, 1 EXTREMITY; MORE THAN 20 INCISIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37766	STAB PHLEBECTOMY OF VARICOSE VEINS, 1 EXTREMITY; MORE THAN 20 INCISIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37780	LIGATION AND DIVISION OF SHORT SAPHENOUS VEIN AT SAPHENOPOPLITEAL JUNCTION (SEPARATE PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37780	LIGATION AND DIVISION OF SHORT SAPHENOUS VEIN AT SAPHENOPOPLITEAL JUNCTION (SEPARATE PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37785	LIGATION, DIVISION, AND/OR EXCISION OF VARICOSE VEIN CLUSTER(S), 1 LEG		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37785	LIGATION, DIVISION, AND/OR EXCISION OF VARICOSE VEIN CLUSTER(S), 1 LEG		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37799	UNLISTED PROCEDURE, VASCULAR SURGERY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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37799	UNLISTED PROCEDURE, VASCULAR SURGERY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37916	REPAIR OF ECTROPION; EXCISION TARSAL WEDGE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
37917	REPAIR OF ECTROPION; EXTENSIVE (E.G. TARSAL STRIP OPERATIONS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
38204	MANAGEMENT OF RECIPIENT HEMATOPOIETIC PROGENITOR CELL DONOR SEARCH AND CELL ACQUISITION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
38205	BLOOD-DERIVED HEMATOPOIETIC PROGENITOR CELL HARVESTING FOR TRANSPLANTATION, PER COLLECTION; ALLOGENEIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
38206	BLOOD-DERIVED HEMATOPOIETIC PROGENITOR CELL HARVESTING FOR TRANSPLANTATION, PER COLLECTION; AUTOLOGOUS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
38207	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR CELLS; CRYOPRESERVATION AND STORAGE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
38208	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR CELLS; THAWING OF PREVIOUSLY FROZEN HARVEST, WITHOUT WASHING, PER DONOR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
38209	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR CELLS; THAWING OF PREVIOUSLY FROZEN HARVEST, WITH WASHING, PER DONOR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
38210	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR CELLS; SPECIFIC CELL DEPLETION WITHIN HARVEST, T-CELL DEPLETION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
38211	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR CELLS; TUMOR CELL DEPLETION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
38212	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR CELLS; RED BLOOD CELL REMOVAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
38213	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR CELLS; PLATELET DEPLETION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
38214	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR CELLS; PLASMA (VOLUME) DEPLETION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
38215	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR CELLS; CELL CONCENTRATION IN PLASMA, MONONUCLEAR, OR BUFFY COAT LAYER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
38225	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		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
38226	CHIMERIC ANTIGEN RECEPTOR T-CELL (CAR-T) THERAPY; PREPARATION OF BLOOD-DERIVED T LYMPHOCYTES FOR TRANSPORTATION (EG, CRYOPRESERVATION, STORAGE)		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
38227	CHIMERIC ANTIGEN RECEPTOR T-CELL (CAR-T) THERAPY; RECEIPT AND PREPARATION OF CAR-T CELLS FOR ADMINISTRATION		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
38228	CHIMERIC ANTIGEN RECEPTOR T-CELL (CAR-T) THERAPY; CAR-T CELL ADMINISTRATION, AUTOLOGOUS		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
38232	BONE MARROW HARVESTING FOR TRANSPLANTATION; AUTOLOGOUS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
38240	HEMATOPOIETIC PROGENITOR CELL (HPC); ALLOGENEIC TRANSPLANTATION PER DONOR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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38241	HEMATOPOIETIC PROGENITOR CELL (HPC); AUTOLOGOUS TRANSPLANTATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
38242	ALLOGENEIC LYMPHOCYTE INFUSIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
38243	HEMATOPOIETIC PROGENITOR CELL (HPC); HPC BOOST		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
38308	LYMPHANGIOTOMY OR OTHER OPERATIONS ON LYMPHATIC CHANNELS		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
40510	EXCISION OF LIP; TRANSVERSE WEDGE EXCISION WITH PRIMARY CLOSURE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
40520	EXCISION OF LIP; V-EXCISION WITH PRIMARY DIRECT LINEAR CLOSURE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
40525	EXCISION OF LIP; FULL THICKNESS, RECONSTRUCTION WITH LOCAL FLAP (EG, ESTLANDER OR FAN)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
40527	EXCISION OF LIP; FULL THICKNESS, RECONSTRUCTION WITH CROSS LIP FLAP (ABBE-ESTLANDER)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
40530	RESECTION OF LIP, MORE THAN ONE-FOURTH, WITHOUT RECONSTRUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
40650	REPAIR LIP, FULL THICKNESS; VERMILION ONLY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
40652	REPAIR LIP, FULL THICKNESS; UP TO HALF VERTICAL HEIGHT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
40654	REPAIR LIP, FULL THICKNESS; OVER ONE-HALF VERTICAL HEIGHT, OR COMPLEX		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
40700	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; PRIMARY, PARTIAL OR COMPLETE, UNILATERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
40702	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; PRIMARY BILATERAL, 1 OF 2 STAGES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
40720	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; SECONDARY, BY RECREATION OF DEFECT AND RECLOSURE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
40761	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; WITH CROSS LIP PEDICLE FLAP (ABBE-ESTLANDER TYPE), INCLUDING SECTIONING AND INSERTING OF PEDICLE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
40799	UNLISTED PROCEDURE, LIPS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
40840	VESTIBULOPLASTY; ANTERIOR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
40842	VESTIBULOPLASTY; POSTERIOR, UNILATERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
40843	VESTIBULOPLASTY; POSTERIOR, BILATERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
40844	VESTIBULOPLASTY; ENTIRE ARCH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
40845	VESTIBULOPLASTY; COMPLEX (INCLUDING RIDGE EXTENSION, MUSCLE REPOSITIONING)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
40899	UNLISTED PROCEDURE, VESTIBULE OF MOUTH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
41512	TONGUE BASE SUSPENSION, PERMANENT SUTURE TECHNIQUE		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
41530	SUBMUCOSAL ABLATION OF THE TONGUE BASE, RADIOFREQUENCY, 1 OR MORE SITES, PER SESSION		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
41828	EXCISION OF HYPERPLASTIC ALVEOLAR MUCOSA, EACH QUADRANT (SPECIFY)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
41830	ALVEOLECTOMY, INCLUDING CURETTAGE OF OSTEITIS OR SEQUESTRECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
41872	GINGIVOPLASTY, EACH QUADRANT (SPECIFY)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
41872	GINGIVOPLASTY, EACH QUADRANT (SPECIFY)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
41874	ALVEOLOPLASTY, EACH QUADRANT (SPECIFY)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
41874	ALVEOLOPLASTY, EACH QUADRANT (SPECIFY)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
41899	UNLISTED PROCEDURE, DENTOALVEOLAR STRUCTURES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
42200	PALATOPLASTY FOR CLEFT PALATE, SOFT AND/OR HARD PALATE ONLY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
42205	PALATOPLASTY FOR CLEFT PALATE, WITH CLOSURE OF ALVEOLAR RIDGE; SOFT TISSUE ONLY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
42210	PALATOPLASTY FOR CLEFT PALATE, WITH CLOSURE OF ALVEOLAR RIDGE; WITH BONE GRAFT TO ALVEOLAR RIDGE (INCLUDES OBTAINING GRAFT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
42215	PALATOPLASTY FOR CLEFT PALATE; MAJOR REVISION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
42220	PALATOPLASTY FOR CLEFT PALATE; SECONDARY LENGTHENING PROCEDURE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
42225	PALATOPLASTY FOR CLEFT PALATE; ATTACHMENT PHARYNGEAL FLAP		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
42260	REPAIR OF NASOLABIAL FISTULA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
43284	LAPAROSCOPY, SURGICAL, ESOPHAGEAL SPHINCTER AUGMENTATION PROCEDURE, PLACEMENT OF SPHINCTER AUGMENTATION DEVICE (IE, MAGNETIC BAND), INCLUDING CRUROPLASTY WHEN PERFORMED		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
43621	GASTRECTOMY, TOTAL; WITH ROUX-EN-Y RECONSTRUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	Evidence of Coverage (EOC, Plan coverage docu ment)
43622	GASTRECTOMY, TOTAL; WITH FORMATION OF INTESTINAL POUCH, ANY TYPE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	Evidence of Coverage (EOC, Plan coverage docu ment)
43631	GASTRECTOMY, PARTIAL, DISTAL; WITH GASTRODUODENOSTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	Evidence of Coverage (EOC, Plan coverage docu ment)
43632	GASTRECTOMY, PARTIAL, DISTAL; WITH GASTROJEJUNOSTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	Evidence of Coverage (EOC, Plan coverage docu ment)
43633	GASTRECTOMY, PARTIAL, DISTAL; WITH ROUX-EN-Y RECONSTRUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	Evidence of Coverage (EOC, Plan coverage docu ment)
43634	GASTRECTOMY, PARTIAL, DISTAL; WITH FORMATION OF INTESTINAL POUCH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	Evidence of Coverage (EOC, Plan coverage docu ment)
43644	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; WITH GASTRIC BYPASS AND ROUX-EN-Y GASTROENTEROSTOMY (ROUX LIMB 150 CM OR LESS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	Evidence of Coverage (EOC, Plan coverage docu ment)

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
43645	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; WITH GASTRIC BYPASS AND SMALL INTESTINE RECONSTRUCTION TO LIMIT ABSORPTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	Evidence of Coverage (EOC, Plan coverage docu ment)
43647	LAPAROSCOPY, SURGICAL; IMPLANTATION OR REPLACEMENT OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
43648	LAPAROSCOPY, SURGICAL; REVISION OR REMOVAL OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
43659	UNLISTED LAPAROSCOPY PROCEDURE, STOMACH		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
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)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	Evidence of Coverage (EOC, Plan coverage docu ment)
43846	GASTRIC RESTRICTIVE PROCEDURE, WITH GASTRIC BYPASS FOR MORBID OBESITY; WITH SHORT LIMB (150 CM OR LESS) ROUX-EN-Y GASTROENTEROSTOMY	Noncovered healthcare service	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
43999	UNLISTED PROCEDURE, STOMACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
44132	DONOR ENTERECTOMY (INCLUDING COLD PRESERVATION), OPEN; FROM CADAVER DONOR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
44133	DONOR ENTERECTOMY (INCLUDING COLD PRESERVATION), OPEN; PARTIAL, FROM LIVING DONOR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
44135	INTESTINAL ALLOTRANSPLANTATION; FROM CADAVER DONOR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
44136	INTESTINAL ALLOTRANSPLANTATION; FROM LIVING DONOR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
44137	REMOVAL OF TRANSPLANTED INTESTINAL ALLOGRAFT, COMPLETE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
44799	UNLISTED PROCEDURE, SMALL INTESTINE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
44799	UNLISTED PROCEDURE, SMALL INTESTINE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
46220	EXCISION OF SINGLE EXTERNAL PAPILLA OR TAG, ANUS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
46230	EXCISION OF MULTIPLE EXTERNAL PAPILLAE OR TAGS, ANUS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
46707	REPAIR OF ANORECTAL FISTULA WITH PLUG (EG, PORCINE SMALL INTESTINE SUBMUCOSA [SIS])		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
47135	LIVER ALLOTRANSPLANTATION, ORTHOTOPIC, PARTIAL OR WHOLE, FROM CADAVER OR LIVING DONOR, ANY AGE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
47136	LIVER ALLOTRANSPLANTATION; HETEROTOPIC, PARTIAL OR WHOLE, FROM CADAVER OR LIVING DONOR, ANY AGE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
47140	DONOR HEPATECTOMY (INCLUDING COLD PRESERVATION), FROM LIVING DONOR; LEFT LATERAL SEGMENT ONLY (SEGMENTS II AND III)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
47141	DONOR HEPATECTOMY (INCLUDING COLD PRESERVATION), FROM LIVING DONOR; TOTAL LEFT LOBECTOMY (SEGMENTS II, III AND IV)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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47142	DONOR HEPATECTOMY (INCLUDING COLD PRESERVATION), FROM LIVING DONOR; TOTAL RIGHT LOBECTOMY (SEGMENTS V, VI, VII AND VIII)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
47143	BACKBENCH STANDARD PREPARATION OF CADAVER DONOR WHOLE LIVER GRAFT PRIOR TO ALLOTRANSPLANTATION, INCLUDING CHOLECYSTECTOMY, IF NECESSARY, AND DISSECTION AND REMOVAL OF SURROUNDING SOFT TISSUES TO PREPARE THE VENA CAVA, PORTAL VEIN, HEPATIC ARTERY, AND COMM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
47144	BACKBENCH STANDARD PREPARATION OF CADAVER DONOR WHOLE LIVER GRAFT PRIOR TO ALLOTRANSPLANTATION, INCLUDING CHOLECYSTECTOMY, IF NECESSARY, AND DISSECTION AND REMOVAL OF SURROUNDING SOFT TISSUES TO PREPARE THE VENA CAVA, PORTAL VEIN, HEPATIC ARTERY, AND COMM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
47145	BACKBENCH STANDARD PREPARATION OF CADAVER DONOR WHOLE LIVER GRAFT PRIOR TO ALLOTRANSPLANTATION, INCLUDING CHOLECYSTECTOMY, IF NECESSARY, AND DISSECTION AND REMOVAL OF SURROUNDING SOFT TISSUES TO PREPARE THE VENA CAVA, PORTAL VEIN, HEPATIC ARTERY, AND COMM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
47146	BACKBENCH RECONSTRUCTION OF CADAVER OR LIVING DONOR LIVER GRAFT PRIOR TO ALLOTRANSPLANTATION; VENOUS ANASTOMOSIS, EACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
47147	BACKBENCH RECONSTRUCTION OF CADAVER OR LIVING DONOR LIVER GRAFT PRIOR TO ALLOTRANSPLANTATION; ARTERIAL ANASTOMOSIS, EACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
47381	ABLATION, OPEN, OF 1 OR MORE LIVER TUMOR(S); CRYOSURGICAL		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
47383	ABLATION, 1 OR MORE LIVER TUMOR(S), PERCUTANEOUS, CRYOABLATION		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
47399	UNLISTED PROCEDURE, LIVER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
48160	PANCREATECTOMY, TOTAL OR SUBTOTAL, WITH AUTOLOGOUS TRANSPLANTATION OF PANCREAS OR PANCREATIC ISLET CELLS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
48550	DONOR PANCREATECTOMY (INCLUDING COLD PRESERVATION), WITH OR WITHOUT DUODENAL SEGMENT FOR TRANSPLANTATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
48551	BACKBENCH STANDARD PREPARATION OF CADAVER DONOR PANCREAS ALLOGRAFT PRIOR TO TRANSPLANTATION, INCLUDING DISSECTION OF ALLOGRAFT FROM SURROUNDING SOFT TISSUES, SPLENECTOMY, DUODENOTOMY, LIGATION OF BILE DUCT, LIGATION OF MESENTERIC VESSELS, AND Y-GRAFT ARTE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
48552	BACKBENCH RECONSTRUCTION OF CADAVER DONOR PANCREAS ALLOGRAFT PRIOR TO TRANSPLANTATION, VENOUS ANASTOMOSIS, EACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
48554	TRANSPLANTATION OF PANCREATIC ALLOGRAFT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
48556	REMOVAL OF TRANSPLANTED PANCREATIC ALLOGRAFT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
48999	UNLISTED PROCEDURE, PANCREAS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
49999	UNLISTED PROCEDURE, ABDOMEN, PERITONEUM AND OMENTUM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
50300	DONOR NEPHRECTOMY (INCLUDING COLD PRESERVATION); FROM CADAVER DONOR, UNILATERAL OR BILATERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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50320	DONOR NEPHRECTOMY (INCLUDING COLD PRESERVATION); OPEN, FROM LIVING DONOR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
50323	BACKBENCH STANDARD PREPARATION OF CADAVER DONOR RENAL ALLOGRAFT PRIOR TO TRANSPLANTATION, INCLUDING DISSECTION AND REMOVAL OF PERINEPHRIC FAT, DIAPHRAGMATIC AND RETROPERITONEAL ATTACHMENTS, EXCISION OF ADRENAL GLAND, AND PREPARATION OF URETER(S), RENAL VE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
50325	BACKBENCH STANDARD PREPARATION OF LIVING DONOR RENAL ALLOGRAFT (OPEN OR LAPAROSCOPIC) PRIOR TO TRANSPLANTATION, INCLUDING DISSECTION AND REMOVAL OF PERINEPHRIC FAT AND PREPARATION OF URETER(S), RENAL VEIN(S), AND RENAL ARTERY(S), LIGATING BRANCHES, AS NEC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
50327	BACKBENCH RECONSTRUCTION OF CADAVER OR LIVING DONOR RENAL ALLOGRAFT PRIOR TO TRANSPLANTATION; VENOUS ANASTOMOSIS, EACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
50328	BACKBENCH RECONSTRUCTION OF CADAVER OR LIVING DONOR RENAL ALLOGRAFT PRIOR TO TRANSPLANTATION; ARTERIAL ANASTOMOSIS, EACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
50329	BACKBENCH RECONSTRUCTION OF CADAVER OR LIVING DONOR RENAL ALLOGRAFT PRIOR TO TRANSPLANTATION; URETERAL ANASTOMOSIS, EACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
50340	RECIPIENT NEPHRECTOMY (SEPARATE PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
50360	RENAL ALLOTRANSPLANTATION, IMPLANTATION OF GRAFT; WITHOUT RECIPIENT NEPHRECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
50365	RENAL ALLOTRANSPLANTATION, IMPLANTATION OF GRAFT; WITH RECIPIENT NEPHRECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
50370	REMOVAL OF TRANSPLANTED RENAL ALLOGRAFT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
50380	RENAL AUTOTRANSPLANTATION, REIMPLANTATION OF KIDNEY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
50546	LAPAROSCOPY, SURGICAL; NEPHRECTOMY, INCLUDING PARTIAL URETERECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
50547	LAPAROSCOPY, SURGICAL; DONOR NEPHRECTOMY (INCLUDING COLD PRESERVATION), FROM LIVING DONOR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
50548	LAPAROSCOPY, SURGICAL; NEPHRECTOMY WITH TOTAL URETERECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
51020	CYSTOTOMY OR CYSTOSTOMY, WITH FULGURATION AND/OR INSERTION OF RADIOACTIVE MATERIAL		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
51715	ENDOSCOPIC INJECTION OF IMPLANT MATERIAL INTO THE SUBMUCOSAL TISSUES OF THE URETHRA AND/OR BLADDER NECK		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
53400	URETHROPLASTY; FIRST STAGE, FOR FISTULA, DIVERTICULUM, OR STRICTURE (EG, JOHANNSEN TYPE)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
53405	URETHROPLASTY; SECOND STAGE (FORMATION OF URETHRA), INCLUDING URINARY DIVERSION		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
53410	URETHROPLASTY, 1-STAGE RECONSTRUCTION OF MALE ANTERIOR URETHRA		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	

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53430	URETHROPLASTY, RECONSTRUCTION OF FEMALE URETHRA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
53431	URETHROPLASTY WITH TUBULARIZATION OF POSTERIOR URETHRA AND/OR LOWER BLADDER FOR INCONTINENCE (EG, TENAGO, LEADBETTER PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
53520	CLOSURE OF URETHROSTOMY OR URETHROCUTANEOUS FISTULA, MALE (SEPARATE PROCEDURE)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
53854	TRANSURETHRAL DESTRUCTION OF PROSTATE TISSUE; BY RADIOFREQUENCY GENERATED WATER VAPOR THERMOTHERAPY		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
54120	AMPUTATION OF PENIS; PARTIAL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
54125	AMPUTATION OF PENIS; COMPLETE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
54200	INJECTION PROCEDURE FOR PEYRONIE DISEASE;		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
54235	INJECTION OF CORPORA CAVERNOSA WITH PHARMACOLOGIC AGENT(S) (EG, PAPAVERINE, PHENTOLAMINE)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
54300	PLASTIC OPERATION OF PENIS FOR STRAIGHTENING OF CHORDEE (EG, HYPOSPADIAS), WITH OR WITHOUT MOBILIZATION OF URETHRA		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
54304	PLASTIC OPERATION ON PENIS FOR CORRECTION OF CHORDEE OR FOR FIRST STAGE HYPOSPADIAS REPAIR WITH OR WITHOUT TRANSPLANTATION OF PREPUCE AND/OR SKIN FLAPS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
54336	1-STAGE PERINEAL HYPOSPADIAS REPAIR REQUIRING EXTENSIVE DISSECTION TO CORRECT CHORDEE AND URETHROPLASTY BY USE OF SKIN GRAFT TUBE AND/OR ISLAND FLAP		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
54400	INSERTION OF PENILE PROSTHESIS; NON-INFLATABLE (SEMI-RIGID)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
54417	REMOVAL AND REPLACEMENT OF NON-INFLATABLE (SEMI-RIGID) OR INFLATABLE (SELF-CONTAINED) PENILE PROSTHESIS THROUGH AN INFECTED FIELD AT THE SAME OPERATIVE SESSION, INCLUDING IRRIGATION AND DEBRIDEMENT OF INFECTED TISSUE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
54520	ORCHIECTOMY, SIMPLE (INCLUDING SUBCAPSULAR), WITH OR WITHOUT TESTICULAR PROSTHESIS, SCROTAL OR INGUINAL APPROACH		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
54660	INSERTION OF TESTICULAR PROSTHESIS (SEPARATE PROCEDURE)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
54660	INSERTION OF TESTICULAR PROSTHESIS (SEPARATE PROCEDURE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
54690	LAPAROSCOPY, SURGICAL; ORCHIECTOMY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
55150	RESECTION OF SCROTUM		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
55175	SCROTOPLASTY; SIMPLE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
55180	SCROTOPLASTY; COMPLICATED		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
55706	BIOPSIES, PROSTATE, NEEDLE, TRANSPERINEAL, STEREOTACTIC TEMPLATE GUIDED SATURATION SAMPLING, INCLUDING IMAGING GUIDANCE		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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55874	TRANSPERINEAL PLACEMENT OF BIODEGRADABLE MATERIAL, PERI-PROSTATIC, SINGLE OR MULTIPLE INJECTION(S), INCLUDING IMAGE GUIDANCE, WHEN PERFORMED		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
56625	VULVECTOMY SIMPLE; COMPLETE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
57106	VAGINECTOMY, PARTIAL REMOVAL OF VAGINAL WALL;		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
57106	VAGINECTOMY, PARTIAL REMOVAL OF VAGINAL WALL;		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
57107	VAGINECTOMY, PARTIAL REMOVAL OF VAGINAL WALL; WITH REMOVAL OF PARAVAGINAL TISSUE (RADICAL VAGINECTOMY)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
57109	VAGINECTOMY, PARTIAL REMOVAL OF VAGINAL WALL; WITH REMOVAL OF PARAVAGINAL TISSUE (RADICAL VAGINECTOMY) WITH BILATERAL TOTAL PELVIC LYMPHADENECTOMY AND PARA-AORTIC LYMPH NODE SAMPLING (BIOPSY)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
57110	VAGINECTOMY, COMPLETE REMOVAL OF VAGINAL WALL;		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
57110	VAGINECTOMY, COMPLETE REMOVAL OF VAGINAL WALL;		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
57111	VAGINECTOMY, COMPLETE REMOVAL OF VAGINAL WALL; WITH REMOVAL OF PARAVAGINAL TISSUE (RADICAL VAGINECTOMY)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
57282	COLPOPEXY, VAGINAL; EXTRA-PERITONEAL APPROACH (SACROSPINOUS, ILIOCOCCYGEUS)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	
57292	CONSTRUCTION OF ARTIFICIAL VAGINA; WITH GRAFT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
57292	CONSTRUCTION OF ARTIFICIAL VAGINA; WITH GRAFT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
58674	LAPAROSCOPY, SURGICAL, ABLATION OF UTERINE FIBROID(S) INCLUDING INTRAOPERATIVE ULTRASOUND GUIDANCE AND MONITORING, RADIOFREQUENCY		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
58999	UNLISTED PROCEDURE, FEMALE GENITAL SYSTEM (NONOBSTETRICAL)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
59840	INDUCED ABORTION, BY DILATION AND CURETTAGE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
59841	INDUCED ABORTION, BY DILATION AND EVACUATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
59850	INDUCED ABORTION, BY 1 OR MORE INTRA-AMNIOTIC INJECTIONS (AMNIOCENTESIS-INJECTIONS), INCLUDING HOSPITAL ADMISSION AND VISITS, DELIVERY OF FETUS AND SECUNDINES;		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
59851	INDUCED ABORTION, BY 1 OR MORE INTRA-AMNIOTIC INJECTIONS (AMNIOCENTESIS-INJECTIONS), INCLUDING HOSPITAL ADMISSION AND VISITS, DELIVERY OF FETUS AND SECUNDINES; WITH DILATION AND CURETTAGE AND/OR EVACUATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
59852	INDUCED ABORTION, BY 1 OR MORE INTRA-AMNIOTIC INJECTIONS (AMNIOCENTESIS-INJECTIONS), INCLUDING HOSPITAL ADMISSION AND VISITS, DELIVERY OF FETUS AND SECUNDINES; WITH HYSTEROTOMY (FAILED INTRA-AMNIOTIC INJECTION)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
59855	INDUCED ABORTION, BY 1 OR MORE VAGINAL SUPPOSITORIES (EG, PROSTAGLANDIN) WITH OR WITHOUT CERVICAL DILATION (EG, LAMINARIA), INCLUDING HOSPITAL ADMISSION AND VISITS, DELIVERY OF FETUS AND SECUNDINES;		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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59856	INDUCED ABORTION, BY 1 OR MORE VAGINAL SUPPOSITORIES (EG, PROSTAGLANDIN) WITH OR WITHOUT CERVICAL DILATION (EG, LAMINARIA), INCLUDING HOSPITAL ADMISSION AND VISITS, DELIVERY OF FETUS AND SECUNDINES; WITH DILATION AND CURETTAGE AND/OR EVACUATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
59857	INDUCED ABORTION, BY 1 OR MORE VAGINAL SUPPOSITORIES (EG, PROSTAGLANDIN) WITH OR WITHOUT CERVICAL DILATION (EG, LAMINARIA), INCLUDING HOSPITAL ADMISSION AND VISITS, DELIVERY OF FETUS AND SECUNDINES; WITH HYSTEROTOMY (FAILED MEDICAL EVACUATION)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
60512	PARATHYROID AUTOTRANSPLANTATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
61330	DECOMPRESSION OF ORBIT ONLY, TRANSCRANIAL APPROACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
61580	CRANIOFACIAL APPROACH TO ANTERIOR CRANIAL FOSSA; EXTRADURAL, INCLUDING LATERAL RHINOTOMY, ETHMOIDECTOMY, SPHENOIDECTOMY, WITHOUT MAXILLECTOMY OR ORBITAL EXENTERATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
61581	CRANIOFACIAL APPROACH TO ANTERIOR CRANIAL FOSSA; EXTRADURAL, INCLUDING LATERAL RHINOTOMY, ORBITAL EXENTERATION, ETHMOIDECTOMY, SPHENOIDECTOMY AND/OR MAXILLECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
61582	CRANIOFACIAL APPROACH TO ANTERIOR CRANIAL FOSSA; EXTRADURAL, INCLUDING UNILATERAL OR BIFRONTAL CRANIOTOMY, ELEVATION OF FRONTAL LOBE(S), OSTEOTOMY OF BASE OF ANTERIOR CRANIAL FOSSA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
61583	CRANIOFACIAL APPROACH TO ANTERIOR CRANIAL FOSSA; INTRADURAL, INCLUDING UNILATERAL OR BIFRONTAL CRANIOTOMY, ELEVATION OR RESECTION OF FRONTAL LOBE, OSTEOTOMY OF BASE OF ANTERIOR CRANIAL FOSSA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
61889	INSERTION OF SKULL-MOUNTED CRANIAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, INCLUDING CRANIECTOMY OR CRANIOTOMY, WHEN PERFORMED, WITH DIRECT OR INDUCTIVE COUPLING, WITH CONNECTION TO DEPTH AND/OR CORTICAL STRIP ELECTRODE ARRAY(S)		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
61891	REVISION OR REPLACEMENT OF SKULL-MOUNTED CRANIAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER WITH CONNECTION TO DEPTH AND/OR CORTICAL STRIP ELECTRODE ARRAY(S)		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
61892	REMOVAL OF SKULL-MOUNTED CRANIAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER WITH CRANIOPLASTY, WHEN PERFORMED		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
62263	PERCUTANEOUS LYSIS OF EPIDURAL ADHESIONS USING SOLUTION INJECTION (EG, HYPERTONIC SALINE, ENZYME) OR MECHANICAL MEANS (EG, CATHETER) INCLUDING RADIOLOGIC LOCALIZATION (INCLUDES CONTRAST WHEN ADMINISTERED), MULTIPLE ADHESIOLYSIS SESSIONS; 2 OR MORE DAYS		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
62264	PERCUTANEOUS LYSIS OF EPIDURAL ADHESIONS USING SOLUTION INJECTION (EG, HYPERTONIC SALINE, ENZYME) OR MECHANICAL MEANS (EG, CATHETER) INCLUDING RADIOLOGIC LOCALIZATION (INCLUDES CONTRAST WHEN ADMINISTERED), MULTIPLE ADHESIOLYSIS SESSIONS; 1 DAY		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
62267	PERCUTANEOUS ASPIRATION WITHIN THE NUCLEUS PULPOSUS, INTERVERTEBRAL DISC, OR PARAVERTEBRAL TISSUE FOR DIAGNOSTIC PURPOSES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
62268	PERCUTANEOUS ASPIRATION, SPINAL CORD CYST OR SYRINX		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
62269	BIOPSY OF SPINAL CORD, PERCUTANEOUS NEEDLE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
62270	SPINAL PUNCTURE, LUMBAR, DIAGNOSTIC;		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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62272	SPINAL PUNCTURE, THERAPEUTIC, FOR DRAINAGE OF CEREBROSPINAL FLUID (BY NEEDLE OR CATHETER);		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
62273	INJECTION, EPIDURAL, OF BLOOD OR CLOT PATCH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
62280	INJECTION/INFUSION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL, PHENOL, ICED SALINE SOLUTIONS), WITH OR WITHOUT OTHER THERAPEUTIC SUBSTANCE; SUBARACHNOID		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
62281	INJECTION/INFUSION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL, PHENOL, ICED SALINE SOLUTIONS), WITH OR WITHOUT OTHER THERAPEUTIC SUBSTANCE; EPIDURAL, CERVICAL OR THORACIC		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
62281	INJECTION/INFUSION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL, PHENOL, ICED SALINE SOLUTIONS), WITH OR WITHOUT OTHER THERAPEUTIC SUBSTANCE; EPIDURAL, CERVICAL OR THORACIC		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
62282	INJECTION/INFUSION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL, PHENOL, ICED SALINE SOLUTIONS), WITH OR WITHOUT OTHER THERAPEUTIC SUBSTANCE; EPIDURAL, LUMBAR, SACRAL (CAUDAL)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
62282	INJECTION/INFUSION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL, PHENOL, ICED SALINE SOLUTIONS), WITH OR WITHOUT OTHER THERAPEUTIC SUBSTANCE; EPIDURAL, LUMBAR, SACRAL (CAUDAL)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
62284	INJECTION PROCEDURE FOR MYELOGRAPHY AND/OR COMPUTED TOMOGRAPHY, LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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 INJ		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
62320	INJECTION(S), OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (EG, ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), NOT INCLUDING NEUROLYTIC SUBSTANCES, INCLUDING NEEDLE OR CATHETER PLACEMENT, INTERLAMINAR EPIDURAL OR SUBARACHNOID, CERVICAL OR THORA		8/15/2018	InterQual® Evidence-Based Criteria & Guidelines	
62321	INJECTION(S), OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (EG, ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), NOT INCLUDING NEUROLYTIC SUBSTANCES, INCLUDING NEEDLE OR CATHETER PLACEMENT, INTERLAMINAR EPIDURAL OR SUBARACHNOID, CERVICAL OR THORA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
62322	INJECTION(S), OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (EG, ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), NOT INCLUDING NEUROLYTIC SUBSTANCES, INCLUDING NEEDLE OR CATHETER PLACEMENT, INTERLAMINAR EPIDURAL OR SUBARACHNOID, LUMBAR OR SACRAL		8/15/2018	InterQual® Evidence-Based Criteria & Guidelines	
62323	INJECTION(S), OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (EG, ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), NOT INCLUDING NEUROLYTIC SUBSTANCES, INCLUDING NEEDLE OR CATHETER PLACEMENT, INTERLAMINAR EPIDURAL OR SUBARACHNOID, LUMBAR OR SACRAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
62324	INJECTION(S), INCLUDING INDWELLING CATHETER PLACEMENT, CONTINUOUS INFUSION OR INTERMITTENT BOLUS, OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (EG, ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), NOT INCLUDING NEUROLYTIC SUBSTANCES, INTERLAMINAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
62325	INJECTION(S), INCLUDING INDWELLING CATHETER PLACEMENT, CONTINUOUS INFUSION OR INTERMITTENT BOLUS, OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (EG, ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), NOT INCLUDING NEUROLYTIC SUBSTANCES, INTERLAMINAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
62326	INJECTION(S), INCLUDING INDWELLING CATHETER PLACEMENT, CONTINUOUS INFUSION OR INTERMITTENT BOLUS, OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (EG, ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), NOT INCLUDING NEUROLYTIC SUBSTANCES, INTERLAMINAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
62327	INJECTION(S), INCLUDING INDWELLING CATHETER PLACEMENT, CONTINUOUS INFUSION OR INTERMITTENT BOLUS, OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (EG, ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), NOT INCLUDING NEUROLYTIC SUBSTANCES, INTERLAMINAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
62350	IMPLANTATION, REVISION OR REPOSITIONING OF TUNNELED INTRATHECAL OR EPIDURAL CATHETER, FOR LONG-TERM MEDICATION ADMINISTRATION VIA AN EXTERNAL PUMP OR IMPLANTABLE RESERVOIR/INFUSION PUMP; WITHOUT LAMINECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
62351	IMPLANTATION, REVISION OR REPOSITIONING OF TUNNELED INTRATHECAL OR EPIDURAL CATHETER, FOR LONG-TERM MEDICATION ADMINISTRATION VIA AN EXTERNAL PUMP OR IMPLANTABLE RESERVOIR/INFUSION PUMP; WITH LAMINECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
62355	REMOVAL OF PREVIOUSLY IMPLANTED INTRATHECAL OR EPIDURAL CATHETER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
62360	IMPLANTATION OR REPLACEMENT OF DEVICE FOR INTRATHECAL OR EPIDURAL DRUG INFUSION; SUBCUTANEOUS RESERVOIR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
62361	IMPLANTATION OR REPLACEMENT OF DEVICE FOR INTRATHECAL OR EPIDURAL DRUG INFUSION; NONPROGRAMMABLE PUMP		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
62362	IMPLANTATION OR REPLACEMENT OF DEVICE FOR INTRATHECAL OR EPIDURAL DRUG INFUSION; PROGRAMMABLE PUMP, INCLUDING PREPARATION OF PUMP, WITH OR WITHOUT PROGRAMMING		1/1/2021	InterQual® Evidence-Based Criteria & Guidelines	
62365	REMOVAL OF SUBCUTANEOUS RESERVOIR OR PUMP, PREVIOUSLY IMPLANTED FOR INTRATHECAL OR EPIDURAL INFUSION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
62380	ENDOSCOPIC DECOMPRESSION OF SPINAL CORD, NERVE ROOT(S), INCLUDING LAMINOTOMY, PARTIAL FACETECTOMY, FORAMINOTOMY, DISCECTOMY AND/OR EXCISION OF HERNIATED INTERVERTEBRAL DISC, 1 INTERSPACE, LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63001	LAMINECTOMY WITH EXPLORATION AND/OR DECOMPRESSION OF SPINAL CORD AND/OR CAUDA EQUINA, WITHOUT FACETECTOMY, FORAMINOTOMY OR DISCECTOMY (EG, SPINAL STENOSIS), 1 OR 2 VERTEBRAL SEGMENTS; CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63003	LAMINECTOMY WITH EXPLORATION AND/OR DECOMPRESSION OF SPINAL CORD AND/OR CAUDA EQUINA, WITHOUT FACETECTOMY, FORAMINOTOMY OR DISCECTOMY (EG, SPINAL STENOSIS), 1 OR 2 VERTEBRAL SEGMENTS; THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63005	LAMINECTOMY WITH EXPLORATION AND/OR DECOMPRESSION OF SPINAL CORD AND/OR CAUDA EQUINA, WITHOUT FACETECTOMY, FORAMINOTOMY OR DISCECTOMY (EG, SPINAL STENOSIS), 1 OR 2 VERTEBRAL SEGMENTS; LUMBAR, EXCEPT FOR SPONDYLOLISTHESIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63011	LAMINECTOMY WITH EXPLORATION AND/OR DECOMPRESSION OF SPINAL CORD AND/OR CAUDA EQUINA, WITHOUT FACETECTOMY, FORAMINOTOMY OR DISCECTOMY (EG, SPINAL STENOSIS), 1 OR 2 VERTEBRAL SEGMENTS; SACRAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63012	LAMINECTOMY WITH REMOVAL OF ABNORMAL FACETS AND/OR PARS INTER-ARTICULARIS WITH DECOMPRESSION OF CAUDA EQUINA AND NERVE ROOTS FOR SPONDYLOLISTHESIS, LUMBAR (GILL TYPE PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
63015	LAMINECTOMY WITH EXPLORATION AND/OR DECOMPRESSION OF SPINAL CORD AND/OR CAUDA EQUINA, WITHOUT FACETECTOMY, FORAMINOTOMY OR DISCECTOMY (EG, SPINAL STENOSIS), MORE THAN 2 VERTEBRAL SEGMENTS; CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63016	LAMINECTOMY WITH EXPLORATION AND/OR DECOMPRESSION OF SPINAL CORD AND/OR CAUDA EQUINA, WITHOUT FACETECTOMY, FORAMINOTOMY OR DISCECTOMY (EG, SPINAL STENOSIS), MORE THAN 2 VERTEBRAL SEGMENTS; THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63017	LAMINECTOMY WITH EXPLORATION AND/OR DECOMPRESSION OF SPINAL CORD AND/OR CAUDA EQUINA, WITHOUT FACETECTOMY, FORAMINOTOMY OR DISCECTOMY (EG, SPINAL STENOSIS), MORE THAN 2 VERTEBRAL SEGMENTS; LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63020	LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF NERVE ROOT(S), INCLUDING PARTIAL FACETECTOMY, FORAMINOTOMY AND/OR EXCISION OF HERNIATED INTERVERTEBRAL DISC; 1 INTERSPACE, CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63030	LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF NERVE ROOT(S), INCLUDING PARTIAL FACETECTOMY, FORAMINOTOMY AND/OR EXCISION OF HERNIATED INTERVERTEBRAL DISC; 1 INTERSPACE, LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63035	LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF NERVE ROOT(S), INCLUDING PARTIAL FACETECTOMY, FORAMINOTOMY AND/OR EXCISION OF HERNIATED INTERVERTEBRAL DISC; EACH ADDITIONAL INTERSPACE, CERVICAL OR LUMBAR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63040	LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF NERVE ROOT(S), INCLUDING PARTIAL FACETECTOMY, FORAMINOTOMY AND/OR EXCISION OF HERNIATED INTERVERTEBRAL DISC, REEXPLORATION, SINGLE INTERSPACE; CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63042	LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF NERVE ROOT(S), INCLUDING PARTIAL FACETECTOMY, FORAMINOTOMY AND/OR EXCISION OF HERNIATED INTERVERTEBRAL DISC, REEXPLORATION, SINGLE INTERSPACE; LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63043	LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF NERVE ROOT(S), INCLUDING PARTIAL FACETECTOMY, FORAMINOTOMY AND/OR EXCISION OF HERNIATED INTERVERTEBRAL DISC, REEXPLORATION, SINGLE INTERSPACE; EACH ADDITIONAL CERVICAL INTERSPACE (LIST SEPARATELY IN ADDI		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63044	LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF NERVE ROOT(S), INCLUDING PARTIAL FACETECTOMY, FORAMINOTOMY AND/OR EXCISION OF HERNIATED INTERVERTEBRAL DISC, REEXPLORATION, SINGLE INTERSPACE; EACH ADDITIONAL LUMBAR INTERSPACE (LIST SEPARATELY IN ADDITI		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63045	LAMINECTOMY, FACETECTOMY AND FORAMINOTOMY (UNILATERAL OR BILATERAL WITH DECOMPRESSION OF SPINAL CORD, CAUDA EQUINA AND/OR NERVE ROOT[S], [EG, SPINAL OR LATERAL RECESS STENOSIS]), SINGLE VERTEBRAL SEGMENT; CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63046	LAMINECTOMY, FACETECTOMY AND FORAMINOTOMY (UNILATERAL OR BILATERAL WITH DECOMPRESSION OF SPINAL CORD, CAUDA EQUINA AND/OR NERVE ROOT[S], [EG, SPINAL OR LATERAL RECESS STENOSIS]), SINGLE VERTEBRAL SEGMENT; THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63047	LAMINECTOMY, FACETECTOMY AND FORAMINOTOMY (UNILATERAL OR BILATERAL WITH DECOMPRESSION OF SPINAL CORD, CAUDA EQUINA AND/OR NERVE ROOT[S], [EG, SPINAL OR LATERAL RECESS STENOSIS]), SINGLE VERTEBRAL SEGMENT; LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
63048	LAMINECTOMY, FACETECTOMY AND FORAMINOTOMY (UNILATERAL OR BILATERAL WITH DECOMPRESSION OF SPINAL CORD, CAUDA EQUINA AND/OR NERVE ROOT[S], [EG, SPINAL OR LATERAL RECESS STENOSIS]), SINGLE VERTEBRAL SEGMENT; EACH ADDITIONAL VERTEBRAL SEGMENT, CERVICAL, THORA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63050	LAMINOPLASTY, CERVICAL, WITH DECOMPRESSION OF THE SPINAL CORD, 2 OR MORE VERTEBRAL SEGMENTS;		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63051	LAMINOPLASTY, CERVICAL, WITH DECOMPRESSION OF THE SPINAL CORD, 2 OR MORE VERTEBRAL SEGMENTS; WITH RECONSTRUCTION OF THE POSTERIOR BONY ELEMENTS (INCLUDING THE APPLICATION OF BRIDGING BONE GRAFT AND NON-SEGMENTAL FIXATION DEVICES [EG, WIRE, SUTURE, MINI-PL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63052	LAMINECTOMY, FACETECTOMY, OR FORAMINOTOMY (UNILATERAL OR BILATERAL WITH DECOMPRESSION OF SPINAL CORD, CAUDA EQUINA AND/OR NERVE ROOT[S] [EG, SPINAL OR LATERAL RECESS STENOSIS]), DURING POSTERIOR INTERBODY ARTHRODESIS, LUMBAR; SINGLE VERTEBRAL SEGMENT (LIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63053	LAMINECTOMY, FACETECTOMY, OR FORAMINOTOMY (UNILATERAL OR BILATERAL WITH DECOMPRESSION OF SPINAL CORD, CAUDA EQUINA AND/OR NERVE ROOT[S] [EG, SPINAL OR LATERAL RECESS STENOSIS]), DURING POSTERIOR INTERBODY ARTHRODESIS, LUMBAR; EACH ADDITIONAL VERTEBRAL SEG		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63055	TRANSPEDICULAR APPROACH WITH DECOMPRESSION OF SPINAL CORD, EQUINA AND/OR NERVE ROOT(S) (EG, HERNIATED INTERVERTEBRAL DISC), SINGLE SEGMENT; THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63056	TRANSPEDICULAR APPROACH WITH DECOMPRESSION OF SPINAL CORD, EQUINA AND/OR NERVE ROOT(S) (EG, HERNIATED INTERVERTEBRAL DISC), SINGLE SEGMENT; LUMBAR (INCLUDING TRANSFACET, OR LATERAL EXTRAFORAMINAL APPROACH) (EG, FAR LATERAL HERNIATED INTERVERTEBRAL DISC)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63057	TRANSPEDICULAR APPROACH WITH DECOMPRESSION OF SPINAL CORD, EQUINA AND/OR NERVE ROOT(S) (EG, HERNIATED INTERVERTEBRAL DISC), SINGLE SEGMENT; EACH ADDITIONAL SEGMENT, THORACIC OR LUMBAR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63064	COSTOVERTEBRAL APPROACH WITH DECOMPRESSION OF SPINAL CORD OR NERVE ROOT(S) (EG, HERNIATED INTERVERTEBRAL DISC), THORACIC; SINGLE SEGMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63066	COSTOVERTEBRAL APPROACH WITH DECOMPRESSION OF SPINAL CORD OR NERVE ROOT(S) (EG, HERNIATED INTERVERTEBRAL DISC), THORACIC; EACH ADDITIONAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63075	DISCECTOMY, ANTERIOR, WITH DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOT(S), INCLUDING OSTEOPHYTECTOMY; CERVICAL, SINGLE INTERSPACE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63076	DISCECTOMY, ANTERIOR, WITH DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOT(S), INCLUDING OSTEOPHYTECTOMY; CERVICAL, EACH ADDITIONAL INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63077	DISCECTOMY, ANTERIOR, WITH DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOT(S), INCLUDING OSTEOPHYTECTOMY; THORACIC, SINGLE INTERSPACE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63078	DISCECTOMY, ANTERIOR, WITH DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOT(S), INCLUDING OSTEOPHYTECTOMY; THORACIC, EACH ADDITIONAL INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
63081	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, ANTERIOR APPROACH WITH DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOT(S); CERVICAL, SINGLE SEGMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63082	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, ANTERIOR APPROACH WITH DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOT(S); CERVICAL, EACH ADDITIONAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63085	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, TRANSTHORACIC APPROACH WITH DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOT(S); THORACIC, SINGLE SEGMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63086	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, TRANSTHORACIC APPROACH WITH DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOT(S); THORACIC, EACH ADDITIONAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63087	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, COMBINED THORACOLUMBAR APPROACH WITH DECOMPRESSION OF SPINAL CORD, CAUDA EQUINA OR NERVE ROOT(S), LOWER THORACIC OR LUMBAR; SINGLE SEGMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63088	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, COMBINED THORACOLUMBAR APPROACH WITH DECOMPRESSION OF SPINAL CORD, CAUDA EQUINA OR NERVE ROOT(S), LOWER THORACIC OR LUMBAR; EACH ADDITIONAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63090	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, TRANSPERITONEAL OR RETROPERITONEAL APPROACH WITH DECOMPRESSION OF SPINAL CORD, CAUDA EQUINA OR NERVE ROOT(S), LOWER THORACIC, LUMBAR, OR SACRAL; SINGLE SEGMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63091	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, TRANSPERITONEAL OR RETROPERITONEAL APPROACH WITH DECOMPRESSION OF SPINAL CORD, CAUDA EQUINA OR NERVE ROOT(S), LOWER THORACIC, LUMBAR, OR SACRAL; EACH ADDITIONAL SEGMENT (LIST SEPARATELY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63101	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, LATERAL EXTRACAVITARY APPROACH WITH DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOT(S) (EG, FOR TUMOR OR RETROPULSED BONE FRAGMENTS); THORACIC, SINGLE SEGMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63102	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, LATERAL EXTRACAVITARY APPROACH WITH DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOT(S) (EG, FOR TUMOR OR RETROPULSED BONE FRAGMENTS); LUMBAR, SINGLE SEGMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63103	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, LATERAL EXTRACAVITARY APPROACH WITH DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOT(S) (EG, FOR TUMOR OR RETROPULSED BONE FRAGMENTS); THORACIC OR LUMBAR, EACH ADDITIONAL SEGMENT (LIST SE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63170	LAMINECTOMY WITH MYELOTOMY (EG, BISCHOF OR DREZ TYPE), CERVICAL, THORACIC, OR THORACOLUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63172	LAMINECTOMY WITH DRAINAGE OF INTRAMEDULLARY CYST/SYRINX; TO SUBARACHNOID SPACE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63173	LAMINECTOMY WITH DRAINAGE OF INTRAMEDULLARY CYST/SYRINX; TO PERITONEAL OR PLEURAL SPACE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
63180	LAMINECTOMY AND SECTION OF DENTATE LIGAMENTS, WITH OR WITHOUT DURAL GRAFT, CERVICAL; 1 OR 2 SEGMENTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63182	LAMINECTOMY AND SECTION OF DENTATE LIGAMENTS, WITH OR WITHOUT DURAL GRAFT, CERVICAL; MORE THAN 2 SEGMENTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63185	LAMINECTOMY WITH RHIZOTOMY; 1 OR 2 SEGMENTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63190	LAMINECTOMY WITH RHIZOTOMY; MORE THAN 2 SEGMENTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63191	LAMINECTOMY WITH SECTION OF SPINAL ACCESSORY NERVE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63194	INCISE SPINAL COLUMN & CORD, NECK		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63195	INCISE SPINAL COLUMN & CORD, THORAX		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63196	INCISE SPINAL COLUMN & CORD, NECK		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63197	LAMINECTOMY WITH CORDOTOMY, WITH SECTION OF BOTH SPINOTHALAMIC TRACTS, 1 STAGE, THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63198	INCISE SPINAL COLUMN & CORD, NECK		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63199	INCISE SPINAL COLUMN & CORD, THORAX		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63200	LAMINECTOMY, WITH RELEASE OF TETHERED SPINAL CORD, LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63250	LAMINECTOMY FOR EXCISION OR OCCLUSION OF ARTERIOVENOUS MALFORMATION OF SPINAL CORD; CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63251	LAMINECTOMY FOR EXCISION OR OCCLUSION OF ARTERIOVENOUS MALFORMATION OF SPINAL CORD; THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63252	LAMINECTOMY FOR EXCISION OR OCCLUSION OF ARTERIOVENOUS MALFORMATION OF SPINAL CORD; THORACOLUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63265	LAMINECTOMY FOR EXCISION OR EVACUATION OF INTRASPINAL LESION OTHER THAN NEOPLASM, EXTRADURAL; CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63266	LAMINECTOMY FOR EXCISION OR EVACUATION OF INTRASPINAL LESION OTHER THAN NEOPLASM, EXTRADURAL; THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63267	LAMINECTOMY FOR EXCISION OR EVACUATION OF INTRASPINAL LESION OTHER THAN NEOPLASM, EXTRADURAL; LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63268	LAMINECTOMY FOR EXCISION OR EVACUATION OF INTRASPINAL LESION OTHER THAN NEOPLASM, EXTRADURAL; SACRAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63270	LAMINECTOMY FOR EXCISION OF INTRASPINAL LESION OTHER THAN NEOPLASM, INTRADURAL; CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63271	LAMINECTOMY FOR EXCISION OF INTRASPINAL LESION OTHER THAN NEOPLASM, INTRADURAL; THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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63272	LAMINECTOMY FOR EXCISION OF INTRASPINAL LESION OTHER THAN NEOPLASM, INTRADURAL; LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63273	LAMINECTOMY FOR EXCISION OF INTRASPINAL LESION OTHER THAN NEOPLASM, INTRADURAL; SACRAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63275	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM; EXTRADURAL, CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63276	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM; EXTRADURAL, THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63277	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM; EXTRADURAL, LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63278	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM; EXTRADURAL, SACRAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63280	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM; INTRADURAL, EXTRAMEDULLARY, CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63281	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM; INTRADURAL, EXTRAMEDULLARY, THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63282	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM; INTRADURAL, EXTRAMEDULLARY, LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63283	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM; INTRADURAL, SACRAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63285	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM; INTRADURAL, INTRAMEDULLARY, CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63286	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM; INTRADURAL, INTRAMEDULLARY, THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63287	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM; INTRADURAL, INTRAMEDULLARY, THORACOLUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63290	LAMINECTOMY FOR BIOPSY/EXCISION OF INTRASPINAL NEOPLASM; COMBINED EXTRADURAL-INTRADURAL LESION, ANY LEVEL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63295	OSTEOPLASTIC RECONSTRUCTION OF DORSAL SPINAL ELEMENTS, FOLLOWING PRIMARY INTRASPINAL PROCEDURE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63300	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, FOR EXCISION OF INTRASPINAL LESION, SINGLE SEGMENT; EXTRADURAL, CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63301	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, FOR EXCISION OF INTRASPINAL LESION, SINGLE SEGMENT; EXTRADURAL, THORACIC BY TRANSTHORACIC APPROACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63302	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, FOR EXCISION OF INTRASPINAL LESION, SINGLE SEGMENT; EXTRADURAL, THORACIC BY THORACOLUMBAR APPROACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63303	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, FOR EXCISION OF INTRASPINAL LESION, SINGLE SEGMENT; EXTRADURAL, LUMBAR OR SACRAL BY TRANSPERITONEAL OR RETROPERITONEAL APPROACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63304	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, FOR EXCISION OF INTRASPINAL LESION, SINGLE SEGMENT; INTRADURAL, CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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63305	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, FOR EXCISION OF INTRASPINAL LESION, SINGLE SEGMENT; INTRADURAL, THORACIC BY TRANSTHORACIC APPROACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63306	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, FOR EXCISION OF INTRASPINAL LESION, SINGLE SEGMENT; INTRADURAL, THORACIC BY THORACOLUMBAR APPROACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63307	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, FOR EXCISION OF INTRASPINAL LESION, SINGLE SEGMENT; INTRADURAL, LUMBAR OR SACRAL BY TRANSPERITONEAL OR RETROPERITONEAL APPROACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63308	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, FOR EXCISION OF INTRASPINAL LESION, SINGLE SEGMENT; EACH ADDITIONAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODES FOR SINGLE SEGMENT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63600	CREATION OF LESION OF SPINAL CORD BY STEREOTACTIC METHOD, PERCUTANEOUS, ANY MODALITY (INCLUDING STIMULATION AND/OR RECORDING)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63610	STEREOTACTIC STIMULATION OF SPINAL CORD, PERCUTANEOUS, SEPARATE PROCEDURE NOT FOLLOWED BY OTHER SURGERY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63615	STEREOTACTIC BIOPSY, ASPIRATION, OR EXCISION OF LESION, SPINAL CORD		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63650	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY, EPIDURAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63655	LAMINECTOMY FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES, PLATE/PADDLE, EPIDURAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63661	REMOVAL OF SPINAL NEUROSTIMULATOR ELECTRODE PERCUTANEOUS ARRAY(S), INCLUDING FLUOROSCOPY, WHEN PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63662	REMOVAL OF SPINAL NEUROSTIMULATOR ELECTRODE PLATE/PADDLE(S) PLACED VIA LAMINOTOMY OR LAMINECTOMY, INCLUDING FLUOROSCOPY, WHEN PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63663	REVISION INCLUDING REPLACEMENT, WHEN PERFORMED, OF SPINAL NEUROSTIMULATOR ELECTRODE PERCUTANEOUS ARRAY(S), INCLUDING FLUOROSCOPY, WHEN PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63664	REVISION INCLUDING REPLACEMENT, WHEN PERFORMED, OF SPINAL NEUROSTIMULATOR ELECTRODE PLATE/PADDLE(S) PLACED VIA LAMINOTOMY OR LAMINECTOMY, INCLUDING FLUOROSCOPY, WHEN PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63685	INSERTION OR REPLACEMENT OF SPINAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, REQUIRING POCKET CREATION AND CONNECTION BETWEEN ELECTRODE ARRAY AND PULSE GENERATOR OR RECEIVER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63688	REVISION OR REMOVAL OF IMPLANTED SPINAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, WITH DETACHABLE CONNECTION TO ELECTRODE ARRAY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63700	REPAIR OF MENINGOCELE; LESS THAN 5 CM DIAMETER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63702	REPAIR OF MENINGOCELE; LARGER THAN 5 CM DIAMETER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63704	REPAIR OF MYELOMENINGOCELE; LESS THAN 5 CM DIAMETER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63706	REPAIR OF MYELOMENINGOCELE; LARGER THAN 5 CM DIAMETER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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63707	REPAIR OF DURAL/CEREBROSPINAL FLUID LEAK, NOT REQUIRING LAMINECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63709	REPAIR OF DURAL/CEREBROSPINAL FLUID LEAK OR PSEUDOMENINGOCELE, WITH LAMINECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63710	DURAL GRAFT, SPINAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63740	CREATION OF SHUNT, LUMBAR, SUBARACHNOID-PERITONEAL, -PLEURAL, OR OTHER; INCLUDING LAMINECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63741	CREATION OF SHUNT, LUMBAR, SUBARACHNOID-PERITONEAL, -PLEURAL, OR OTHER; PERCUTANEOUS, NOT REQUIRING LAMINECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63744	REPLACEMENT, IRRIGATION OR REVISION OF LUMBOSUBARACHNOID SHUNT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
63746	REMOVAL OF ENTIRE LUMBOSUBARACHNOID SHUNT SYSTEM WITHOUT REPLACEMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64400	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; TRIGEMINAL NERVE, EACH BRANCH (IE, OPHTHALMIC, MAXILLARY, MANDIBULAR)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64405	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; GREATER OCCIPITAL NERVE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64408	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; VAGUS NERVE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64415	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; BRACHIAL PLEXUS, INCLUDING IMAGING GUIDANCE, WHEN PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64416	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; BRACHIAL PLEXUS, CONTINUOUS INFUSION BY CATHETER (INCLUDING CATHETER PLACEMENT), INCLUDING IMAGING GUIDANCE, WHEN PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64417	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; AXILLARY NERVE, INCLUDING IMAGING GUIDANCE, WHEN PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64418	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; SUPRASCAPULAR NERVE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64420	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; INTERCOSTAL NERVE, SINGLE LEVEL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64421	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; INTERCOSTAL NERVE, EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64424	DESTRUCTION BY NEUROLYTIC AGENT, GENICULAR NERVE BRANCHES INCLUDING IMAGING GUIDANCE, WHEN PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64425	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; ILIOINGUINAL, ILIOHYPOGASTRIC NERVES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64430	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; PUDENDAL NERVE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64431	PARAVERTEBRAL BLOCK (PVB) (PARASPINOUS BLOCK), THORACIC; SINGLE INJECTION SITE (INCLUDES IMAGING GUIDANCE, WHEN PERFORMED)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64435	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; PARACERVICAL (UTERINE) NERVE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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64445	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; SCIATIC NERVE, INCLUDING IMAGING GUIDANCE, WHEN PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64446	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; SCIATIC NERVE, CONTINUOUS INFUSION BY CATHETER (INCLUDING CATHETER PLACEMENT), INCLUDING IMAGING GUIDANCE, WHEN PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64447	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; FEMORAL NERVE, INCLUDING IMAGING GUIDANCE, WHEN PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64448	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; FEMORAL NERVE, CONTINUOUS INFUSION BY CATHETER (INCLUDING CATHETER PLACEMENT), INCLUDING IMAGING GUIDANCE, WHEN PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64449	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; LUMBAR PLEXUS, POSTERIOR APPROACH, CONTINUOUS INFUSION BY CATHETER (INCLUDING CATHETER PLACEMENT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64450	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; OTHER PERIPHERAL NERVE OR BRANCH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64451	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; NERVES INNERVATING THE SACROILIAC JOINT, WITH IMAGE GUIDANCE (IE, FLUOROSCOPY OR COMPUTED TOMOGRAPHY)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64454	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; GENICULAR NERVE BRANCHES, INCLUDING IMAGING GUIDANCE, WHEN PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64455	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; PLANTAR COMMON DIGITAL NERVE(S) (EG, MORTON'S NEUROMA)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64462	PARAVERTEBRAL BLOCK (PVB) (PARASPINOUS BLOCK), THORACIC; SECOND AND ANY ADDITIONAL INJECTION SITE(S) (INCLUDES IMAGING GUIDANCE, WHEN PERFORMED) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64463	PARAVERTEBRAL BLOCK (PVB) (PARASPINOUS BLOCK), THORACIC; CONTINUOUS INFUSION BY CATHETER (INCLUDES IMAGING GUIDANCE, WHEN PERFORMED)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64466	THORACIC FASCIAL PLANE BLOCK, UNILATERAL; BY INJECTION(S), INCLUDING IMAGING GUIDANCE, WHEN PERFORMED		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
64467	THORACIC FASCIAL PLANE BLOCK, UNILATERAL; BY CONTINUOUS INFUSION(S), INCLUDING IMAGING GUIDANCE, WHEN PERFORMED		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
64468	THORACIC FASCIAL PLANE BLOCK, BILATERAL; BY INJECTION(S), INCLUDING IMAGING GUIDANCE, WHEN PERFORMED		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
64469	THORACIC FASCIAL PLANE BLOCK, BILATERAL; BY CONTINUOUS INFUSION(S), INCLUDING IMAGING GUIDANCE, WHEN PERFORMED		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
64473	LOWER EXTREMITY FASCIAL PLANE BLOCK, UNILATERAL; BY INJECTION(S), INCLUDING IMAGING GUIDANCE, WHEN PERFORMED		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
64474	LOWER EXTREMITY FASCIAL PLANE BLOCK, UNILATERAL; BY CONTINUOUS INFUSION(S), INCLUDING IMAGING GUIDANCE, WHEN PERFORMED		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
64479	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT), CERVICAL OR THORACIC, SINGLE LEVEL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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64480	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT), CERVICAL OR THORACIC, EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64483	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL, SINGLE LEVEL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64484	INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL, EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64486	TRANSVERSUS ABDOMINIS PLANE (TAP) BLOCK (ABDOMINAL PLANE BLOCK, RECTUS SHEATH BLOCK) UNILATERAL; BY INJECTION(S) (INCLUDES IMAGING GUIDANCE, WHEN PERFORMED)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64487	TRANSVERSUS ABDOMINIS PLANE (TAP) BLOCK (ABDOMINAL PLANE BLOCK, RECTUS SHEATH BLOCK) UNILATERAL; BY CONTINUOUS INFUSION(S) (INCLUDES IMAGING GUIDANCE, WHEN PERFORMED)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64488	TRANSVERSUS ABDOMINIS PLANE (TAP) BLOCK (ABDOMINAL PLANE BLOCK, RECTUS SHEATH BLOCK) BILATERAL; BY INJECTIONS (INCLUDES IMAGING GUIDANCE, WHEN PERFORMED)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64489	TRANSVERSUS ABDOMINIS PLANE (TAP) BLOCK (ABDOMINAL PLANE BLOCK, RECTUS SHEATH BLOCK) BILATERAL; BY CONTINUOUS INFUSIONS (INCLUDES IMAGING GUIDANCE, WHEN PERFORMED)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64490	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), CERVICAL OR THORACIC; SINGLE LEVEL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64491	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), CERVICAL OR THORACIC; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64492	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), CERVICAL OR THORACIC; THIRD AND ANY ADDITIONAL LEVEL(S) (LIST SEPARATELY IN ADDITION TO CO		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64493	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; SINGLE LEVEL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64494	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64495	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; THIRD AND ANY ADDITIONAL LEVEL(S) (LIST SEPARATELY IN ADDITION TO CODE F		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64510	INJECTION, ANESTHETIC AGENT; STELLATE GANGLION (CERVICAL SYMPATHETIC)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64517	INJECTION, ANESTHETIC AGENT; SUPERIOR HYPOGASTRIC PLEXUS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64520	INJECTION, ANESTHETIC AGENT; LUMBAR OR THORACIC (PARAVERTEBRAL SYMPATHETIC)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64530	INJECTION, ANESTHETIC AGENT; CELIAC PLEXUS, WITH OR WITHOUT RADIOLOGIC MONITORING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
64553	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY; CRANIAL NERVE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64555	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY; PERIPHERAL NERVE (EXCLUDES SACRAL NERVE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64561	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY; SACRAL NERVE (TRANSFORAMINAL PLACEMENT) INCLUDING IMAGE GUIDANCE, IF PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64565	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY; NEUROMUSCULAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64566	POSTERIOR TIBIAL NEUROSTIMULATION, PERCUTANEOUS NEEDLE ELECTRODE, SINGLE TREATMENT, INCLUDES PROGRAMMING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64568	OPEN IMPLANTATION OF CRANIAL NERVE (EG, VAGUS NERVE) NEUROSTIMULATOR ELECTRODE ARRAY AND PULSE GENERATOR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64569	REVISION OR REPLACEMENT OF CRANIAL NERVE (EG, VAGUS NERVE) NEUROSTIMULATOR ELECTRODE ARRAY, INCLUDING CONNECTION TO EXISTING PULSE GENERATOR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64575	OPEN IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY; PERIPHERAL NERVE (EXCLUDES SACRAL NERVE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64580	OPEN IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY; NEUROMUSCULAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64581	OPEN IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY; SACRAL NERVE (TRANSFORAMINAL PLACEMENT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64582	OPEN IMPLANTATION OF HYPOGLOSSAL NERVE NEUROSTIMULATOR ARRAY, PULSE GENERATOR, AND DISTAL RESPIRATORY SENSOR ELECTRODE OR ELECTRODE ARRAY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64583	REVISION OR REPLACEMENT OF HYPOGLOSSAL NERVE NEUROSTIMULATOR ARRAY AND DISTAL RESPIRATORY SENSOR ELECTRODE OR ELECTRODE ARRAY, INCLUDING CONNECTION TO EXISTING PULSE GENERATOR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64585	REVISION OR REMOVAL OF PERIPHERAL NEUROSTIMULATOR ELECTRODE ARRAY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64596	INSERTION OR REPLACEMENT OF PERCUTANEOUS ELECTRODE ARRAY, PERIPHERAL NERVE, WITH INTEGRATED NEUROSTIMULATOR, INCLUDING IMAGING GUIDANCE, WHEN PERFORMED; INITIAL ELECTRODE ARRAY		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
64597	INSERTION OR REPLACEMENT OF PERCUTANEOUS ELECTRODE ARRAY, PERIPHERAL NERVE, WITH INTEGRATED NEUROSTIMULATOR, INCLUDING IMAGING GUIDANCE, WHEN PERFORMED; EACH ADDITIONAL ELECTRODE ARRAY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
64598	REVISION OR REMOVAL OF NEUROSTIMULATOR ELECTRODE ARRAY, PERIPHERAL NERVE, WITH INTEGRATED NEUROSTIMULATOR		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
64600	DESTRUCTION BY NEUROLYTIC AGENT, TRIGEMINAL NERVE; SUPRAORBITAL, INFRAORBITAL, MENTAL, OR INFERIOR ALVEOLAR BRANCH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64605	DESTRUCTION BY NEUROLYTIC AGENT, TRIGEMINAL NERVE; SECOND AND THIRD DIVISION BRANCHES AT FORAMEN OVALE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64610	DESTRUCTION BY NEUROLYTIC AGENT, TRIGEMINAL NERVE; SECOND AND THIRD DIVISION BRANCHES AT FORAMEN OVALE UNDER RADIOLOGIC MONITORING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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64620	DESTRUCTION BY NEUROLYTIC AGENT, INTERCOSTAL NERVE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64622	DESTROY PARAVERT NERV LUMB/SAC SNGL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64623	DESTROY PARAVERT NRV, LUMB/SAC, ADD		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64624	DESTRUCTION BY NEUROLYTIC AGENT, GENICULAR NERVE BRANCHES INCLUDING IMAGING GUIDANCE, WHEN PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64625	RADIOFREQUENCY ABLATION, NERVES INNERVATING THE SACROILIAC JOINT, WITH IMAGE GUIDANCE (IE, FLUOROSCOPY OR COMPUTED TOMOGRAPHY)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64628	THERMAL DESTRUCTION OF INTRAOSSEOUS BASIVERTEBRAL NERVE, INCLUDING ALL IMAGING GUIDANCE; FIRST 2 VERTEBRAL BODIES, LUMBAR OR SACRAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64630	DESTRUCTION BY NEUROLYTIC AGENT; PUDENDAL NERVE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64632	DESTRUCTION BY NEUROLYTIC AGENT; PLANTAR COMMON DIGITAL NERVE		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
64633	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE(S), WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); CERVICAL OR THORACIC, SINGLE FACET JOINT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64634	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE(S), WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); CERVICAL OR THORACIC, EACH ADDITIONAL FACET JOINT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64635	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE(S), WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, SINGLE FACET JOINT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64636	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE(S), WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, EACH ADDITIONAL FACET JOINT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64640	DESTRUCTION BY NEUROLYTIC AGENT; OTHER PERIPHERAL NERVE OR BRANCH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64680	DESTRUCTION BY NEUROLYTIC AGENT, WITH OR WITHOUT RADIOLOGIC MONITORING; CELIAC PLEXUS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64681	DESTRUCTION BY NEUROLYTIC AGENT, WITH OR WITHOUT RADIOLOGIC MONITORING; SUPERIOR HYPOGASTRIC PLEXUS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
64999	UNLISTED PROCEDURE, NERVOUS SYSTEM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
65710	KERATOPLASTY (CORNEAL TRANSPLANT); ANTERIOR LAMELLAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
65730	KERATOPLASTY (CORNEAL TRANSPLANT); PENETRATING (EXCEPT IN APHAKIA OR PSEUDOPHAKIA)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
65750	KERATOPLASTY (CORNEAL TRANSPLANT); PENETRATING (IN APHAKIA)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
65755	KERATOPLASTY (CORNEAL TRANSPLANT); PENETRATING (IN PSEUDOPHAKIA)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
65756	KERATOPLASTY (CORNEAL TRANSPLANT); ENDOTHELIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
65757	BACKBENCH PREPARATION OF CORNEAL ENDOTHELIAL ALLOGRAFT PRIOR TO TRANSPLANTATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
65767	EPIKERATOPLASTY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
65855	TRABECULOPLASTY BY LASER SURGERY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
66683	IMPLANTATION OF IRIS PROSTHESIS, INCLUDING SUTURE FIXATION AND REPAIR OR REMOVAL OF IRIS, WHEN PERFORMED		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
67414	ORBITOTOMY WITHOUT BONE FLAP (FRONTAL OR TRANSCONJUNCTIVAL APPROACH); WITH REMOVAL OF BONE FOR DECOMPRESSION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67445	ORBITOTOMY WITH BONE FLAP OR WINDOW, LATERAL APPROACH (EG, KROENLEIN); WITH REMOVAL OF BONE FOR DECOMPRESSION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67800	EXCISION OF CHALAZION; SINGLE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67801	EXCISION OF CHALAZION; MULTIPLE, SAME LID		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67805	EXCISION OF CHALAZION; MULTIPLE, DIFFERENT LIDS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67808	EXCISION OF CHALAZION; UNDER GENERAL ANESTHESIA AND/OR REQUIRING HOSPITALIZATION, SINGLE OR MULTIPLE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67880	CONSTRUCTION OF INTERMARGINAL ADHESIONS, MEDIAN TARSORRHAPHY, OR CANTHORRHAPHY;		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67882	CONSTRUCTION OF INTERMARGINAL ADHESIONS, MEDIAN TARSORRHAPHY, OR CANTHORRHAPHY; WITH TRANSPOSITION OF TARSAL PLATE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67900	REPAIR OF BROW PTOSIS (SUPRACILIARY, MID-FOREHEAD OR CORONAL APPROACH)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67901	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH SUTURE OR OTHER MATERIAL (EG, BANKED FASCIA)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67902	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH AUTOLOGOUS FASCIAL SLING (INCLUDES OBTAINING FASCIA)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67903	REPAIR OF BLEPHAROPTOSIS; (TARSO) LEVATOR RESECTION OR ADVANCEMENT, INTERNAL APPROACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67904	REPAIR OF BLEPHAROPTOSIS; (TARSO) LEVATOR RESECTION OR ADVANCEMENT, EXTERNAL APPROACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67906	REPAIR OF BLEPHAROPTOSIS; SUPERIOR RECTUS TECHNIQUE WITH FASCIAL SLING (INCLUDES OBTAINING FASCIA)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67908	REPAIR OF BLEPHAROPTOSIS; CONJUNCTIVO-TARSO-MULLER'S MUSCLE-LEVATOR RESECTION (EG, FASANELLA-SERVAT TYPE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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67909	REDUCTION OF OVERCORRECTION OF PTOSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67912	CORRECTION OF LAGOPHTHALMOS, WITH IMPLANTATION OF UPPER EYELID LID LOAD (EG, GOLD WEIGHT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67914	REPAIR OF ECTROPION; SUTURE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67915	REPAIR OF ECTROPION; THERMOCAUTERIZATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67921	REPAIR OF ENTROPION; SUTURE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67922	REPAIR OF ENTROPION; THERMOCAUTERIZATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67923	REPAIR OF ENTROPION; EXCISION TARSAL WEDGE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67924	REPAIR OF ENTROPION; EXTENSIVE (EG, TARSAL STRIP OR CAPSULOPALPEBRAL FASCIA REPAIRS OPERATION)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67950	CANTHOPLASTY (RECONSTRUCTION OF CANTHUS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67961	EXCISION AND REPAIR OF EYELID, INVOLVING LID MARGIN, TARSUS, CONJUNCTIVA, CANTHUS, OR FULL THICKNESS, MAY INCLUDE PREPARATION FOR SKIN GRAFT OR PEDICLE FLAP WITH ADJACENT TISSUE TRANSFER OR REARRANGEMENT; UP TO ONE-FOURTH OF LID MARGIN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67966	EXCISION AND REPAIR OF EYELID, INVOLVING LID MARGIN, TARSUS, CONJUNCTIVA, CANTHUS, OR FULL THICKNESS, MAY INCLUDE PREPARATION FOR SKIN GRAFT OR PEDICLE FLAP WITH ADJACENT TISSUE TRANSFER OR REARRANGEMENT; OVER ONE-FOURTH OF LID MARGIN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67971	RECONSTRUCTION OF EYELID, FULL THICKNESS BY TRANSFER OF TARSOCONJUNCTIVAL FLAP FROM OPPOSING EYELID; UP TO TWO-THIRDS OF EYELID, 1 STAGE OR FIRST STAGE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67973	RECONSTRUCTION OF EYELID, FULL THICKNESS BY TRANSFER OF TARSOCONJUNCTIVAL FLAP FROM OPPOSING EYELID; TOTAL EYELID, LOWER, 1 STAGE OR FIRST STAGE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67974	RECONSTRUCTION OF EYELID, FULL THICKNESS BY TRANSFER OF TARSOCONJUNCTIVAL FLAP FROM OPPOSING EYELID; TOTAL EYELID, UPPER, 1 STAGE OR FIRST STAGE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67975	RECONSTRUCTION OF EYELID, FULL THICKNESS BY TRANSFER OF TARSOCONJUNCTIVAL FLAP FROM OPPOSING EYELID; SECOND STAGE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
67999	UNLISTED PROCEDURE, EYELIDS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
68841	INSERTION OF DRUG-ELUTING IMPLANT, INCLUDING PUNCTAL DILATION WHEN PERFORMED, INTO LACRIMAL CANALICULUS, EACH		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
69310	RECONSTRUCTION OF EXTERNAL AUDITORY CANAL (MEATOPLASTY) (EG, FOR STENOSIS DUE TO INJURY, INFECTION) (SEPARATE PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
69320	RECONSTRUCTION EXTERNAL AUDITORY CANAL FOR CONGENITAL ATRESIA, SINGLE STAGE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
69620	MYRINGOPLASTY (SURGERY CONFINED TO DRUMHEAD AND DONOR AREA)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
69631	TYMPANOPLASTY WITHOUT MASTOIDECTOMY (INCLUDING CANALPLASTY, ATTICOTOMY AND/OR MIDDLE EAR SURGERY), INITIAL OR REVISION; WITHOUT OSSICULAR CHAIN RECONSTRUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
69632	TYMPANOPLASTY WITHOUT MASTOIDECTOMY (INCLUDING CANALPLASTY, ATTICOTOMY AND/OR MIDDLE EAR SURGERY), INITIAL OR REVISION; WITH OSSICULAR CHAIN RECONSTRUCTION (EG, POSTFENESTRATION)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
69633	TYMPANOPLASTY WITHOUT MASTOIDECTOMY (INCLUDING CANALPLASTY, ATTICOTOMY AND/OR MIDDLE EAR SURGERY), INITIAL OR REVISION; WITH OSSICULAR CHAIN RECONSTRUCTION AND SYNTHETIC PROSTHESIS (EG, PARTIAL OSSICULAR REPLACEMENT PROSTHESIS [PORP], TOTAL OSSICULAR REPL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
69635	TYMPANOPLASTY WITH ANTROTOMY OR MASTOIDOTOMY (INCLUDING CANALPLASTY, ATTICOTOMY, MIDDLE EAR SURGERY, AND/OR TYMPANIC MEMBRANE REPAIR); WITHOUT OSSICULAR CHAIN RECONSTRUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
69636	TYMPANOPLASTY WITH ANTROTOMY OR MASTOIDOTOMY (INCLUDING CANALPLASTY, ATTICOTOMY, MIDDLE EAR SURGERY, AND/OR TYMPANIC MEMBRANE REPAIR); WITH OSSICULAR CHAIN RECONSTRUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
69637	TYMPANOPLASTY WITH ANTROTOMY OR MASTOIDOTOMY (INCLUDING CANALPLASTY, ATTICOTOMY, MIDDLE EAR SURGERY, AND/OR TYMPANIC MEMBRANE REPAIR); WITH OSSICULAR CHAIN RECONSTRUCTION AND SYNTHETIC PROSTHESIS (EG, PARTIAL OSSICULAR REPLACEMENT PROSTHESIS [PORP], TOTAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
69641	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING CANALPLASTY, MIDDLE EAR SURGERY, TYMPANIC MEMBRANE REPAIR); WITHOUT OSSICULAR CHAIN RECONSTRUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
69642	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING CANALPLASTY, MIDDLE EAR SURGERY, TYMPANIC MEMBRANE REPAIR); WITH OSSICULAR CHAIN RECONSTRUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
69643	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING CANALPLASTY, MIDDLE EAR SURGERY, TYMPANIC MEMBRANE REPAIR); WITH INTACT OR RECONSTRUCTED WALL, WITHOUT OSSICULAR CHAIN RECONSTRUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
69644	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING CANALPLASTY, MIDDLE EAR SURGERY, TYMPANIC MEMBRANE REPAIR); WITH INTACT OR RECONSTRUCTED CANAL WALL, WITH OSSICULAR CHAIN RECONSTRUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
69660	STAPEDECTOMY OR STAPEDOTOMY WITH REESTABLISHMENT OF OSSICULAR CONTINUITY, WITH OR WITHOUT USE OF FOREIGN MATERIAL;		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
69661	STAPEDECTOMY OR STAPEDOTOMY WITH REESTABLISHMENT OF OSSICULAR CONTINUITY, WITH OR WITHOUT USE OF FOREIGN MATERIAL; WITH FOOTPLATE DRILL OUT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
69662	REVISION OF STAPEDECTOMY OR STAPEDOTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
69728	REMOVAL, ENTIRE 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 TO THE OUTER CRANIAL CORTEX		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
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		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
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 BO		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
69930	COCHLEAR DEVICE IMPLANTATION, WITH OR WITHOUT MASTOIDECTOMY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70336	MAGNETIC RESONANCE (EG, PROTON) IMAGING, TEMPOROMANDIBULAR JOINT(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70450	COMPUTED TOMOGRAPHY, HEAD OR BRAIN; WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70460	COMPUTED TOMOGRAPHY, HEAD OR BRAIN; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70470	COMPUTED TOMOGRAPHY, HEAD OR BRAIN; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70480	COMPUTED TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA OR OUTER, MIDDLE, OR INNER EAR; WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70481	COMPUTED TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA OR OUTER, MIDDLE, OR INNER EAR; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70482	COMPUTED TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA OR OUTER, MIDDLE, OR INNER EAR; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70486	COMPUTED TOMOGRAPHY, MAXILLOFACIAL AREA; WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70487	COMPUTED TOMOGRAPHY, MAXILLOFACIAL AREA; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70488	COMPUTED TOMOGRAPHY, MAXILLOFACIAL AREA; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70490	COMPUTED TOMOGRAPHY, SOFT TISSUE NECK; WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70491	COMPUTED TOMOGRAPHY, SOFT TISSUE NECK; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70492	COMPUTED TOMOGRAPHY, SOFT TISSUE NECK; WITHOUT CONTRAST MATERIAL FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70496	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, HEAD, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70498	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, NECK, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70540	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ORBIT, FACE, AND/OR NECK; WITHOUT CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70542	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ORBIT, FACE, AND/OR NECK; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70543	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ORBIT, FACE, AND/OR NECK; WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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70544	MAGNETIC RESONANCE ANGIOGRAPHY, HEAD; WITHOUT CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70545	MAGNETIC RESONANCE ANGIOGRAPHY, HEAD; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70546	MAGNETIC RESONANCE ANGIOGRAPHY, HEAD; WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70547	MAGNETIC RESONANCE ANGIOGRAPHY, NECK; WITHOUT CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70548	MAGNETIC RESONANCE ANGIOGRAPHY, NECK; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70549	MAGNETIC RESONANCE ANGIOGRAPHY, NECK; WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70551	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM); WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70552	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM); WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70553	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM); WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70554	MAGNETIC RESONANCE IMAGING, BRAIN, FUNCTIONAL MRI; INCLUDING TEST SELECTION AND ADMINISTRATION OF REPETITIVE BODY PART MOVEMENT AND/OR VISUAL STIMULATION, NOT REQUIRING PHYSICIAN OR PSYCHOLOGIST ADMINISTRATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70555	MAGNETIC RESONANCE IMAGING, BRAIN, FUNCTIONAL MRI; REQUIRING PHYSICIAN OR PSYCHOLOGIST ADMINISTRATION OF ENTIRE NEUROFUNCTIONAL TESTING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70557	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM AND SKULL BASE), DURING OPEN INTRACRANIAL PROCEDURE (EG, TO ASSESS FOR RESIDUAL TUMOR OR RESIDUAL VASCULAR MALFORMATION); WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70558	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM AND SKULL BASE), DURING OPEN INTRACRANIAL PROCEDURE (EG, TO ASSESS FOR RESIDUAL TUMOR OR RESIDUAL VASCULAR MALFORMATION); WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
70559	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM AND SKULL BASE), DURING OPEN INTRACRANIAL PROCEDURE (EG, TO ASSESS FOR RESIDUAL TUMOR OR RESIDUAL VASCULAR MALFORMATION); WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) A		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
71250	COMPUTED TOMOGRAPHY, THORAX, DIAGNOSTIC; WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
71260	COMPUTED TOMOGRAPHY, THORAX, DIAGNOSTIC; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
71270	COMPUTED TOMOGRAPHY, THORAX, DIAGNOSTIC; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
71271	COMPUTED TOMOGRAPHY, THORAX, LOW DOSE FOR LUNG CANCER SCREENING, WITHOUT CONTRAST MATERIAL(S)		1/1/2021	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
71275	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, CHEST (NONCORONARY), WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
71550	MAGNETIC RESONANCE (EG, PROTON) IMAGING, CHEST (EG, FOR EVALUATION OF HILAR AND MEDIASTINAL LYMPHADENOPATHY); WITHOUT CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
71551	MAGNETIC RESONANCE (EG, PROTON) IMAGING, CHEST (EG, FOR EVALUATION OF HILAR AND MEDIASTINAL LYMPHADENOPATHY); WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
71552	MAGNETIC RESONANCE (EG, PROTON) IMAGING, CHEST (EG, FOR EVALUATION OF HILAR AND MEDIASTINAL LYMPHADENOPATHY); WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
71555	MAGNETIC RESONANCE ANGIOGRAPHY, CHEST (EXCLUDING MYOCARDIUM), WITH OR WITHOUT CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72125	COMPUTED TOMOGRAPHY, CERVICAL SPINE; WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72126	COMPUTED TOMOGRAPHY, CERVICAL SPINE; WITH CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72127	COMPUTED TOMOGRAPHY, CERVICAL SPINE; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72128	COMPUTED TOMOGRAPHY, THORACIC SPINE; WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72129	COMPUTED TOMOGRAPHY, THORACIC SPINE; WITH CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72130	COMPUTED TOMOGRAPHY, THORACIC SPINE; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72131	COMPUTED TOMOGRAPHY, LUMBAR SPINE; WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72132	COMPUTED TOMOGRAPHY, LUMBAR SPINE; WITH CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72133	COMPUTED TOMOGRAPHY, LUMBAR SPINE; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72141	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, CERVICAL; WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72142	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, CERVICAL; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72146	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, THORACIC; WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72147	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, THORACIC; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72148	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, LUMBAR; WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72149	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, LUMBAR; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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72156	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES; CERVICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72157	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES; THORACIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72158	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES; LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72159	MAGNETIC RESONANCE ANGIOGRAPHY, SPINAL CANAL AND CONTENTS, WITH OR WITHOUT CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72191	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, PELVIS, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72192	COMPUTED TOMOGRAPHY, PELVIS; WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72193	COMPUTED TOMOGRAPHY, PELVIS; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72194	COMPUTED TOMOGRAPHY, PELVIS; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72195	MAGNETIC RESONANCE (EG, PROTON) IMAGING, PELVIS; WITHOUT CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72196	MAGNETIC RESONANCE (EG, PROTON) IMAGING, PELVIS; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72197	MAGNETIC RESONANCE (EG, PROTON) IMAGING, PELVIS; WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
72198	MAGNETIC RESONANCE ANGIOGRAPHY, PELVIS, WITH OR WITHOUT CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73200	COMPUTED TOMOGRAPHY, UPPER EXTREMITY; WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73201	COMPUTED TOMOGRAPHY, UPPER EXTREMITY; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73202	COMPUTED TOMOGRAPHY, UPPER EXTREMITY; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73206	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, UPPER EXTREMITY, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73218	MAGNETIC RESONANCE (EG, PROTON) IMAGING, UPPER EXTREMITY, OTHER THAN JOINT; WITHOUT CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73219	MAGNETIC RESONANCE (EG, PROTON) IMAGING, UPPER EXTREMITY, OTHER THAN JOINT; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73220	MAGNETIC RESONANCE (EG, PROTON) IMAGING, UPPER EXTREMITY, OTHER THAN JOINT; WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73221	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF UPPER EXTREMITY; WITHOUT CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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73222	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF UPPER EXTREMITY; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73223	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF UPPER EXTREMITY; WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73225	MAGNETIC RESONANCE ANGIOGRAPHY, UPPER EXTREMITY, WITH OR WITHOUT CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73700	COMPUTED TOMOGRAPHY, LOWER EXTREMITY; WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73701	COMPUTED TOMOGRAPHY, LOWER EXTREMITY; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73702	COMPUTED TOMOGRAPHY, LOWER EXTREMITY; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73706	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, LOWER EXTREMITY, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73718	MAGNETIC RESONANCE (EG, PROTON) IMAGING, LOWER EXTREMITY OTHER THAN JOINT; WITHOUT CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73719	MAGNETIC RESONANCE (EG, PROTON) IMAGING, LOWER EXTREMITY OTHER THAN JOINT; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73720	MAGNETIC RESONANCE (EG, PROTON) IMAGING, LOWER EXTREMITY OTHER THAN JOINT; WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73721	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF LOWER EXTREMITY; WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73722	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF LOWER EXTREMITY; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73723	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF LOWER EXTREMITY; WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
73725	MAGNETIC RESONANCE ANGIOGRAPHY, LOWER EXTREMITY, WITH OR WITHOUT CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
74150	COMPUTED TOMOGRAPHY, ABDOMEN; WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
74160	COMPUTED TOMOGRAPHY, ABDOMEN; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
74170	COMPUTED TOMOGRAPHY, ABDOMEN; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
74174	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, ABDOMEN AND PELVIS, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
74175	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, ABDOMEN, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
74176	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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74177	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
74178	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL IN ONE OR BOTH BODY REGIONS, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS IN ONE OR BOTH BODY REGIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
74181	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ABDOMEN; WITHOUT CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
74182	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ABDOMEN; WITH CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
74183	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ABDOMEN; WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY WITH CONTRAST MATERIAL(S) AND FURTHER SEQUENCES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
74185	MAGNETIC RESONANCE ANGIOGRAPHY, ABDOMEN, WITH OR WITHOUT CONTRAST MATERIAL(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
74261	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, DIAGNOSTIC, INCLUDING IMAGE POSTPROCESSING; WITHOUT CONTRAST MATERIAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
74262	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, DIAGNOSTIC, INCLUDING IMAGE POSTPROCESSING; WITH CONTRAST MATERIAL(S) INCLUDING NON-CONTRAST IMAGES, IF PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
74712	MAGNETIC RESONANCE (EG, PROTON) IMAGING, FETAL, INCLUDING PLACENTAL AND MATERNAL PELVIC IMAGING WHEN PERFORMED; SINGLE OR FIRST GESTATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
74713	MAGNETIC RESONANCE (EG, PROTON) IMAGING, FETAL, INCLUDING PLACENTAL AND MATERNAL PELVIC IMAGING WHEN PERFORMED; EACH ADDITIONAL GESTATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
75557	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL;		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
75559	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL; WITH STRESS IMAGING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
75561	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES;		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
75563	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES; WITH STRESS IMAGING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
75565	CARDIAC MAGNETIC RESONANCE IMAGING FOR VELOCITY FLOW MAPPING (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
75572	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL, FOR EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY (INCLUDING 3D IMAGE POSTPROCESSING, ASSESSMENT OF CARDIAC FUNCTION, AND EVALUATION OF VENOUS STRUCTURES, IF PERFORMED)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
75573	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL, FOR EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY IN THE SETTING OF CONGENITAL HEART DISEASE (INCLUDING 3D IMAGE POSTPROCESSING, ASSESSMENT OF LEFT VENTRICULAR [LV] CARDIAC FUNCTION, RIGHT VENTRICULAR [		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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75574	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, HEART, CORONARY ARTERIES AND BYPASS GRAFTS (WHEN PRESENT), WITH CONTRAST MATERIAL, INCLUDING 3D IMAGE POSTPROCESSING (INCLUDING EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY, ASSESSMENT OF CARDIAC FUNCTION, AND EVALUATIO		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
75635	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, ABDOMINAL AORTA AND BILATERAL ILIOFEMORAL LOWER EXTREMITY RUNOFF, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
76120	CINERADIOGRAPHY/VIDEORADIOGRAPHY, EXCEPT WHERE SPECIFICALLY INCLUDED		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
76125	CINERADIOGRAPHY/VIDEORADIOGRAPHY TO COMPLEMENT ROUTINE EXAMINATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
76380	COMPUTED TOMOGRAPHY, LIMITED OR LOCALIZED FOLLOW-UP STUDY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
76390	MAGNETIC RESONANCE SPECTROSCOPY		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
76391	MAGNETIC RESONANCE (EG, VIBRATION) ELASTOGRAPHY		8/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
76497	UNLISTED COMPUTED TOMOGRAPHY PROCEDURE (EG, DIAGNOSTIC, INTERVENTIONAL)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
76498	UNLISTED MAGNETIC RESONANCE PROCEDURE (EG, DIAGNOSTIC, INTERVENTIONAL)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
77011	COMPUTED TOMOGRAPHY GUIDANCE FOR STEREOTACTIC LOCALIZATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
77012	COMPUTED TOMOGRAPHY GUIDANCE FOR NEEDLE PLACEMENT (EG, BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE), RADIOLOGICAL SUPERVISION AND INTERPRETATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
77013	COMPUTED TOMOGRAPHY GUIDANCE FOR, AND MONITORING OF, PARENCHYMAL TISSUE ABLATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
77021	MAGNETIC RESONANCE IMAGING GUIDANCE FOR NEEDLE PLACEMENT (EG, FOR BIOPSY, NEEDLE ASPIRATION, INJECTION, OR PLACEMENT OF LOCALIZATION DEVICE) RADIOLOGICAL SUPERVISION AND INTERPRETATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
77022	MAGNETIC RESONANCE IMAGING GUIDANCE FOR, AND MONITORING OF, PARENCHYMAL TISSUE ABLATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
77046	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT CONTRAST MATERIAL; UNILATERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
77047	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT CONTRAST MATERIAL; BILATERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
77048	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND WITH CONTRAST MATERIAL(S), INCLUDING COMPUTER-AIDED DETECTION (CAD REAL-TIME LESION DETECTION, CHARACTERIZATION AND PHARMACOKINETIC ANALYSIS), WHEN PERFORMED; UNILATERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
77049	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND WITH CONTRAST MATERIAL(S), INCLUDING COMPUTER-AIDED DETECTION (CAD REAL-TIME LESION DETECTION, CHARACTERIZATION AND PHARMACOKINETIC ANALYSIS), WHEN PERFORMED; BILATERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
77058	MAGNETIC RESONANCE IMAGING, BREAST,WITHOUT AND/OR WITH CONTRAST MATERIAL(S); UNILATERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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77059	MAGNETIC RESONANCE IMAGING, BREAST,WITHOUT AND/OR WITH CONTRAST MATERIAL(S); BILATERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
77078	COMPUTED TOMOGRAPHY, BONE MINERAL DENSITY STUDY, 1 OR MORE SITES, AXIAL SKELETON (EG, HIPS, PELVIS, SPINE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
77084	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BONE MARROW BLOOD SUPPLY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78071	PARATHYROID PLANAR IMAGING (INCLUDING SUBTRACTION, WHEN PERFORMED); WITH TOMOGRAPHIC (SPECT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78072	PARATHYROID PLANAR IMAGING (INCLUDING SUBTRACTION, WHEN PERFORMED); WITH TOMOGRAPHIC (SPECT), AND CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPHY (CT) FOR ANATOMICAL LOCALIZATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78205	LIVER IMAGING (SPECT);		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78206	LIVER IMAGING (SPECT); WITH VASCULAR FLOW		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78320	BONE AND/OR JOINT IMAGING; TOMOGRAPHIC (SPECT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78451	MYOCARDIAL PERFUSION IMAGING, TOMOGRAPHIC (SPECT) (INCLUDING ATTENUATION CORRECTION, QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); SINGLE STUDY, AT REST OR STRESS (		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78452	MYOCARDIAL PERFUSION IMAGING, TOMOGRAPHIC (SPECT) (INCLUDING ATTENUATION CORRECTION, QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); MULTIPLE STUDIES, AT REST AND/OR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78459	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), METABOLIC EVALUATION STUDY (INCLUDING VENTRICULAR WALL MOTION[S] AND/OR EJECTION FRACTION[S], WHEN PERFORMED), SINGLE STUDY;		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78469	MYOCARDIAL IMAGING, INFARCT AVID, PLANAR; TOMOGRAPHIC SPECT WITH OR WITHOUT QUANTIFICATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78491	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), PERFUSION STUDY (INCLUDING VENTRICULAR WALL MOTION[S] AND/OR EJECTION FRACTION[S], WHEN PERFORMED); SINGLE STUDY, AT REST OR STRESS (EXERCISE OR PHARMACOLOGIC)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78492	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), PERFUSION STUDY (INCLUDING VENTRICULAR WALL MOTION[S] AND/OR EJECTION FRACTION[S], WHEN PERFORMED); MULTIPLE STUDIES AT REST AND STRESS (EXERCISE OR PHARMACOLOGIC)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78494	CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SPECT, AT REST, WALL MOTION STUDY PLUS EJECTION FRACTION, WITH OR WITHOUT QUANTITATIVE PROCESSING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78608	BRAIN IMAGING, POSITRON EMISSION TOMOGRAPHY (PET); METABOLIC EVALUATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78609	BRAIN IMAGING, POSITRON EMISSION TOMOGRAPHY (PET); PERFUSION EVALUATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78647	CEREBROSPINAL FLUID FLOW, IMAGING (NOT INCLUDING INTRODUCTION OF MATERIAL); TOMOGRAPHIC (SPECT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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78710	KIDNEY IMAGING MORPHOLOGY; TOMOGRAPHIC (SPECT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78803	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR, INFLAMMATORY PROCESS OR DISTRIBUTION OF RADIOPHARMACEUTICAL AGENT(S) (INCLUDES VASCULAR FLOW AND BLOOD POOL IMAGING, WHEN PERFORMED); TOMOGRAPHIC (SPECT), SINGLE AREA (EG, HEAD, NECK, CHEST, PELVIS) OR ACQUISITIO		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78804	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR, INFLAMMATORY PROCESS OR DISTRIBUTION OF RADIOPHARMACEUTICAL AGENT(S) (INCLUDES VASCULAR FLOW AND BLOOD POOL IMAGING, WHEN PERFORMED); PLANAR, WHOLE BODY, REQUIRING 2 OR MORE DAYS IMAGING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78807	RADIOPHARMACEUTICAL LOCALIZATION OF INFLAMMATORY PROCESS; TOMOGRAPHIC (SPECT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78811	POSITRON EMISSION TOMOGRAPHY (PET) IMAGING; LIMITED AREA (EG, CHEST, HEAD/NECK)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78812	POSITRON EMISSION TOMOGRAPHY (PET) IMAGING; SKULL BASE TO MID-THIGH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78813	POSITRON EMISSION TOMOGRAPHY (PET) IMAGING; WHOLE BODY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78814	POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; LIMITED AREA (EG, CHEST, HEAD/NECK)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78815	POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; SKULL BASE TO MID-THIGH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
78816	POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; WHOLE BODY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81161	DMD (DYSTROPHIN) (EG, DUCHENNE/BECKER MUSCULAR DYSTROPHY) DELETION ANALYSIS, AND DUPLICATION ANALYSIS, IF PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81162	BRCA1 (BRCA1, DNA REPAIR ASSOCIATED), BRCA2 (BRCA2, DNA REPAIR ASSOCIATED) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS AND FULL DUPLICATION/DELETION ANALYSIS (IE, DETECTION OF LARGE GENE REARRANGEMENTS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81163	BRCA1 (BRCA1, DNA REPAIR ASSOCIATED), BRCA2 (BRCA2, DNA REPAIR ASSOCIATED) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81164	BRCA1 (BRCA1, DNA REPAIR ASSOCIATED), BRCA2 (BRCA2, DNA REPAIR ASSOCIATED) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL DUPLICATION/DELETION ANALYSIS (IE, DETECTION OF LARGE GENE REARRANGEMENTS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81165	BRCA1 (BRCA1, DNA REPAIR ASSOCIATED) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81166	BRCA1 (BRCA1, DNA REPAIR ASSOCIATED) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL DUPLICATION/DELETION ANALYSIS (IE, DETECTION OF LARGE GENE REARRANGEMENTS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81167	BRCA2 (BRCA2, DNA REPAIR ASSOCIATED) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL DUPLICATION/DELETION ANALYSIS (IE, DETECTION OF LARGE GENE REARRANGEMENTS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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81170	ABL1 (ABL PROTO-ONCOGENE 1, NON-RECEPTOR TYROSINE KINASE) (EG, ACQUIRED IMATINIB TYROSINE KINASE INHIBITOR RESISTANCE), GENE ANALYSIS, VARIANTS IN THE KINASE DOMAIN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81177	ATN1 (ATROPHIN 1) (EG, DENTATORUBRAL-PALLIDOLUYSIAN ATROPHY) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81178	ATXN1 (ATAXIN 1) (EG, SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81179	ATXN2 (ATAXIN 2) (EG, SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81180	ATXN3 (ATAXIN 3) (EG, SPINOCEREBELLAR ATAXIA, MACHADO-JOSEPH DISEASE) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81181	ATXN7 (ATAXIN 7) (EG, SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81182	ATXN8OS (ATXN8 OPPOSITE STRAND [NON-PROTEIN CODING]) (EG, SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81183	ATXN10 (ATAXIN 10) (EG, SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81184	CACNA1A (CALCIUM VOLTAGE-GATED CHANNEL SUBUNIT ALPHA1 A) (EG, SPINOCEREBELLAR ATAXIA) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81185	CACNA1A (CALCIUM VOLTAGE-GATED CHANNEL SUBUNIT ALPHA1 A) (EG, SPINOCEREBELLAR ATAXIA) GENE ANALYSIS; FULL GENE SEQUENCE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81186	CACNA1A (CALCIUM VOLTAGE-GATED CHANNEL SUBUNIT ALPHA1 A) (EG, SPINOCEREBELLAR ATAXIA) GENE ANALYSIS; KNOWN FAMILIAL VARIANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81187	CNBP (CCHC-TYPE ZINC FINGER NUCLEIC ACID BINDING PROTEIN) (EG, MYOTONIC DYSTROPHY TYPE 2) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81191	NTRK1 (NEUROTROPHIC RECEPTOR TYROSINE KINASE 1) (EG, SOLID TUMORS) TRANSLOCATION ANALYSIS		1/1/2021	InterQual® Evidence-Based Criteria & Guidelines	
81192	NTRK2 (NEUROTROPHIC RECEPTOR TYROSINE KINASE 2) (EG, SOLID TUMORS) TRANSLOCATION ANALYSIS		1/1/2021	InterQual® Evidence-Based Criteria & Guidelines	
81193	NTRK3 (NEUROTROPHIC RECEPTOR TYROSINE KINASE 3) (EG, SOLID TUMORS) TRANSLOCATION ANALYSIS		1/1/2021	InterQual® Evidence-Based Criteria & Guidelines	
81194	NTRK (NEUROTROPHIC RECEPTOR TYROSINE KINASE 1, 2, AND 3) (EG, SOLID TUMORS) TRANSLOCATION ANALYSIS		1/1/2021	InterQual® Evidence-Based Criteria & Guidelines	
81195	CYTOGENOMIC (GENOME-WIDE) ANALYSIS, HEMATOLOGIC MALIGNANCY, STRUCTURAL VARIANTS AND COPY NUMBER VARIANTS, OPTICAL GENOME MAPPING (OGM)		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81200	ASPA (ASPARTOACYLASE) (EG, CANAVAN DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, E285A, Y231X)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81201	APC (ADENOMATOUS POLYPOSIS COLI) (EG, FAMILIAL ADENOMATOSIS POLYPOSIS [FAP], ATTENUATED FAP) GENE ANALYSIS; FULL GENE SEQUENCE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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81202	APC (ADENOMATOUS POLYPOSIS COLI) (EG, FAMILIAL ADENOMATOSIS POLYPOSIS [FAP], ATTENUATED FAP) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81203	APC (ADENOMATOUS POLYPOSIS COLI) (EG, FAMILIAL ADENOMATOSIS POLYPOSIS [FAP], ATTENUATED FAP) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81205	BCKDHB (BRANCHED-CHAIN KETO ACID DEHYDROGENASE E1, BETA POLYPEPTIDE) (EG, MAPLE SYRUP URINE DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, R183P, G278S, E422X)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81206	BCR/ABL1 (T(9;22)) (EG, CHRONIC MYELOGENOUS LEUKEMIA) TRANSLOCATION ANALYSIS; MAJOR BREAKPOINT, QUALITATIVE OR QUANTITATIVE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81207	BCR/ABL1 (T(9;22)) (EG, CHRONIC MYELOGENOUS LEUKEMIA) TRANSLOCATION ANALYSIS; MINOR BREAKPOINT, QUALITATIVE OR QUANTITATIVE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81208	BCR/ABL1 (T(9;22)) (EG, CHRONIC MYELOGENOUS LEUKEMIA) TRANSLOCATION ANALYSIS; OTHER BREAKPOINT, QUALITATIVE OR QUANTITATIVE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81209	BLM (BLOOM SYNDROME, RECQ HELICASE-LIKE) (EG, BLOOM SYNDROME) GENE ANALYSIS, 2281DEL6INS7 VARIANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81210	BRAF (B-RAF PROTO-ONCOGENE, SERINE/THREONINE KINASE) (EG, COLON CANCER, MELANOMA), GENE ANALYSIS, V600 VARIANT(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81212	BRCA1 (BRCA1, DNA REPAIR ASSOCIATED), BRCA2 (BRCA2, DNA REPAIR ASSOCIATED) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; 185DELAG, 5385INSC, 6174DELT VARIANTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81215	BRCA1 (BRCA1, DNA REPAIR ASSOCIATED) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; KNOWN FAMILIAL VARIANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81216	BRCA2 (BRCA2, DNA REPAIR ASSOCIATED) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81217	BRCA2 (BRCA2, DNA REPAIR ASSOCIATED) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; KNOWN FAMILIAL VARIANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81218	CEBPA (CCAAT/ENHANCER BINDING PROTEIN [C/EBP], ALPHA) (EG, ACUTE MYELOID LEUKEMIA), GENE ANALYSIS, FULL GENE SEQUENCE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81219	CALR (CALRETICULIN) (EG, MYELOPROLIFERATIVE DISORDERS), GENE ANALYSIS, COMMON VARIANTS IN EXON 9		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81220	CFTR (CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR) (EG, CYSTIC FIBROSIS) GENE ANALYSIS; COMMON VARIANTS (EG, ACMG/ACOG GUIDELINES)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81221	CFTR (CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR) (EG, CYSTIC FIBROSIS) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81222	CFTR (CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR) (EG, CYSTIC FIBROSIS) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81223	CFTR (CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR) (EG, CYSTIC FIBROSIS) GENE ANALYSIS; FULL GENE SEQUENCE		7/1/2019	InterQual® Evidence-Based Criteria & Guidelines	
81224	CFTR (CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR) (EG, CYSTIC FIBROSIS) GENE ANALYSIS; INTRON 8 POLY-T ANALYSIS (EG, MALE INFERTILITY)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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81225	CYP2C19 (CYTOCHROME P450, FAMILY 2, SUBFAMILY C, POLYPEPTIDE 19) (EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *2, *3, *4, *8, *17)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81225	CYP2C19 (CYTOCHROME P450, FAMILY 2, SUBFAMILY C, POLYPEPTIDE 19) (EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *2, *3, *4, *8, *17)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81226	CYP2D6 (CYTOCHROME P450, FAMILY 2, SUBFAMILY D, POLYPEPTIDE 6) (EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81226	CYP2D6 (CYTOCHROME P450, FAMILY 2, SUBFAMILY D, POLYPEPTIDE 6) (EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81227	CYP2C9 (CYTOCHROME P450, FAMILY 2, SUBFAMILY C, POLYPEPTIDE 9) (EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *2, *3, *5, *6)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81227	CYP2C9 (CYTOCHROME P450, FAMILY 2, SUBFAMILY C, POLYPEPTIDE 9) (EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *2, *3, *5, *6)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81228	CYTOGENOMIC (GENOME-WIDE) ANALYSIS FOR CONSTITUTIONAL CHROMOSOMAL ABNORMALITIES; INTERROGATION OF GENOMIC REGIONS FOR COPY NUMBER VARIANTS, COMPARATIVE GENOMIC HYBRIDIZATION [CGH] MICROARRAY ANALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81229	CYTOGENOMIC (GENOME-WIDE) ANALYSIS FOR CONSTITUTIONAL CHROMOSOMAL ABNORMALITIES; INTERROGATION OF GENOMIC REGIONS FOR COPY NUMBER AND SINGLE NUCLEOTIDE POLYMORPHISM (SNP) VARIANTS, COMPARATIVE GENOMIC HYBRIDIZATION (CGH) MICROARRAY ANALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81230	CYP3A4 (CYTOCHROME P450 FAMILY 3 SUBFAMILY A MEMBER 4) (EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANT(S) (EG, *2, *22)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81231	CYP3A5 (CYTOCHROME P450 FAMILY 3 SUBFAMILY A MEMBER 5) (EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *2, *3, *4, *5, *6, *7)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81232	DPYD (DIHYDROPYRIMIDINE DEHYDROGENASE) (EG, 5-FLUOROURACIL/5-FU AND CAPECITABINE DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANT(S) (EG, *2A, *4, *5, *6)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81233	BTK (BRUTON'S TYROSINE KINASE) (EG, CHRONIC LYMPHOCYTIC LEUKEMIA) GENE ANALYSIS, COMMON VARIANTS (EG, C481S, C481R, C481F)		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81234	DMPK (DM1 PROTEIN KINASE) (EG, MYOTONIC DYSTROPHY TYPE 1) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (EXPANDED) ALLELES		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81236	EZH2 (ENHANCER OF ZESTE 2 POLYCOMB REPRESSIVE COMPLEX 2 SUBUNIT) (EG, MYELODYSPLASTIC SYNDROME, MYELOPROLIFERATIVE NEOPLASMS) GENE ANALYSIS, FULL GENE SEQUENCE		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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)		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81238	F9 (COAGULATION FACTOR IX) (EG, HEMOPHILIA B), FULL GENE SEQUENCE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81239	DMPK (DM1 PROTEIN KINASE) (EG, MYOTONIC DYSTROPHY TYPE 1) GENE ANALYSIS; CHARACTERIZATION OF ALLELES (EG, EXPANDED SIZE)		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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81240	F2 (PROTHROMBIN, COAGULATION FACTOR II) (EG, HEREDITARY HYPERCOAGULABILITY) GENE ANALYSIS, 20210G>A VARIANT		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81241	F5 (COAGULATION FACTOR V) (EG, HEREDITARY HYPERCOAGULABILITY) GENE ANALYSIS, LEIDEN VARIANT		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81242	FANCC (FANCONI ANEMIA, COMPLEMENTATION GROUP C) (EG, FANCONI ANEMIA, TYPE C) GENE ANALYSIS, COMMON VARIANT (EG, IVS4+4A>T)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81243	FMR1 (FRAGILE X MESSENGER RIBONUCLEOPROTEIN 1) (EG, FRAGILE X SYNDROME, X-LINKED INTELLECTUAL DISABILITY [XLID]) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81244	FMR1 (FRAGILE X MESSENGER RIBONUCLEOPROTEIN 1) (EG, FRAGILE X SYNDROME, X-LINKED INTELLECTUAL DISABILITY [XLID]) GENE ANALYSIS; CHARACTERIZATION OF ALLELES (EG, EXPANDED SIZE AND PROMOTER METHYLATION STATUS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81245	FLT3 (FMS-RELATED TYROSINE KINASE 3) (EG, ACUTE MYELOID LEUKEMIA), GENE ANALYSIS; INTERNAL TANDEM DUPLICATION (ITD) VARIANTS (IE, EXONS 14, 15)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81246	FLT3 (FMS-RELATED TYROSINE KINASE 3) (EG, ACUTE MYELOID LEUKEMIA), GENE ANALYSIS; TYROSINE KINASE DOMAIN (TKD) VARIANTS (EG, D835, I836)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81250	G6PC (GLUCOSE-6-PHOSPHATASE, CATALYTIC SUBUNIT) (EG, GLYCOGEN STORAGE DISEASE, TYPE 1A, VON GIERKE DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, R83C, Q347X)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81251	GBA (GLUCOSIDASE, BETA, ACID) (EG, GAUCHER DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, N370S, 84GG, L444P, IVS2+1G>A)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81252	GJB2 (GAP JUNCTION PROTEIN, BETA 2, 26KDA, CONNEXIN 26) (EG, NONSYNDROMIC HEARING LOSS) GENE ANALYSIS; FULL GENE SEQUENCE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81253	GJB2 (GAP JUNCTION PROTEIN, BETA 2, 26KDA, CONNEXIN 26) (EG, NONSYNDROMIC HEARING LOSS) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81254	GJB6 (GAP JUNCTION PROTEIN, BETA 6, 30KDA, CONNEXIN 30) (EG, NONSYNDROMIC HEARING LOSS) GENE ANALYSIS, COMMON VARIANTS (EG, 309KB [DEL(GJB6-D13S1830)] AND 232KB [DEL(GJB6-D13S1854)])		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81255	HEXA (HEXOSAMINIDASE A [ALPHA POLYPEPTIDE]) (EG, TAY-SACHS DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, 1278INSTATC, 1421+1G>C, G269S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81256	HFE (HEMOCHROMATOSIS) (EG, HEREDITARY HEMOCHROMATOSIS) GENE ANALYSIS, COMMON VARIANTS (EG, C282Y, H63D)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81257	HBA1/HBA2 (ALPHA GLOBIN 1 AND ALPHA GLOBIN 2) (EG, ALPHA THALASSEMIA, HB BART HYDROPS FETALIS SYNDROME, HBH DISEASE), GENE ANALYSIS; COMMON DELETIONS OR VARIANT (EG, SOUTHEAST ASIAN, THAI, FILIPINO, MEDITERRANEAN, ALPHA3.7, ALPHA4.2, ALPHA20.5, CONSTANT S		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81258	HBA1/HBA2 (ALPHA GLOBIN 1 AND ALPHA GLOBIN 2) (EG, ALPHA THALASSEMIA, HB BART HYDROPS FETALIS SYNDROME, HBH DISEASE), GENE ANALYSIS; KNOWN FAMILIAL VARIANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81259	HBA1/HBA2 (ALPHA GLOBIN 1 AND ALPHA GLOBIN 2) (EG, ALPHA THALASSEMIA, HB BART HYDROPS FETALIS SYNDROME, HBH DISEASE), GENE ANALYSIS; FULL GENE SEQUENCE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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81260	IKBKAP (INHIBITOR OF KAPPA LIGHT POLYPEPTIDE GENE ENHANCER IN B-CELLS, KINASE COMPLEX-ASSOCIATED PROTEIN) (EG, FAMILIAL DYSAUTONOMIA) GENE ANALYSIS, COMMON VARIANTS (EG, 2507+6T>C, R696P)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81265	COMPARATIVE ANALYSIS USING SHORT TANDEM REPEAT (STR) MARKERS; PATIENT AND COMPARATIVE SPECIMEN (EG, PRE-TRANSPLANT RECIPIENT AND DONOR GERMLINE TESTING, POST-TRANSPLANT NON-HEMATOPOIETIC RECIPIENT GERMLINE [EG, BUCCAL SWAB OR OTHER GERMLINE TISSUE SAMPLE]		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81266	COMPARATIVE ANALYSIS USING SHORT TANDEM REPEAT (STR) MARKERS; EACH ADDITIONAL SPECIMEN (EG, ADDITIONAL CORD BLOOD DONOR, ADDITIONAL FETAL SAMPLES FROM DIFFERENT CULTURES, OR ADDITIONAL ZYGOSITY IN MULTIPLE BIRTH PREGNANCIES) (LIST SEPARATELY IN ADDITION T		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81267	CHIMERISM (ENGRAFTMENT) ANALYSIS, POST TRANSPLANTATION SPECIMEN (EG, HEMATOPOIETIC STEM CELL), INCLUDES COMPARISON TO PREVIOUSLY PERFORMED BASELINE ANALYSES; WITHOUT CELL SELECTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81268	CHIMERISM (ENGRAFTMENT) ANALYSIS, POST TRANSPLANTATION SPECIMEN (EG, HEMATOPOIETIC STEM CELL), INCLUDES COMPARISON TO PREVIOUSLY PERFORMED BASELINE ANALYSES; WITH CELL SELECTION (EG, CD3, CD33), EACH CELL TYPE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81270	JAK2 (JANUS KINASE 2) (EG, MYELOPROLIFERATIVE DISORDER) GENE ANALYSIS, P.VAL617PHE (V617F) VARIANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81271	HTT (HUNTINGTIN) (EG, HUNTINGTON DISEASE) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81274	HTT (HUNTINGTIN) (EG, HUNTINGTON DISEASE) GENE ANALYSIS; CHARACTERIZATION OF ALLELES (EG, EXPANDED SIZE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81276	KRAS (KIRSTEN RAT SARCOMA VIRAL ONCOGENE HOMOLOG) (EG, CARCINOMA) GENE ANALYSIS; ADDITIONAL VARIANT(S) (EG, CODON 61, CODON 146)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81279	JAK2 (JANUS KINASE 2) (EG, MYELOPROLIFERATIVE DISORDER) TARGETED SEQUENCE ANALYSIS (EG, EXONS 12 AND 13)		1/1/2021	InterQual® Evidence-Based Criteria & Guidelines	
81284	FXN (FRATAXIN) (EG, FRIEDREICH ATAXIA) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (EXPANDED) ALLELES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81285	FXN (FRATAXIN) (EG, FRIEDREICH ATAXIA) GENE ANALYSIS; CHARACTERIZATION OF ALLELES (EG, EXPANDED SIZE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81286	FXN (FRATAXIN) (EG, FRIEDREICH ATAXIA) GENE ANALYSIS; FULL GENE SEQUENCE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81287	MGMT (O-6-METHYLGUANINE-DNA METHYLTRANSFERASE) (EG, GLIOBLASTOMA MULTIFORME) PROMOTER METHYLATION ANALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81288	MLH1 (MUTL HOMOLOG 1, COLON CANCER, NONPOLYPOSIS TYPE 2) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; PROMOTER METHYLATION ANALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81289	FXN (FRATAXIN) (EG, FRIEDREICH ATAXIA) GENE ANALYSIS; KNOWN FAMILIAL VARIANT(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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81290	MCOLN1 (MUCOLIPIN 1) (EG, MUCOLIPIDOSIS, TYPE IV) GENE ANALYSIS, COMMON VARIANTS (EG, IVS3-2A>G, DEL6.4KB)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81291	MTHFR (5,10-METHYLENETETRAHYDROFOLATE REDUCTASE) (EG, HEREDITARY HYPERCOAGULABILITY) GENE ANALYSIS, COMMON VARIANTS (EG, 677T, 1298C)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81292	MLH1 (MUTL HOMOLOG 1, COLON CANCER, NONPOLYPOSIS TYPE 2) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81293	MLH1 (MUTL HOMOLOG 1, COLON CANCER, NONPOLYPOSIS TYPE 2) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81294	MLH1 (MUTL HOMOLOG 1, COLON CANCER, NONPOLYPOSIS TYPE 2) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81295	MSH2 (MUTS HOMOLOG 2, COLON CANCER, NONPOLYPOSIS TYPE 1) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81296	MSH2 (MUTS HOMOLOG 2, COLON CANCER, NONPOLYPOSIS TYPE 1) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81297	MSH2 (MUTS HOMOLOG 2, COLON CANCER, NONPOLYPOSIS TYPE 1) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81298	MSH6 (MUTS HOMOLOG 6 [E. COLI]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81299	MSH6 (MUTS HOMOLOG 6 [E. COLI]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81300	MSH6 (MUTS HOMOLOG 6 [E. COLI]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81301	MICROSATELLITE INSTABILITY ANALYSIS (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) OF MARKERS FOR MISMATCH REPAIR DEFICIENCY (EG, BAT25, BAT26), INCLUDES COMPARISON OF NEOPLASTIC AND NORMAL TISSUE, IF PERFORMED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81302	MECP2 (METHYL CPG BINDING PROTEIN 2) (EG, RETT SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81303	MECP2 (METHYL CPG BINDING PROTEIN 2) (EG, RETT SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81304	MECP2 (METHYL CPG BINDING PROTEIN 2) (EG, RETT SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81310	NPM1 (NUCLEOPHOSMIN) (EG, ACUTE MYELOID LEUKEMIA) GENE ANALYSIS, EXON 12 VARIANTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81312	PABPN1 (POLY[A] BINDING PROTEIN NUCLEAR 1) (EG, OCULOPHARYNGEAL MUSCULAR DYSTROPHY) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81313	PCA3/KLK3 (PROSTATE CANCER ANTIGEN 3 [NON-PROTEIN CODING]/KALLIKREIN-RELATED PEPTIDASE 3 [PROSTATE SPECIFIC ANTIGEN]) RATIO (EG, PROSTATE CANCER)		7/1/2019	InterQual® Evidence-Based Criteria & Guidelines	

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81314	PDGFRA (PLATELET-DERIVED GROWTH FACTOR RECEPTOR, ALPHA POLYPEPTIDE) (EG, GASTROINTESTINAL STROMAL TUMOR [GIST]), GENE ANALYSIS, TARGETED SEQUENCE ANALYSIS (EG, EXONS 12, 18)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81315	PML/RARALPHA, (T(15;17)), (PROMYELOCYTIC LEUKEMIA/RETINOIC ACID RECEPTOR ALPHA) (EG, PROMYELOCYTIC LEUKEMIA) TRANSLOCATION ANALYSIS; COMMON BREAKPOINTS (EG, INTRON 3 AND INTRON 6), QUALITATIVE OR QUANTITATIVE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81316	PML/RARALPHA, (T(15;17)), (PROMYELOCYTIC LEUKEMIA/RETINOIC ACID RECEPTOR ALPHA) (EG, PROMYELOCYTIC LEUKEMIA) TRANSLOCATION ANALYSIS; SINGLE BREAKPOINT (EG, INTRON 3, INTRON 6 OR EXON 6), QUALITATIVE OR QUANTITATIVE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81317	PMS2 (POSTMEIOTIC SEGREGATION INCREASED 2 [S. CEREVISIAE]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81318	PMS2 (POSTMEIOTIC SEGREGATION INCREASED 2 [S. CEREVISIAE]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81319	PMS2 (POSTMEIOTIC SEGREGATION INCREASED 2 [S. CEREVISIAE]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81321	PTEN (PHOSPHATASE AND TENSIN HOMOLOG) (EG, COWDEN SYNDROME, PTEN HAMARTOMA TUMOR SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81322	PTEN (PHOSPHATASE AND TENSIN HOMOLOG) (EG, COWDEN SYNDROME, PTEN HAMARTOMA TUMOR SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81323	PTEN (PHOSPHATASE AND TENSIN HOMOLOG) (EG, COWDEN SYNDROME, PTEN HAMARTOMA TUMOR SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81324	PMP22 (PERIPHERAL MYELIN PROTEIN 22) (EG, CHARCOT-MARIE-TOOTH, HEREDITARY NEUROPATHY WITH LIABILITY TO PRESSURE PALSIES) GENE ANALYSIS; DUPLICATION/DELETION ANALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81325	PMP22 (PERIPHERAL MYELIN PROTEIN 22) (EG, CHARCOT-MARIE-TOOTH, HEREDITARY NEUROPATHY WITH LIABILITY TO PRESSURE PALSIES) GENE ANALYSIS; FULL SEQUENCE ANALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81326	PMP22 (PERIPHERAL MYELIN PROTEIN 22) (EG, CHARCOT-MARIE-TOOTH, HEREDITARY NEUROPATHY WITH LIABILITY TO PRESSURE PALSIES) GENE ANALYSIS; KNOWN FAMILIAL VARIANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81330	SMPD1 (SPHINGOMYELIN PHOSPHODIESTERASE 1, ACID LYSOSOMAL) (EG, NIEMANN-PICK DISEASE, TYPE A) GENE ANALYSIS, COMMON VARIANTS (EG, R496L, L302P, FSP330)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81331	SNRPN/UBE3A (SMALL NUCLEAR RIBONUCLEOPROTEIN POLYPEPTIDE N AND UBIQUITIN PROTEIN LIGASE E3A) (EG, PRADER-WILLI SYNDROME AND/OR ANGELMAN SYNDROME), METHYLATION ANALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81332	SERPINA1 (SERPIN PEPTIDASE INHIBITOR, CLADE A, ALPHA-1 ANTIPROTEINASE, ANTITRYPSIN, MEMBER 1) (EG, ALPHA-1-ANTITRYPSIN DEFICIENCY), GENE ANALYSIS, COMMON VARIANTS (EG, *S AND *Z)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81340	TRB@ (T CELL ANTIGEN RECEPTOR, BETA) (EG, LEUKEMIA AND LYMPHOMA), GENE REARRANGEMENT ANALYSIS TO DETECT ABNORMAL CLONAL POPULATION(S); USING AMPLIFICATION METHODOLOGY (EG, POLYMERASE CHAIN REACTION)		7/1/2019	InterQual® Evidence-Based Criteria & Guidelines	

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81341	TRB@ (T CELL ANTIGEN RECEPTOR, BETA) (EG, LEUKEMIA AND LYMPHOMA), GENE REARRANGEMENT ANALYSIS TO DETECT ABNORMAL CLONAL POPULATION(S); USING DIRECT PROBE METHODOLOGY (EG, SOUTHERN BLOT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81342	TRG@ (T CELL ANTIGEN RECEPTOR, GAMMA) (EG, LEUKEMIA AND LYMPHOMA), GENE REARRANGEMENT ANALYSIS, EVALUATION TO DETECT ABNORMAL CLONAL POPULATION(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81343	PPP2R2B (PROTEIN PHOSPHATASE 2 REGULATORY SUBUNIT BBETA) (EG, SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81344	TBP (TATA BOX BINDING PROTEIN) (EG, SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81346	TYMS (THYMIDYLATE SYNTHETASE) (EG, 5-FLUOROURACIL/5-FU DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANT(S) (EG, TANDEM REPEAT VARIANT)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81349	CYTOGENOMIC (GENOME-WIDE) ANALYSIS FOR CONSTITUTIONAL CHROMOSOMAL ABNORMALITIES; INTERROGATION OF GENOMIC REGIONS FOR COPY NUMBER AND LOSS-OF-HETEROZYGOSITY VARIANTS, LOW-PASS SEQUENCING ANALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81350	UGT1A1 (UDP GLUCURONOSYLTRANSFERASE 1 FAMILY, POLYPEPTIDE A1) (EG, DRUG METABOLISM, HEREDITARY UNCONJUGATED HYPERBILIRUBINEMIA [GILBERT SYNDROME]) GENE ANALYSIS, COMMON VARIANTS (EG, *28, *36, *37)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81353	TP53 (TUMOR PROTEIN 53) (EG, LI-FRAUMENI SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81355	VKORC1 (VITAMIN K EPOXIDE REDUCTASE COMPLEX, SUBUNIT 1) (EG, WARFARIN METABOLISM), GENE ANALYSIS, COMMON VARIANT(S) (EG, -1639G>A, C.173+1000C>T)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81361	HBB (HEMOGLOBIN, SUBUNIT BETA) (EG, SICKLE CELL ANEMIA, BETA THALASSEMIA, HEMOGLOBINOPATHY); COMMON VARIANT(S) (EG, HBS, HBC, HBE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81362	HBB (HEMOGLOBIN, SUBUNIT BETA) (EG, SICKLE CELL ANEMIA, BETA THALASSEMIA, HEMOGLOBINOPATHY); KNOWN FAMILIAL VARIANT(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81363	HBB (HEMOGLOBIN, SUBUNIT BETA) (EG, SICKLE CELL ANEMIA, BETA THALASSEMIA, HEMOGLOBINOPATHY); DUPLICATION/DELETION VARIANT(S)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81364	HBB (HEMOGLOBIN, SUBUNIT BETA) (EG, SICKLE CELL ANEMIA, BETA THALASSEMIA, HEMOGLOBINOPATHY); FULL GENE SEQUENCE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81400	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 1 (EG, IDENTIFICATION OF SINGLE GERMLINE VARIANT [EG, SNP] BY TECHNIQUES SUCH AS RESTRICTION ENZYME DIGESTION OR MELT CURVE ANALYSIS) ACADM (ACYL-COA DEHYDROGENASE, C-4 TO C-12 STRAIGHT CHAIN, MCAD) (EG, MEDIUM CHAIN A		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81401	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 2 (EG, 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) ABCC8 (ATP-BINDING CASSETTE, SUB-FAMILY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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 E		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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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) ANG (ANGIOGENI		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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) ACAD		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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) ABCD1 (ATP-BINDING CASSETTE, SUB-FAMILY D [ALD]		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81406	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 7 (EG, ANALYSIS OF 11-25 EXONS BY DNA SEQUENCE ANALYSIS, MUTATION SCANNING OR DUPLICATION/DELETION VARIANTS OF 26-50 EXONS) ACADVL (ACYL-COA DEHYDROGENASE, VERY LONG CHAIN) (EG, VERY LONG CHAIN ACYL-COENZYME A DEHYDROG		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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 ONE PLATFORM) ABCC8 (ATP-BINDING CASSETTE, SUB-FAMILY C [		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81408	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 9 (EG, ANALYSIS OF >50 EXONS IN A SINGLE GENE BY DNA SEQUENCE ANALYSIS) ABCA4 (ATP-BINDING CASSETTE, SUB-FAMILY A [ABC1], MEMBER 4) (EG, STARGARDT DISEASE, AGE-RELATED MACULAR DEGENERATION), FULL GENE SEQUENCE ATM (ATA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81410	AORTIC DYSFUNCTION OR DILATION (EG, MARFAN SYNDROME, LOEYS DIETZ SYNDROME, EHLER DANLOS SYNDROME TYPE IV, ARTERIAL TORTUOSITY SYNDROME); GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 9 GENES, INCLUDING FBN1, TGFBR1, TGFBR2, COL3A1,		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 GENES,		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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, CAV3, KCN		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
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 AND KCNQ1		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
81415	EXOME (EG, UNEXPLAINED CONSTITUTIONAL OR HERITABLE DISORDER OR SYNDROME); SEQUENCE ANALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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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)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81417	EXOME (EG, UNEXPLAINED CONSTITUTIONAL OR HERITABLE DISORDER OR SYNDROME); RE-EVALUATION OF PREVIOUSLY OBTAINED EXOME SEQUENCE (EG, UPDATED KNOWLEDGE OR UNRELATED CONDITION/SYNDROME)		7/1/2019	InterQual® Evidence-Based Criteria & Guidelines	
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		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
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, SYNGAP1, TCF4, TPP1, TSC1, TSC2, AND ZEB2		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81422	FETAL CHROMOSOMAL MICRODELETION(S) GENOMIC SEQUENCE ANALYSIS (EG, DIGEORGE SYNDROME, CRI-DU-CHAT SYNDROME), CIRCULATING CELL-FREE FETAL DNA IN MATERNAL BLOOD		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81425	GENOME (EG, UNEXPLAINED CONSTITUTIONAL OR HERITABLE DISORDER OR SYNDROME); SEQUENCE ANALYSIS		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81426	GENOME (EG, UNEXPLAINED CONSTITUTIONAL OR HERITABLE DISORDER OR SYNDROME); SEQUENCE ANALYSIS, EACH COMPARATOR GENOME (EG, PARENTS, SIBLINGS) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81427	GENOME (EG, UNEXPLAINED CONSTITUTIONAL OR HERITABLE DISORDER OR SYNDROME); RE-EVALUATION OF PREVIOUSLY OBTAINED GENOME SEQUENCE (EG, UPDATED KNOWLEDGE OR UNRELATED CONDITION/SYNDROME)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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, SLC26A4, TMC1, TMPRSS3		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81432	HEREDITARY BREAST CANCER-RELATED DISORDERS (EG, HEREDITARY BREAST CANCER, HEREDITARY OVARIAN CANCER, HEREDITARY ENDOMETRIAL CANCER, HEREDITARY PANCREATIC CANCER, HEREDITARY PROSTATE CANCER), GENOMIC SEQUENCE ANALYSIS PANEL, 5 OR MORE GENES, INTERROGATION		7/1/2019	InterQual® Evidence-Based Criteria & Guidelines	
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		7/1/2019	InterQual® Evidence-Based Criteria & Guidelines	
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, PRPH2, RDH12,		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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81435	HEREDITARY COLON CANCER-RELATED DISORDERS (EG, LYNCH SYNDROME, PTEN HAMARTOMA SYNDROME, COWDEN SYNDROME, FAMILIAL ADENOMATOSIS POLYPOSIS), GENOMIC SEQUENCE ANALYSIS PANEL, 5 OR MORE GENES, INTERROGATION FOR SEQUENCE VARIANTS AND COPY NUMBER VARIANTS		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81436	HEREDITARY COLON CANCER DISORDERS (EG, LYNCH SYNDROME, PTEN HAMARTOMA SYNDROME, COWDEN SYNDROME, FAMILIAL ADENOMATOSIS POLYPOSIS); DUPLICATION/DELETION ANALYSIS PANEL, MUST INCLUDE ANALYSIS OF AT LEAST 5 GENES, INCLUDING MLH1, MSH2, EPCAM, SMAD4, AND STK1		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81437	HEREDITARY NEUROENDOCRINE TUMOR-RELATED DISORDERS (EG, MEDULLARY THYROID CARCINOMA, PARATHYROID CARCINOMA, MALIGNANT PHEOCHROMOCYTOMA OR PARAGANGLIOMA), GENOMIC SEQUENCE ANALYSIS PANEL, 5 OR MORE GENES, INTERROGATION FOR SEQUENCE VARIANTS AND COPY NUMBER		7/1/2019	InterQual® Evidence-Based Criteria & Guidelines	
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		7/1/2019	InterQual® Evidence-Based Criteria & Guidelines	
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, DSG2, MYBPC3, MY		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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, SLC25A4, S		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 ANALYSIS PANEL, MUST INCLUDE		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
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, HRAS, KRAS, MA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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, P		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81445	SOLID ORGAN NEOPLASM, GENOMIC SEQUENCE ANALYSIS PANEL, 5-50 GENES, INTERROGATION FOR SEQUENCE VARIANTS AND COPY NUMBER VARIANTS OR REARRANGEMENTS, IF PERFORMED; DNA ANALYSIS OR COMBINED DNA AND RNA ANALYSIS		7/1/2019	InterQual® Evidence-Based Criteria & Guidelines	
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)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
81449	SOLID ORGAN NEOPLASM, GENOMIC SEQUENCE ANALYSIS PANEL, 5-50 GENES, INTERROGATION FOR SEQUENCE VARIANTS AND COPY NUMBER VARIANTS OR REARRANGEMENTS, IF PERFORMED; RNA ANALYSIS		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	

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81450	HEMATOLYMPHOID NEOPLASM OR DISORDER, GENOMIC SEQUENCE ANALYSIS PANEL, 5-50 GENES, INTERROGATION FOR SEQUENCE VARIANTS, AND COPY NUMBER VARIANTS OR REARRANGEMENTS, OR ISOFORM EXPRESSION OR MRNA EXPRESSION LEVELS, IF PERFORMED; DNA ANALYSIS OR COMBINED DNA		7/1/2019	InterQual® Evidence-Based Criteria & Guidelines	
81451	HEMATOLYMPHOID NEOPLASM OR DISORDER, GENOMIC SEQUENCE ANALYSIS PANEL, 5-50 GENES, INTERROGATION FOR SEQUENCE VARIANTS, AND COPY NUMBER VARIANTS OR REARRANGEMENTS, OR ISOFORM EXPRESSION OR MRNA EXPRESSION LEVELS, IF PERFORMED; RNA ANALYSIS		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
81455	SOLID ORGAN OR HEMATOLYMPHOID NEOPLASM OR DISORDER, 51 OR GREATER GENES, GENOMIC SEQUENCE ANALYSIS PANEL, INTERROGATION FOR SEQUENCE VARIANTS AND COPY NUMBER VARIANTS OR REARRANGEMENTS, OR ISOFORM EXPRESSION OR MRNA EXPRESSION LEVELS, IF PERFORMED; DNA AN		7/1/2019	InterQual® Evidence-Based Criteria & Guidelines	
81456	SOLID ORGAN OR HEMATOLYMPHOID NEOPLASM OR DISORDER, 51 OR GREATER GENES, GENOMIC SEQUENCE ANALYSIS PANEL, INTERROGATION FOR SEQUENCE VARIANTS AND COPY NUMBER VARIANTS OR REARRANGEMENTS, OR ISOFORM EXPRESSION OR MRNA EXPRESSION LEVELS, IF PERFORMED; RNA AN		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
81457	SOLID ORGAN NEOPLASM, GENOMIC SEQUENCE ANALYSIS PANEL, INTERROGATION FOR SEQUENCE VARIANTS; DNA ANALYSIS, MICROSATELLITE INSTABILITY		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
81458	SOLID ORGAN NEOPLASM, GENOMIC SEQUENCE ANALYSIS PANEL, INTERROGATION FOR SEQUENCE VARIANTS; DNA ANALYSIS, COPY NUMBER VARIANTS AND MICROSATELLITE INSTABILITY		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
81459	SOLID ORGAN NEOPLASM, GENOMIC SEQUENCE ANALYSIS PANEL, INTERROGATION FOR SEQUENCE VARIANTS; DNA ANALYSIS OR COMBINED DNA AND RNA ANALYSIS, COPY NUMBER VARIANTS, MICROSATELLITE INSTABILITY, TUMOR MUTATION BURDEN, AND REARRANGEMENTS		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
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 HEREDITARY OP		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
81463	SOLID ORGAN NEOPLASM, GENOMIC SEQUENCE ANALYSIS PANEL, CELL-FREE NUCLEIC ACID (EG, PLASMA), INTERROGATION FOR SEQUENCE VARIANTS; DNA ANALYSIS, COPY NUMBER VARIANTS, AND MICROSATELLITE INSTABILITY		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
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, COPY NUMBER VARIANTS, MICROSATELLITE INSTABILITY, TUMOR MUTATION BURDEN, AND RE		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
81465	WHOLE MITOCHONDRIAL GENOME LARGE DELETION ANALYSIS PANEL (EG, KEARNS-SAYRE SYNDROME, CHRONIC PROGRESSIVE EXTERNAL OPHTHALMOPLEGIA), INCLUDING HETEROPLASMY DETECTION, IF PERFORMED		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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, OCRL,		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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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, OCRL,		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81479	UNLISTED MOLECULAR PATHOLOGY PROCEDURE		1/1/2021	InterQual® Evidence-Based Criteria & Guidelines	
81490	AUTOIMMUNE (RHEUMATOID ARTHRITIS), ANALYSIS OF 12 BIOMARKERS USING IMMUNOASSAYS, UTILIZING SERUM, PROGNOSTIC ALGORITHM REPORTED AS A DISEASE ACTIVITY SCORE		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81500	ONCOLOGY (OVARIAN), BIOCHEMICAL ASSAYS OF TWO PROTEINS (CA-125 AND HE4), UTILIZING SERUM, WITH MENOPAUSAL STATUS, ALGORITHM REPORTED AS A RISK SCORE		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81503	ONCOLOGY (OVARIAN), BIOCHEMICAL ASSAYS OF FIVE PROTEINS (CA-125, APOLIPOPROTEIN A1, BETA-2 MICROGLOBULIN, TRANSFERRIN, AND PRE-ALBUMIN), UTILIZING SERUM, ALGORITHM REPORTED AS A RISK SCORE		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81504	ONCOLOGY (TISSUE OF ORIGIN), MICROARRAY GENE EXPRESSION PROFILING OF > 2000 GENES, UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS TISSUE SIMILARITY SCORES		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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 PR		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81538	ONCOLOGY (LUNG), MASS SPECTROMETRIC 8-PROTEIN SIGNATURE, INCLUDING AMYLOID A, UTILIZING SERUM, PROGNOSTIC AND PREDICTIVE ALGORITHM REPORTED AS GOOD VERSUS POOR OVERALL SURVIVAL		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		1/1/2021	InterQual® Evidence-Based Criteria & Guidelines	

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81542	ONCOLOGY (PROSTATE), MRNA, MICROARRAY GENE EXPRESSION PROFILING OF 22 CONTENT GENES, UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS METASTASIS RISK SCORE		1/1/2021	InterQual® Evidence-Based Criteria & Guidelines	
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)		1/1/2021	InterQual® Evidence-Based Criteria & Guidelines	
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		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81552	ONCOLOGY (UVEAL MELANOMA), MRNA, GENE EXPRESSION PROFILING BY REAL-TIME RT-PCR OF 15 GENES (12 CONTENT AND 3 HOUSEKEEPING), UTILIZING FINE NEEDLE ASPIRATE OR FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS RISK OF METASTASIS		1/1/2021	InterQual® Evidence-Based Criteria & Guidelines	
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 INTERSTITI		1/1/2021	InterQual® Evidence-Based Criteria & Guidelines	
81558	TRANSPLANTATION MEDICINE (ALLOGRAFT REJECTION, KIDNEY), MRNA, GENE EXPRESSION PROFILING BY QUANTITATIVE POLYMERASE CHAIN REACTION (QPCR) OF 139 GENES, UTILIZING WHOLE BLOOD, ALGORITHM REPORTED AS A BINARY CATEGORIZATION AS TRANSPLANT EXCELLENCE, WHICH IND		3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
81599	UNLISTED MULTIANALYTE ASSAY WITH ALGORITHMIC ANALYSIS		1/1/2021	InterQual® Evidence-Based Criteria & Guidelines	
82233	BETA-AMYLOID; 1-40 (ABETA 40)		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
82234	BETA-AMYLOID; 1-42 (ABETA 42)		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
82656	ELASTASE, PANCREATIC (EL-1), FECAL; QUALITATIVE OR SEMI-QUANTITATIVE		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
82710	FAT OR LIPIDS, FECES; QUANTITATIVE		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
82715	FAT DIFFERENTIAL, FECES, QUANTITATIVE		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
82725	FATTY ACIDS, NONESTERIFIED		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
83006	GROWTH STIMULATION EXPRESSED GENE 2 (ST2, INTERLEUKIN 1 RECEPTOR LIKE-1)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
83719	LIPOPROTEIN, DIRECT MEASUREMENT; VLDL CHOLESTEROL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
83722	LIPOPROTEIN, DIRECT MEASUREMENT; SMALL DENSE LDL CHOLESTEROL		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
83884	NEUROFILAMENT LIGHT CHAIN (NFL)		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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83987	PH; EXHALED BREATH CONDENSATE		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
84393	TAU, PHOSPHORYLATED (EG, PTAU 181, PTAU 217), EACH		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
84394	TAU, TOTAL (TTAU)		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
84443	THYROID STIMULATING HORMONE (TSH)		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
86015	ACTIN (SMOOTH MUSCLE) ANTIBODY (ASMA), EACH		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
86036	ANTINEUTROPHIL CYTOPLASMIC ANTIBODY (ANCA); SCREEN, EACH ANTIBODY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
86037	ANTINEUTROPHIL CYTOPLASMIC ANTIBODY (ANCA); TITER, EACH ANTIBODY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
86051	AQUAPORIN-4 (NEUROMYELITIS OPTICA [NMO]) ANTIBODY; ENZYME-LINKED IMMUNOSORBENT IMMUNOASSAY (ELISA)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
86052	AQUAPORIN-4 (NEUROMYELITIS OPTICA [NMO]) ANTIBODY; CELL-BASED IMMUNOFLUORESCENCE ASSAY (CBA), EACH		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
86053	AQUAPORIN-4 (NEUROMYELITIS OPTICA [NMO]) ANTIBODY; FLOW CYTOMETRY (IE, FLUORESCENCE-ACTIVATED CELL SORTING [FACS]), EACH		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
86231	ENDOMYSIAL ANTIBODY (EMA), EACH IMMUNOGLOBULIN (IG) CLASS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
86258	GLIADIN (DEAMIDATED) (DGP) ANTIBODY, EACH IMMUNOGLOBULIN (IG) CLASS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
86352	CELLULAR FUNCTION ASSAY INVOLVING STIMULATION (EG, MITOGEN OR ANTIGEN) AND DETECTION OF BIOMARKER (EG, ATP)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
86364	TISSUE TRANSGLUTAMINASE, EACH IMMUNOGLOBULIN (IG) CLASS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
86596	VOLTAGE-GATED CALCIUM CHANNEL ANTIBODY, EACH		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
87336	INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOASSAY TECHNIQUE (EG, ENZYME IMMUNOASSAY [EIA], ENZYME-LINKED IMMUNOSORBENT ASSAY [ELISA], FLUORESCENCE IMMUNOASSAY [FIA], IMMUNOCHEMILUMINOMETRIC ASSAY [IMCA]), QUALITATIVE OR SEMIQUANTITATIVE; ENTAMOEBA HISTOLY		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
87513	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); HELICOBACTER PYLORI (H. PYLORI), CLARITHROMYCIN RESISTANCE, AMPLIFIED PROBE TECHNIQUE		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
87525	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); HEPATITIS G, DIRECT PROBE TECHNIQUE		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
87526	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); HEPATITIS G, AMPLIFIED PROBE TECHNIQUE		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
87527	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); HEPATITIS G, QUANTIFICATION		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
87594	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); PNEUMOCYSTIS JIROVECII, AMPLIFIED PROBE TECHNIQUE		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
88245	CHROMOSOME ANALYSIS FOR BREAKAGE SYNDROMES; BASELINE SISTER CHROMATID EXCHANGE (SCE), 20-25 CELLS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
88249	CHROMOSOME ANALYSIS FOR BREAKAGE SYNDROMES; SCORE 100 CELLS, CLASTOGEN STRESS (EG, DIEPOXYBUTANE, MITOMYCIN C, IONIZING RADIATION, UV RADIATION)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
88261	CHROMOSOME ANALYSIS; COUNT 5 CELLS, 1 KARYOTYPE, WITH BANDING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
88262	CHROMOSOME ANALYSIS; COUNT 15-20 CELLS, 2 KARYOTYPES, WITH BANDING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
88263	CHROMOSOME ANALYSIS; COUNT 45 CELLS FOR MOSAICISM, 2 KARYOTYPES, WITH BANDING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
88264	CHROMOSOME ANALYSIS; ANALYZE 20-25 CELLS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
88267	CHROMOSOME ANALYSIS, AMNIOTIC FLUID OR CHORIONIC VILLUS, COUNT 15 CELLS, 1 KARYOTYPE, WITH BANDING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
88269	CHROMOSOME ANALYSIS, IN SITU FOR AMNIOTIC FLUID CELLS, COUNT CELLS FROM 6-12 COLONIES, 1 KARYOTYPE, WITH BANDING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
88271	MOLECULAR CYTOGENETICS; DNA PROBE, EACH (EG, FISH)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
88272	MOLECULAR CYTOGENETICS; CHROMOSOMAL IN SITU HYBRIDIZATION, ANALYZE 3-5 CELLS (EG, FOR DERIVATIVES AND MARKERS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
88273	MOLECULAR CYTOGENETICS; CHROMOSOMAL IN SITU HYBRIDIZATION, ANALYZE 10-30 CELLS (EG, FOR MICRODELETIONS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
88274	MOLECULAR CYTOGENETICS; INTERPHASE IN SITU HYBRIDIZATION, ANALYZE 25-99 CELLS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
88275	MOLECULAR CYTOGENETICS; INTERPHASE IN SITU HYBRIDIZATION, ANALYZE 100-300 CELLS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
88280	CHROMOSOME ANALYSIS; ADDITIONAL KARYOTYPES, EACH STUDY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
88283	CHROMOSOME ANALYSIS; ADDITIONAL SPECIALIZED BANDING TECHNIQUE (EG, NOR, C-BANDING)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
88285	CHROMOSOME ANALYSIS; ADDITIONAL CELLS COUNTED, EACH STUDY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
88289	CHROMOSOME ANALYSIS; ADDITIONAL HIGH RESOLUTION STUDY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
88291	CYTOGENETICS AND MOLECULAR CYTOGENETICS, INTERPRETATION AND REPORT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
88299	UNLISTED CYTOGENETIC STUDY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
88375	OPTICAL ENDOMICROSCOPIC IMAGE(S), INTERPRETATION AND REPORT, REAL-TIME OR REFERRED, EACH ENDOSCOPIC SESSION		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
89160	MEAT FIBERS, FECES		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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90378	RESPIRATORY SYNCYTIAL VIRUS, MONOCLONAL ANTIBODY, RECOMBINANT, FOR INTRAMUSCULAR USE, 50 MG, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
90870	ELECTROCONVULSIVE THERAPY (INCLUDES NECESSARY MONITORING)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
90871	ECT (MULTIPLE SEIZURES)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
91112	GASTROINTESTINAL TRANSIT AND PRESSURE MEASUREMENT, STOMACH THROUGH COLON, WIRELESS CAPSULE, WITH INTERPRETATION AND REPORT		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
91299	UNLISTED DIAGNOSTIC GASTROENTEROLOGY PROCEDURE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
92132	COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING (EG, OPTICAL COHERENCE TOMOGRAPHY [OCT]), ANTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
92137	COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING (EG, OPTICAL COHERENCE TOMOGRAPHY [OCT]), POSTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL; RETINA, INCLUDING OCT ANGIOGRAPHY		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
92507	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY PROCESSING DISORDER; INDIVIDUAL		7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
92508	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY PROCESSING DISORDER; GROUP, 2 OR MORE INDIVIDUALS		7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
92524	BEHAVIORAL AND QUALITATIVE ANALYSIS OF VOICE AND RESONANCE		7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
92526	TREATMENT OF SWALLOWING DYSFUNCTION AND/OR ORAL FUNCTION FOR FEEDING		7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
92548	COMPUTERIZED DYNAMIC POSTUROGRAPHY SENSORY ORGANIZATION TEST (CDP-SOT), 6 CONDITIONS (IE, EYES OPEN, EYES CLOSED, VISUAL SWAY, PLATFORM SWAY, EYES CLOSED PLATFORM SWAY, PLATFORM AND VISUAL SWAY), INCLUDING INTERPRETATION AND REPORT;		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
92549	COMPUTERIZED DYNAMIC POSTUROGRAPHY SENSORY ORGANIZATION TEST (CDP-SOT), 6 CONDITIONS (IE, EYES OPEN, EYES CLOSED, VISUAL SWAY, PLATFORM SWAY, EYES CLOSED PLATFORM SWAY, PLATFORM AND VISUAL SWAY), INCLUDING INTERPRETATION AND REPORT; WITH MOTOR CONTROL TES		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
92972	PERCUTANEOUS TRANSLUMINAL CORONARY LITHOTRIPSY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
93050	ARTERIAL PRESSURE WAVEFORM ANALYSIS FOR ASSESSMENT OF CENTRAL ARTERIAL PRESSURES, INCLUDES OBTAINING WAVEFORM(S), DIGITIZATION AND APPLICATION OF NONLINEAR MATHEMATICAL TRANSFORMATIONS TO DETERMINE CENTRAL ARTERIAL PRESSURES AND AUGMENTATION INDEX, WITH I		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
93701	BIOIMPEDANCE-DERIVED PHYSIOLOGIC CARDIOVASCULAR ANALYSIS		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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93702	BIOIMPEDANCE SPECTROSCOPY (BIS), EXTRACELLULAR FLUID ANALYSIS FOR LYMPHEDEMA ASSESSMENT(S)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
93740	TEMPERATURE GRADIENT STUDIES		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
94014	PATIENT-INITIATED SPIROMETRIC RECORDING PER 30-DAY PERIOD OF TIME; INCLUDES REINFORCED EDUCATION, TRANSMISSION OF SPIROMETRIC TRACING, DATA CAPTURE, ANALYSIS OF TRANSMITTED DATA, PERIODIC RECALIBRATION AND REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
94015	PATIENT-INITIATED SPIROMETRIC RECORDING PER 30-DAY PERIOD OF TIME; RECORDING (INCLUDES HOOK-UP, REINFORCED EDUCATION, DATA TRANSMISSION, DATA CAPTURE, TREND ANALYSIS, AND PERIODIC RECALIBRATION)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
94016	PATIENT-INITIATED SPIROMETRIC RECORDING PER 30-DAY PERIOD OF TIME; REVIEW AND INTERPRETATION ONLY BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
95782	POLYSOMNOGRAPHY; YOUNGER THAN 6 YEARS, SLEEP STAGING WITH 4 OR MORE ADDITIONAL PARAMETERS OF SLEEP, ATTENDED BY A TECHNOLOGIST		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
95783	POLYSOMNOGRAPHY; YOUNGER THAN 6 YEARS, SLEEP STAGING WITH 4 OR MORE ADDITIONAL PARAMETERS OF SLEEP, WITH INITIATION OF CONTINUOUS POSITIVE AIRWAY PRESSURE THERAPY OR BI-LEVEL VENTILATION, ATTENDED BY A TECHNOLOGIST		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
95803	ACTIGRAPHY TESTING, RECORDING, ANALYSIS, INTERPRETATION, AND REPORT (MINIMUM OF 72 HOURS TO 14 CONSECUTIVE DAYS OF RECORDING)		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
95805	MULTIPLE SLEEP LATENCY OR MAINTENANCE OF WAKEFULNESS TESTING, RECORDING, ANALYSIS AND INTERPRETATION OF PHYSIOLOGICAL MEASUREMENTS OF SLEEP DURING MULTIPLE TRIALS TO ASSESS SLEEPINESS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
95807	SLEEP STUDY, SIMULTANEOUS RECORDING OF VENTILATION, RESPIRATORY EFFORT, ECG OR HEART RATE, AND OXYGEN SATURATION, ATTENDED BY A TECHNOLOGIST		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
95808	POLYSOMNOGRAPHY; ANY AGE, SLEEP STAGING WITH 1-3 ADDITIONAL PARAMETERS OF SLEEP, ATTENDED BY A TECHNOLOGIST		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
95810	POLYSOMNOGRAPHY; AGE 6 YEARS OR OLDER, SLEEP STAGING WITH 4 OR MORE ADDITIONAL PARAMETERS OF SLEEP, ATTENDED BY A TECHNOLOGIST		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
95811	POLYSOMNOGRAPHY; AGE 6 YEARS OR OLDER, SLEEP STAGING WITH 4 OR MORE ADDITIONAL PARAMETERS OF SLEEP, WITH INITIATION OF CONTINUOUS POSITIVE AIRWAY PRESSURE THERAPY OR BILEVEL VENTILATION, ATTENDED BY A TECHNOLOGIST		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
95905	MOTOR AND/OR SENSORY NERVE CONDUCTION, USING PRECONFIGURED ELECTRODE ARRAY(S), AMPLITUDE AND LATENCY/VELOCITY STUDY, EACH LIMB, INCLUDES F-WAVE STUDY WHEN PERFORMED, WITH INTERPRETATION AND REPORT		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
96002	DYNAMIC SURFACE ELECTROMYOGRAPHY, DURING WALKING OR OTHER FUNCTIONAL ACTIVITIES, 1-12 MUSCLES		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
96130	PSYCHOLOGICAL TESTING EVALUATION SERVICES BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, INCLUDING INTEGRATION OF PATIENT DATA, INTERPRETATION OF STANDARDIZED TEST RESULTS AND CLINICAL DATA, CLINICAL DECISION MAKING, TREATMENT PLANNING AND REPO		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	

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96131	PSYCHOLOGICAL TESTING EVALUATION SERVICES BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, INCLUDING INTEGRATION OF PATIENT DATA, INTERPRETATION OF STANDARDIZED TEST RESULTS AND CLINICAL DATA, CLINICAL DECISION MAKING, TREATMENT PLANNING AND REPO		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
96133	NEUROPSYCHOLOGICAL TESTING EVALUATION SERVICES BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, INCLUDING INTEGRATION OF PATIENT DATA, INTERPRETATION OF STANDARDIZED TEST RESULTS AND CLINICAL DATA, CLINICAL DECISION MAKING, TREATMENT PLANNING AND		8/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
96136	PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST ADMINISTRATION AND SCORING BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, TWO OR MORE TESTS, ANY METHOD; FIRST 30 MINUTES		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
96137	PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST ADMINISTRATION AND SCORING BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, TWO OR MORE TESTS, ANY METHOD; EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
96138	PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST ADMINISTRATION AND SCORING BY TECHNICIAN, TWO OR MORE TESTS, ANY METHOD; FIRST 30 MINUTES		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
96139	PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST ADMINISTRATION AND SCORING BY TECHNICIAN, TWO OR MORE TESTS, ANY METHOD; EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
96900	ACTINOTHERAPY (ULTRAVIOLET LIGHT)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
96910	PHOTOCHEMOTHERAPY; TAR AND ULTRAVIOLET B (GOECKERMAN TREATMENT) OR PETROLATUM AND ULTRAVIOLET B		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
96912	PHOTOCHEMOTHERAPY; PSORALENS AND ULTRAVIOLET A (PUVA)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
96913	PHOTOCHEMOTHERAPY (GOECKERMAN AND/OR PUVA) FOR SEVERE PHOTORESPONSIVE DERMATOSES REQUIRING AT LEAST 4-8 HOURS OF CARE UNDER DIRECT SUPERVISION OF THE PHYSICIAN (INCLUDES APPLICATION OF MEDICATION AND DRESSINGS)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
96920	EXCIMER LASER TREATMENT FOR PSORIASIS; TOTAL AREA LESS THAN 250 SQ CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
96921	EXCIMER LASER TREATMENT FOR PSORIASIS; 250 SQ CM TO 500 SQ CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
96922	EXCIMER LASER TREATMENT FOR PSORIASIS; OVER 500 SQ CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
97010	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; HOT OR COLD PACKS	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97012	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; TRACTION, MECHANICAL	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	

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97014	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ELECTRICAL STIMULATION (UNATTENDED)	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97016	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; VASOPNEUMATIC DEVICES	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97018	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; PARAFFIN BATH	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97022	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; WHIRLPOOL	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97024	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; DIATHERMY (EG, MICROWAVE)	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
97026	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; INFRARED	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97028	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ULTRAVIOLET	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97032	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ELECTRICAL STIMULATION (MANUAL), EACH 15 MINUTES	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97033	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; IONTOPHORESIS, EACH 15 MINUTES	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97034	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; CONTRAST BATHS, EACH 15 MINUTES	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97035	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ULTRASOUND, EACH 15 MINUTES	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97036	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; HUBBARD TANK, EACH 15 MINUTES	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	

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97037	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; LOW-LEVEL LASER THERAPY (IE, NONTHERMAL AND NON-ABLATIVE) FOR POST-OPERATIVE PAIN REDUCTION		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
97039	UNLISTED MODALITY (SPECIFY TYPE AND TIME IF CONSTANT ATTENDANCE)	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97110	THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; THERAPEUTIC EXERCISES TO DEVELOP STRENGTH AND ENDURANCE, RANGE OF MOTION AND FLEXIBILITY	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97112	THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; NEUROMUSCULAR REEDUCATION OF MOVEMENT, BALANCE, COORDINATION, KINESTHETIC SENSE, POSTURE, AND/OR PROPRIOCEPTION FOR SITTING AND/OR STANDING ACTIVITIES	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97113	THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; AQUATIC THERAPY WITH THERAPEUTIC EXERCISES	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97116	THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; GAIT TRAINING (INCLUDES STAIR CLIMBING)	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97124	THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; MASSAGE, INCLUDING EFFLEURAGE, PETRISSAGE AND/OR TAPOTEMENT (STROKING, COMPRESSION, PERCUSSION)	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97129	THERAPEUTIC INTERVENTIONS THAT FOCUS ON COGNITIVE FUNCTION (EG, ATTENTION, MEMORY, REASONING, EXECUTIVE FUNCTION, PROBLEM SOLVING, AND/OR PRAGMATIC FUNCTIONING) AND COMPENSATORY STRATEGIES TO MANAGE THE PERFORMANCE OF AN ACTIVITY (EG, MANAGING TIME OR SCH	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
97130	THERAPEUTIC INTERVENTIONS THAT FOCUS ON COGNITIVE FUNCTION (EG, ATTENTION, MEMORY, REASONING, EXECUTIVE FUNCTION, PROBLEM SOLVING, AND/OR PRAGMATIC FUNCTIONING) AND COMPENSATORY STRATEGIES TO MANAGE THE PERFORMANCE OF AN ACTIVITY (EG, MANAGING TIME OR SCH	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
97139	UNLISTED THERAPEUTIC PROCEDURE (SPECIFY)	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97140	MANUAL THERAPY TECHNIQUES (EG, MOBILIZATION/ MANIPULATION, MANUAL LYMPHATIC DRAINAGE, MANUAL TRACTION), 1 OR MORE REGIONS, EACH 15 MINUTES	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97150	THERAPEUTIC PROCEDURE(S), GROUP (2 OR MORE INDIVIDUALS)	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
97151	BEHAVIOR IDENTIFICATION ASSESSMENT, ADMINISTERED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, EACH 15 MINUTES OF THE PHYSICIAN'S OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL'S TIME FACE-TO-FACE WITH PATIENT AND/OR GUARDIAN(S)/CAREGIVER(S) AD		4/15/2020	Sendero Health Plans Medical Policy, "Applied Behavioral An	InterQual® Evidence-Based Criteria & Guidelines
97152	BEHAVIOR IDENTIFICATION-SUPPORTING ASSESSMENT, ADMINISTERED BY ONE TECHNICIAN UNDER THE DIRECTION OF A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, FACE-TO-FACE WITH THE PATIENT, EACH 15 MINUTES		4/15/2020	Sendero Health Plans Medical Policy, "Applied Behavioral An	InterQual® Evidence-Based Criteria & Guidelines
97153	ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL, ADMINISTERED BY TECHNICIAN UNDER THE DIRECTION OF A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, FACE-TO-FACE WITH ONE PATIENT, EACH 15 MINUTES		4/15/2020	Sendero Health Plans Medical Policy, "Applied Behavioral An	InterQual® Evidence-Based Criteria & Guidelines
97154	GROUP ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL, ADMINISTERED BY TECHNICIAN UNDER THE DIRECTION OF A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, FACE-TO-FACE WITH TWO OR MORE PATIENTS, EACH 15 MINUTES		4/15/2020	Sendero Health Plans Medical Policy, "Applied Behavioral An	InterQual® Evidence-Based Criteria & Guidelines
97155	ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION, ADMINISTERED BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, WHICH MAY INCLUDE SIMULTANEOUS DIRECTION OF TECHNICIAN, FACE-TO-FACE WITH ONE PATIENT, EACH 15 MINUTES		4/15/2020	Sendero Health Plans Medical Policy, "Applied Behavioral An	InterQual® Evidence-Based Criteria & Guidelines
97156	FAMILY ADAPTIVE BEHAVIOR TREATMENT GUIDANCE, ADMINISTERED BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL (WITH OR WITHOUT THE PATIENT PRESENT), FACE-TO-FACE WITH GUARDIAN(S)/CAREGIVER(S), EACH 15 MINUTES		4/15/2020	Sendero Health Plans Medical Policy, "Applied Behavioral An	InterQual® Evidence-Based Criteria & Guidelines
97157	MULTIPLE-FAMILY GROUP ADAPTIVE BEHAVIOR TREATMENT GUIDANCE, ADMINISTERED BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL (WITHOUT THE PATIENT PRESENT), FACE-TO-FACE WITH MULTIPLE SETS OF GUARDIANS/CAREGIVERS, EACH 15 MINUTES		4/15/2020	Sendero Health Plans Medical Policy, "Applied Behavioral An	InterQual® Evidence-Based Criteria & Guidelines
97158	GROUP ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION, ADMINISTERED BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, FACE-TO-FACE WITH MULTIPLE PATIENTS, EACH 15 MINUTES		4/15/2020	Sendero Health Plans Medical Policy, "Applied Behavioral An	InterQual® Evidence-Based Criteria & Guidelines
97530	THERAPEUTIC ACTIVITIES, DIRECT (ONE-ON-ONE) PATIENT CONTACT (USE OF DYNAMIC ACTIVITIES TO IMPROVE FUNCTIONAL PERFORMANCE), EACH 15 MINUTES	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97533	SENSORY INTEGRATIVE TECHNIQUES TO ENHANCE SENSORY PROCESSING AND PROMOTE ADAPTIVE RESPONSES TO ENVIRONMENTAL DEMANDS, DIRECT (ONE-ON-ONE) PATIENT CONTACT, EACH 15 MINUTES		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
97535	SELF-CARE/HOME MANAGEMENT TRAINING (EG, ACTIVITIES OF DAILY LIVING (ADL) AND COMPENSATORY TRAINING, MEAL PREPARATION, SAFETY PROCEDURES, AND INSTRUCTIONS IN USE OF ASSISTIVE TECHNOLOGY DEVICES/ADAPTIVE EQUIPMENT) DIRECT ONE-ON-ONE CONTACT, EACH 15 MINUTES	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97537	COMMUNITY/WORK REINTEGRATION TRAINING (EG, SHOPPING, TRANSPORTATION, MONEY MANAGEMENT, AVOCATIONAL ACTIVITIES AND/OR WORK ENVIRONMENT/MODIFICATION ANALYSIS, WORK TASK ANALYSIS, USE OF ASSISTIVE TECHNOLOGY DEVICE/ADAPTIVE EQUIPMENT), DIRECT ONE-ON-ONE CONT	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97542	WHEELCHAIR MANAGEMENT (EG, ASSESSMENT, FITTING, TRAINING), EACH 15 MINUTES	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
97545	WORK HARDENING/CONDITIONING; INITIAL 2 HOURS	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97546	WORK HARDENING/CONDITIONING; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97550	CAREGIVER TRAINING IN STRATEGIES AND TECHNIQUES TO FACILITATE THE PATIENT'S FUNCTIONAL PERFORMANCE IN THE HOME OR COMMUNITY (EG, ACTIVITIES OF DAILY LIVING [ADLS], INSTRUMENTAL ADLS [IADLS], TRANSFERS, MOBILITY, COMMUNICATION, SWALLOWING, FEEDING, PROBLEM	For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded). Authorization required for all visits pertaining to Speech Therapy.	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
97551	CAREGIVER TRAINING IN STRATEGIES AND TECHNIQUES TO FACILITATE THE PATIENT'S FUNCTIONAL PERFORMANCE IN THE HOME OR COMMUNITY (EG, ACTIVITIES OF DAILY LIVING [ADLS], INSTRUMENTAL ADLS [IADLS], TRANSFERS, MOBILITY, COMMUNICATION, SWALLOWING, FEEDING, PROBLEM	For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded). Authorization required for all visits pertaining to Speech Therapy.	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
97552	GROUP CAREGIVER TRAINING IN STRATEGIES AND TECHNIQUES TO FACILITATE THE PATIENT'S FUNCTIONAL PERFORMANCE IN THE HOME OR COMMUNITY (EG, ACTIVITIES OF DAILY LIVING [ADLS], INSTRUMENTAL ADLS [IADLS], TRANSFERS, MOBILITY, COMMUNICATION, SWALLOWING, FEEDING, P	For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded). Authorization required for all visits pertaining to Speech Therapy.	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
97610	LOW FREQUENCY, NON-CONTACT, NON-THERMAL ULTRASOUND, INCLUDING TOPICAL APPLICATION(S), WHEN PERFORMED, WOUND ASSESSMENT, AND INSTRUCTION(S) FOR ONGOING CARE, PER DAY		7/1/2019	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
97760	ORTHOTIC(S) MANAGEMENT AND TRAINING (INCLUDING ASSESSMENT AND FITTING WHEN NOT OTHERWISE REPORTED), UPPER EXTREMITY(IES), LOWER EXTREMITY(IES) AND/OR TRUNK, INITIAL ORTHOTIC(S) ENCOUNTER, EACH 15 MINUTES	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97761	PROSTHETIC(S) TRAINING, UPPER AND/OR LOWER EXTREMITY(IES), INITIAL PROSTHETIC(S) ENCOUNTER, EACH 15 MINUTES	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
97763	ORTHOTIC(S)/PROSTHETIC(S) MANAGEMENT AND/OR TRAINING, UPPER EXTREMITY(IES), LOWER EXTREMITY(IES), AND/OR TRUNK, SUBSEQUENT ORTHOTIC(S)/PROSTHETIC(S) ENCOUNTER, EACH 15 MINUTES	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	8/15/2018	InterQual® Evidence-Based Criteria & Guidelines	
97799	UNLISTED PHYSICAL MEDICINE/REHABILITATION SERVICE OR PROCEDURE	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/27/2020	InterQual® Evidence-Based Criteria & Guidelines	
98978	REMOTE THERAPEUTIC MONITORING (EG, THERAPY ADHERENCE, THERAPY RESPONSE, DIGITAL THERAPEUTIC INTERVENTION); DEVICE(S) SUPPLY FOR DATA ACCESS OR DATA TRANSMISSIONS TO SUPPORT MONITORING OF COGNITIVE BEHAVIORAL THERAPY, EACH 30 DAYS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
99500	HOME VISIT FOR PRENATAL MONITORING AND ASSESSMENT TO INCLUDE FETAL HEART RATE, NON-STRESS TEST, UTERINE MONITORING, AND GESTATIONAL DIABETES MONITORING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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99501	HOME VISIT FOR POSTNATAL ASSESSMENT AND FOLLOW-UP CARE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
99502	HOME VISIT FOR NEWBORN CARE AND ASSESSMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
99503	HOME VISIT FOR RESPIRATORY THERAPY CARE (EG, BRONCHODILATOR, OXYGEN THERAPY, RESPIRATORY ASSESSMENT, APNEA EVALUATION)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
99504	HOME VISIT FOR MECHANICAL VENTILATION CARE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
99505	HOME VISIT FOR STOMA CARE AND MAINTENANCE INCLUDING COLOSTOMY AND CYSTOSTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
99506	HOME VISIT FOR INTRAMUSCULAR INJECTIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
99507	HOME VISIT FOR CARE AND MAINTENANCE OF CATHETER(S) (EG, URINARY, DRAINAGE, AND ENTERAL)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
99509	HOME VISIT FOR ASSISTANCE WITH ACTIVITIES OF DAILY LIVING AND PERSONAL CARE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
99510	HOME VISIT FOR INDIVIDUAL, FAMILY, OR MARRIAGE COUNSELING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
99511	HOME VISIT FOR FECAL IMPACTION MANAGEMENT AND ENEMA ADMINISTRATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
99512	HOME VISIT FOR HEMODIALYSIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
99600	UNLISTED HOME VISIT SERVICE OR PROCEDURE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
99601	HOME INFUSION/SPECIALTY DRUG ADMINISTRATION, PER VISIT (UP TO 2 HOURS);		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
99602	HOME INFUSION/SPECIALTY DRUG ADMINISTRATION, PER VISIT (UP TO 2 HOURS); EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A0140	NON-EMERGENCY TRANSPORTATION AND AIR TRAVEL (PRIVATE OR COMMERCIAL) INTRA OR INTER STATE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A0425	GROUND MILEAGE, PER STATUTE MILE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A0426	AMBULANCE SERVICE, ADVANCED LIFE SUPPORT, NON-EMERGENCY TRANSPORT, LEVEL 1 (ALS 1)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A0428	AMBULANCE SERVICE, BASIC LIFE SUPPORT, NON-EMERGENCY TRANSPORT, (BLS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A0430	AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (FIXED WING)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A0431	AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (ROTARY WING)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A0432	PARAMEDIC INTERCEPT (PI), RURAL AREA, TRANSPORT FURNISHED BY A VOLUNTEER AMBULANCE COMPANY WHICH IS PROHIBITED BY STATE LAW FROM BILLING THIRD PARTY PAYERS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A0433	ADVANCED LIFE SUPPORT, LEVEL 2 (ALS 2)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A0434	SPECIALTY CARE TRANSPORT (SCT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
A0435	FIXED WING AIR MILEAGE, PER STATUTE MILE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A0436	ROTARY WING AIR MILEAGE, PER STATUTE MILE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A0999	UNLISTED AMBULANCE SERVICE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A2019	KERECIS OMEGA3 MARIGEN SHIELD, PER SQUARE CENTIMETER		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
A2020	AC5 ADVANCED WOUND SYSTEM (AC5)		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
A2021	NEOMATRIX, PER SQUARE CENTIMETER		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
A2026	RESTRATA MINIMATRIX, 5 MG		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
A2027	MATRIDERM, PER SQUARE CENTIMETER		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
A2028	MICROMATRIX FLEX, PER MG		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
A2029	MIROTRACT WOUND MATRIX SHEET, PER CUBIC CENTIMETER		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
A2030	MIRO3D FIBERS, PER MILLIGRAM		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
A2031	MIRODRY WOUND MATRIX, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
A2032	MYRIAD MATRIX, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
A2033	MYRIAD MORCELLS, 4 MILLIGRAMS		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
A2034	FOUNDATION DRS SOLO, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
A2035	CORPLEX P OR THERACOR P OR ALLACOR P, PER MILLIGRAM		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
A4220	REFILL KIT FOR IMPLANTABLE INFUSION PUMP	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A4305	DISPOSABLE DRUG DELIVERY SYSTEM, FLOW RATE OF 50 ML OR GREATER PER HOUR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A4306	DISPOSABLE DRUG DELIVERY SYSTEM, FLOW RATE OF LESS THAN 50 ML PER HOUR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A4483	MOISTURE EXCHANGER, DISPOSABLE, FOR USE WITH INVASIVE MECHANICAL VENTILATION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A4540	DISTAL TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR, STIMULATES PERIPHERAL NERVES OF THE UPPER ARM		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
A4541	MONTHLY SUPPLIES FOR USE OF DEVICE CODED AT E0733		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
A4542	SUPPLIES AND ACCESSORIES FOR EXTERNAL UPPER LIMB TREMOR STIMULATOR OF THE PERIPHERAL NERVES OF THE WRIST	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
A4560	NEUROMUSCULAR ELECTRICAL STIMULATOR (NMES), DISPOSABLE, REPLACEMENT ONLY	Preauthorization required when billed charges exceed $500 per line item	8/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
A4593	NEUROMODULATION STIMULATOR SYSTEM, ADJUNCT TO REHABILITATION THERAPY REGIME, CONTROLLER	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
A4594	NEUROMODULATION STIMULATOR SYSTEM, ADJUNCT TO REHABILITATION THERAPY REGIME, MOUTHPIECE EACH	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
A4608	TRANSTRACHEAL OXYGEN CATHETER, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A4611	BATTERY, HEAVY DUTY; REPLACEMENT FOR PATIENT OWNED VENTILATOR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A4612	BATTERY CABLES; REPLACEMENT FOR PATIENT-OWNED VENTILATOR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A4613	BATTERY CHARGER; REPLACEMENT FOR PATIENT-OWNED VENTILATOR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A4614	PEAK EXPIRATORY FLOW RATE METER, HAND HELD	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A4648	TISSUE MARKER, IMPLANTABLE, ANY TYPE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A4649	SURGICAL SUPPLY; MISCELLANEOUS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A4650	IMPLANTABLE RADIATION DOSIMETER, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A5500	FOR DIABETICS ONLY, FITTING (INCLUDING FOLLOW-UP), CUSTOM PREPARATION AND SUPPLY OF OFF-THE-SHELF DEPTH-INLAY SHOE MANUFACTURED TO ACCOMMODATE MULTI-DENSITY INSERT(S), PER SHOE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A5501	FOR DIABETICS ONLY, FITTING (INCLUDING FOLLOW-UP), CUSTOM PREPARATION AND SUPPLY OF SHOE MOLDED FROM CAST(S) OF PATIENT'S FOOT (CUSTOM MOLDED SHOE), PER SHOE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A5503	FOR DIABETICS ONLY, MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE WITH ROLLER OR RIGID ROCKER BOTTOM, PER SHOE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A5504	FOR DIABETICS ONLY, MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE WITH WEDGE(S), PER SHOE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A5505	FOR DIABETICS ONLY, MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE WITH METATARSAL BAR, PER SHOE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A5506	FOR DIABETICS ONLY, MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE WITH OFF-SET HEEL(S), PER SHOE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A5507	FOR DIABETICS ONLY, NOT OTHERWISE SPECIFIED MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE, PER SHOE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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A5508	FOR DIABETICS ONLY, DELUXE FEATURE OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE, PER SHOE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A5512	FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, DIRECT FORMED, MOLDED TO FOOT AFTER EXTERNAL HEAT SOURCE OF 230 DEGREES FAHRENHEIT OR HIGHER, TOTAL CONTACT WITH PATIENT'S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 1/4 INCH MATERIAL OF SHORE A 35 DUROMETER O	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A5513	FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, CUSTOM MOLDED FROM MODEL OF PATIENT'S FOOT, TOTAL CONTACT WITH PATIENT'S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 3/16 INCH MATERIAL OF SHORE A 35 DUROMETER (OR HIGHER), INCLUDES ARCH FILLER AND OTHER SHAPIN	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A6231	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT WOUND CONTACT, STERILE, PAD SIZE 16 SQ. IN. OR LESS, EACH DRESSING	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A6501	COMPRESSION BURN GARMENT, BODYSUIT (HEAD TO FOOT), CUSTOM FABRICATED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A6502	COMPRESSION BURN GARMENT, CHIN STRAP, CUSTOM FABRICATED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A6503	COMPRESSION BURN GARMENT, FACIAL HOOD, CUSTOM FABRICATED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A6507	COMPRESSION BURN GARMENT, FOOT TO KNEE LENGTH, CUSTOM FABRICATED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A6508	COMPRESSION BURN GARMENT, FOOT TO THIGH LENGTH, CUSTOM FABRICATED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A6509	COMPRESSION BURN GARMENT, UPPER TRUNK TO WAIST INCLUDING ARM OPENINGS (VEST), CUSTOM FABRICATED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A6510	COMPRESSION BURN GARMENT, TRUNK, INCLUDING ARMS DOWN TO LEG OPENINGS (LEOTARD), CUSTOM FABRICATED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A6511	COMPRESSION BURN GARMENT, LOWER TRUNK INCLUDING LEG OPENINGS (PANTY), CUSTOM FABRICATED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A6512	COMPRESSION BURN GARMENT, NOT OTHERWISE CLASSIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A7023	MECHANICAL ALLERGEN PARTICLE BARRIER/INHALATION FILTER, CREAM, NASAL, TOPICAL		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
A8000	HELMET, PROTECTIVE, SOFT, PREFABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A8001	HELMET, PROTECTIVE, HARD, PREFABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A8002	HELMET, PROTECTIVE, SOFT, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A8003	HELMET, PROTECTIVE, HARD, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A8004	SOFT INTERFACE FOR HELMET, REPLACEMENT ONLY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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A9274	EXTERNAL AMBULATORY INSULIN DELIVERY SYSTEM, DISPOSABLE, EACH, INCLUDES ALL SUPPLIES AND ACCESSORIES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A9275	HOME GLUCOSE DISPOSABLE MONITOR, INCLUDES TEST STRIPS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A9279	MONITORING FEATURE/DEVICE, STAND-ALONE OR INTEGRATED, ANY TYPE, INCLUDES ALL ACCESSORIES, COMPONENTS AND ELECTRONICS, NOT OTHERWISE CLASSIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A9285	INVERSION/EVERSION CORRECTION DEVICE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
A9606	RADIUM RA-223 DICHLORIDE, THERAPEUTIC, PER MICROCURIE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A9900	MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
A9999	MISCELLANEOUS DME SUPPLY OR ACCESSORY, NOT OTHERWISE SPECIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
B4034	ENTERAL FEEDING SUPPLY KIT; SYRINGE FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
B4035	ENTERAL FEEDING SUPPLY KIT; PUMP FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
B4036	ENTERAL FEEDING SUPPLY KIT; GRAVITY FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
B4081	NASOGASTRIC TUBING WITH STYLET	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
B4082	NASOGASTRIC TUBING WITHOUT STYLET	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
B4083	STOMACH TUBE - LEVINE TYPE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
B4087	GASTROSTOMY/JEJUNOSTOMY TUBE, STANDARD, ANY MATERIAL, ANY TYPE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
B4088	GASTROSTOMY/JEJUNOSTOMY TUBE, LOW-PROFILE, ANY MATERIAL, ANY TYPE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
B9002	ENTERAL NUTRITION INFUSION PUMP, ANY TYPE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
B9004	PARENTERAL NUTRITION INFUSION PUMP, PORTABLE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
B9006	PARENTERAL NUTRITION INFUSION PUMP, STATIONARY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1721	CARDIOVERTER-DEFIBRILLATOR, DUAL CHAMBER (IMPLANTABLE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1722	CARDIOVERTER-DEFIBRILLATOR, SINGLE CHAMBER (IMPLANTABLE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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C1749	ENDOSCOPE, RETROGRADE IMAGING/ILLUMINATION COLONOSCOPE DEVICE (IMPLANTABLE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1760	CLOSURE DEVICE, VASCULAR (IMPLANTABLE/INSERTABLE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1764	EVENT RECORDER, CARDIAC (IMPLANTABLE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1767	GENERATOR, NEUROSTIMULATOR (IMPLANTABLE), NON-RECHARGEABLE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1776	JOINT DEVICE (IMPLANTABLE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1780	LENS, INTRAOCULAR (NEW TECHNOLOGY)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1783	OCULAR IMPLANT, AQUEOUS DRAINAGE ASSIST DEVICE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1784	OCULAR DEVICE, INTRAOPERATIVE, DETACHED RETINA	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1787	PATIENT PROGRAMMER, NEUROSTIMULATOR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1789	PROSTHESIS, BREAST (IMPLANTABLE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1789	PROSTHESIS, BREAST (IMPLANTABLE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1813	PROSTHESIS, PENILE, INFLATABLE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1816	RECEIVER AND/OR TRANSMITTER, NEUROSTIMULATOR (IMPLANTABLE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1817	SEPTAL DEFECT IMPLANT SYSTEM, INTRACARDIAC	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1817	SEPTAL DEFECT IMPLANT SYSTEM, INTRACARDIAC	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1818	INTEGRATED KERATOPROSTHESIS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1820	GENERATOR, NEUROSTIMULATOR (IMPLANTABLE), WITH RECHARGEABLE BATTERY AND CHARGING SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1820	GENERATOR, NEUROSTIMULATOR (IMPLANTABLE), WITH RECHARGEABLE BATTERY AND CHARGING SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1821	INTERSPINOUS PROCESS DISTRACTION DEVICE (IMPLANTABLE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C1821	INTERSPINOUS PROCESS DISTRACTION DEVICE (IMPLANTABLE)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C1821	INTERSPINOUS PROCESS DISTRACTION DEVICE (IMPLANTABLE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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C1822	GENERATOR, NEUROSTIMULATOR (IMPLANTABLE), HIGH FREQUENCY, WITH RECHARGEABLE BATTERY AND CHARGING SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1822	GENERATOR, NEUROSTIMULATOR (IMPLANTABLE), HIGH FREQUENCY, WITH RECHARGEABLE BATTERY AND CHARGING SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1823	GENERATOR, NEUROSTIMULATOR (IMPLANTABLE), NON-RECHARGEABLE, WITH TRANSVENOUS SENSING AND STIMULATION LEADS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C1823	GENERATOR, NEUROSTIMULATOR (IMPLANTABLE), NON-RECHARGEABLE, WITH TRANSVENOUS SENSING AND STIMULATION LEADS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C1824	GENERATOR, CARDIAC CONTRACTILITY MODULATION (IMPLANTABLE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1824	GENERATOR, CARDIAC CONTRACTILITY MODULATION (IMPLANTABLE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1825	GENERATOR, NEUROSTIMULATOR (IMPLANTABLE), NON-RECHARGEABLE WITH CAROTID SINUS BARORECEPTOR STIMULATION LEAD(S)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1825	GENERATOR, NEUROSTIMULATOR (IMPLANTABLE), NON-RECHARGEABLE WITH CAROTID SINUS BARORECEPTOR STIMULATION LEAD(S)	Preauthorization required when billed charges exceed $500 per line item	1/1/2021	InterQual® Evidence-Based Criteria & Guidelines	
C1826	GENERATOR, NEUROSTIMULATOR (IMPLANTABLE), INCLUDES CLOSED FEEDBACK LOOP LEADS AND ALL IMPLANTABLE COMPONENTS, WITH RECHARGEABLE BATTERY AND CHARGING SYSTEM	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
C1827	GENERATOR, NEUROSTIMULATOR (IMPLANTABLE), NON-RECHARGEABLE, WITH IMPLANTABLE STIMULATION LEAD AND EXTERNAL PAIRED STIMULATION CONTROLLER	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
C1833	MONITOR, CARDIAC, INCLUDING INTRACARDIAC LEAD AND ALL SYSTEM COMPONENTS (IMPLANTABLE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1833	MONITOR, CARDIAC, INCLUDING INTRACARDIAC LEAD AND ALL SYSTEM COMPONENTS (IMPLANTABLE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1840	LENS, INTRAOCULAR (TELESCOPIC)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1889	IMPLANTABLE/INSERTABLE DEVICE, NOT OTHERWISE CLASSIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C1889	IMPLANTABLE/INSERTABLE DEVICE, NOT OTHERWISE CLASSIFIED		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C1889	IMPLANTABLE/INSERTABLE DEVICE, NOT OTHERWISE CLASSIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C1891	INFUSION PUMP, NON-PROGRAMMABLE, PERMANENT (IMPLANTABLE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C1891	INFUSION PUMP, NON-PROGRAMMABLE, PERMANENT (IMPLANTABLE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C2622	PROSTHESIS, PENILE, NON-INFLATABLE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C2622	PROSTHESIS, PENILE, NON-INFLATABLE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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C2623	CATHETER, TRANSLUMINAL ANGIOPLASTY, DRUG-COATED, NON-LASER	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C2626	INFUSION PUMP, NON-PROGRAMMABLE, TEMPORARY (IMPLANTABLE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C2626	INFUSION PUMP, NON-PROGRAMMABLE, TEMPORARY (IMPLANTABLE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C7501	PERCUTANEOUS BREAST BIOPSIES USING STEREOTACTIC GUIDANCE, WITH PLACEMENT OF BREAST LOCALIZATION DEVICE(S) (E.G., CLIP, METALLIC PELLET), WHEN PERFORMED, AND IMAGING OF THE BIOPSY SPECIMEN, WHEN PERFORMED, ALL LESIONS UNILATERAL AND BILATERAL (FOR SINGLE L		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
C7502	PERCUTANEOUS BREAST BIOPSIES USING MAGNETIC RESONANCE GUIDANCE, WITH PLACEMENT OF BREAST LOCALIZATION DEVICE(S) (E.G., CLIP, METALLIC PELLET), WHEN PERFORMED, AND IMAGING OF THE BIOPSY SPECIMEN, WHEN PERFORMED, ALL LESIONS UNILATERAL OR BILATERAL (FOR SIN		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
C7504	PERCUTANEOUS VERTEBROPLASTIES (BONE BIOPSIES INCLUDED WHEN PERFORMED), FIRST CERVICOTHORACIC AND ANY ADDITIONAL CERVICOTHORACIC OR LUMBOSACRAL VERTEBRAL BODIES, UNILATERAL OR BILATERAL INJECTION, INCLUSIVE OF ALL IMAGING GUIDANCE		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
C7505	PERCUTANEOUS VERTEBROPLASTIES (BONE BIOPSIES INCLUDED WHEN PERFORMED), FIRST LUMBOSACRAL AND ANY ADDITIONAL CERVICOTHORACIC OR LUMBOSACRAL VERTEBRAL BODIES, UNILATERAL OR BILATERAL INJECTION, INCLUSIVE OF ALL IMAGING GUIDANCE		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
C7507	PERCUTANEOUS VERTEBRAL AUGMENTATIONS, FIRST THORACIC AND ANY ADDITIONAL THORACIC OR LUMBAR VERTEBRAL BODIES, INCLUDING CAVITY CREATIONS (FRACTURE REDUCTIONS AND BONE BIOPSIES INCLUDED WHEN PERFORMED) USING MECHANICAL DEVICE (E.G., KYPHOPLASTY), UNILATERAL		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
C7508	PERCUTANEOUS VERTEBRAL AUGMENTATIONS, FIRST LUMBAR AND ANY ADDITIONAL THORACIC OR LUMBAR VERTEBRAL BODIES, INCLUDING CAVITY CREATIONS (FRACTURE REDUCTIONS AND BONE BIOPSIES INCLUDED WHEN PERFORMED) USING MECHANICAL DEVICE (E.G., KYPHOPLASTY), UNILATERAL O		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
C8001	3D ANATOMICAL SEGMENTATION IMAGING FOR PREOPERATIVE PLANNING, DATA PREPARATION AND TRANSMISSION, OBTAINED FROM PREVIOUS DIAGNOSTIC COMPUTED TOMOGRAPHIC OR MAGNETIC RESONANCE EXAMINATION OF THE SAME ANATOMY		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C8002	PREPARATION OF SKIN CELL SUSPENSION AUTOGRAFT, AUTOMATED, INCLUDING ALL ENZYMATIC PROCESSING AND DEVICE COMPONENTS (DO NOT REPORT WITH MANUAL SUSPENSION PREPARATION)		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C8003	IMPLANTATION OF MEDIAL KNEE EXTRAARTICULAR IMPLANTABLE SHOCK ABSORBER SPANNING THE KNEE JOINT FROM DISTAL FEMUR TO PROXIMAL TIBIA, OPEN, INCLUDES MEASUREMENTS, POSITIONING AND ADJUSTMENTS, WITH IMAGING GUIDANCE (E.G., FLUOROSCOPY)		6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
C8005	BRONCHOSCOPY, RIGID OR FLEXIBLE, NON-THERMAL TRANSBRONCHIAL ABLATION OF LESION(S) BY PULSED ELECTRIC FIELD (PEF) ENERGY, INCLUDING FLUOROSCOPIC AND/OR ULTRASOUND GUIDANCE, WHEN PERFORMED, WITH COMPUTED TOMOGRAPHY ACQUISITION(S) AND 3D RENDERING, COMPUTER-		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C8900	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, ABDOMEN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8901	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, ABDOMEN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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C8902	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, ABDOMEN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8903	MAGNETIC RESONANCE IMAGING WITH CONTRAST, BREAST; UNILATERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8904	MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST, BREAST; UNILATERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8905	MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, BREAST; UNILATERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8906	MAGNETIC RESONANCE IMAGING WITH CONTRAST, BREAST; BILATERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8907	MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST, BREAST; BILATERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8908	MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, BREAST; BILATERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8909	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, CHEST (EXCLUDING MYOCARDIUM)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8910	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, CHEST (EXCLUDING MYOCARDIUM)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8911	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, CHEST (EXCLUDING MYOCARDIUM)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8912	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, LOWER EXTREMITY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8913	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, LOWER EXTREMITY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8914	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, LOWER EXTREMITY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8918	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, PELVIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8919	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, PELVIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8920	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, PELVIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8931	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, SPINAL CANAL AND CONTENTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8932	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, SPINAL CANAL AND CONTENTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8933	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, SPINAL CANAL AND CONTENTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8934	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, UPPER EXTREMITY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8935	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, UPPER EXTREMITY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C8936	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST FOLLOWED BY WITH CONTRAST, UPPER EXTREMITY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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C9047	INJECTION, CAPLACIZUMAB-YHDP, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C9072	INJECTION, IMMUNE GLOBULIN (ASCENIV), 500 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C9094	INJ, SUTIMLIMAB-JOME, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C9095	INJ, TEBENTAFUSP-TEBN, 1 MCG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C9096	INJECTION, FILGRASTIM-AYOW, BIOSIMILAR, (RELEUKO), 1 MICROGRAM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C9097	INJ, FARICIMAB-SVOA, 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C9098	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	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C9160	INJECTION, DAXIBOTULINUMTOXINA-LANM, 1 UNIT		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
C9161	INJECTION, AFLIBERCEPT HD, 1 MG	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
C9162	INJECTION, AVACINCAPTAD PEGOL, 0.1 MG		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C9163	INJECTION, TALQUETAMAB-TGVS, 0.25 MG	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
C9164	CANTHARIDIN FOR TOPICAL ADMINISTRATION, 0.7%, SINGLE UNIT DOSE APPLICATOR (3.2 MG)		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
C9165	INJECTION, ELRANATAMAB-BCMM, 1 MG	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
C9166	INJECTION, SECUKINUMAB, INTRAVENOUS, 1 MG	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	OncoHealth Global Medical Necessity Review criteria	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications
C9167	INJECTION, ADAMTS13, RECOMBINANT-KRHN, 10 IU	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
C9168	INJECTION, MIRIKIZUMAB-MRKZ, 1 MG		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
C9169	INJECTION, NOGAPENDEKIN ALFA INBAKICEPT-PMLN, FOR INTRAVESICAL USE, 1 MICROGRAM	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
C9170	INJECTION, TARLATAMAB-DLLE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
C9172	INJECTION, FIDANACOGENE ELAPARVOVEC-DZKT, PER THERAPEUTIC DOSE	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
C9173	INJECTION, FILGRASTIM-TXID (NYPOZI), BIOSIMILAR, 1 MICROGRAM	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
C9257	INJECTION, BEVACIZUMAB, 0.25 MG	Pays without authorization for Ophthalmic condition Dx codes listed here when delivered by Providers in the Sendero network. Requires preauthorization for any other condition when billed charges exceed $500 per line item or when administered by a provider that is not part of the Sendero provider network. Diagnosis codes: B39.9, E08.311, E08.321, E08.331, E08.39, E08.341 through E08.359, E09.311, E09.321, E09.331, E09.39, E09.341 through E09.359, E10.311 through E10.39, E11.311 through E11.39, E13.311, E13.321, E13.331, E13.34, E13.341 through E13.359, H21.1X1, H21.1X2, H21.1X3, H21.1X9, H34.811 through H34.9, H35.00 through H35.9, H40.5, H40.89, H43.1, H44.2A1 through H44.2A9, and H54.0X33 through H54.8.	1/1/2022	OncoHealth global Medical Necessity Criteria for oncology in	InterQual® Evidence-Based Criteria & Guidelines
C9301	OBECABTAGENE AUTOLEUCEL, UP TO 410 MILLION CD19 CAR-POSITIVE VIABLE T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE		6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
C9302	INJECTION, ZANIDATAMAB-HRII, 2 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
C9303	INJECTION, ZOLBETUXIMAB-CLZB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
C9304	INJECTION, MARSTACIMAB-HNCQ, 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
C9352	MICROPOROUS COLLAGEN IMPLANTABLE TUBE (NEURAGEN NERVE GUIDE), PER CENTIMETER LENGTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C9353	MICROPOROUS COLLAGEN IMPLANTABLE SLIT TUBE (NEURAWRAP NERVE PROTECTOR), PER CENTIMETER LENGTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C9354	ACELLULAR PERICARDIAL TISSUE MATRIX OF NON-HUMAN ORIGIN (VERITAS), PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C9356	TENDON, POROUS MATRIX OF CROSS-LINKED COLLAGEN AND GLYCOSAMINOGLYCAN MATRIX (TENOGLIDE TENDON PROTECTOR SHEET), PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C9358	DERMAL SUBSTITUTE, NATIVE, NON-DENATURED COLLAGEN, FETAL BOVINE ORIGIN (SURGIMEND COLLAGEN MATRIX), PER 0.5 SQUARE CENTIMETERS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C9360	DERMAL SUBSTITUTE, NATIVE, NON-DENATURED COLLAGEN, NEONATAL BOVINE ORIGIN (SURGIMEND COLLAGEN MATRIX), PER 0.5 SQUARE CENTIMETERS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C9363	SKIN SUBSTITUTE, INTEGRA MESHED BILAYER WOUND MATRIX, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C9364	PORCINE IMPLANT, PERMACOL, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C9399	UNCLASSIFIED DRUGS OR BIOLOGICALS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
C9399	UNCLASSIFIED DRUGS OR BIOLOGICALS		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	

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C9610	CATHETER, TRANSLUMINAL DRUG DELIVERY WITH OR WITHOUT ANGIOPLASTY, CORONARY, NON-LASER (INSERTABLE)		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C9727	INSERTION OF IMPLANTS INTO THE SOFT PALATE; MINIMUM OF THREE IMPLANTS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C9745	NASAL ENDOSCOPY, SURGICAL; BALLOON DILATION OF EUSTACHIAN TUBE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C9747	ABLATION OF PROSTATE, TRANSRECTAL, HIGH INTENSITY FOCUSED ULTRASOUND (HIFU), INCLUDING IMAGING GUIDANCE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C9749	REPAIR OF NASAL VESTIBULAR LATERAL WALL STENOSIS WITH IMPLANT(S)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C9794	THERAPEUTIC RADIOLOGY SIMULATION-AIDED FIELD SETTING; COMPLEX, INCLUDING ACQUISITION OF PET AND CT IMAGING DATA REQUIRED FOR RADIOPHARMACEUTICAL-DIRECTED RADIATION THERAPY TREATMENT PLANNING (I.E., MODELING)		4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
C9795	STEREOTACTIC BODY RADIATION THERAPY, TREATMENT DELIVERY, PER FRACTION TO 1 OR MORE LESIONS, INCLUDING IMAGE GUIDANCE AND REAL-TIME POSITRON EMISSIONS-BASED DELIVERY ADJUSTMENTS TO 1 OR MORE LESIONS, ENTIRE COURSE NOT TO EXCEED 5 FRACTIONS		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C9807	NERVE STIMULATOR, PERCUTANEOUS, PERIPHERAL (E.G., SPRINT PERIPHERAL NERVE STIMULATION SYSTEM), INCLUDING ELECTRODE AND ALL DISPOSABLE SYSTEM COMPONENTS, NON-OPIOID MEDICAL DEVICE (MUST BE A QUALIFYING MEDICARE NON-OPIOID MEDICAL DEVICE FOR POST-SURGICAL P		6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	InterQual® Evidence-Based Criteria & Guidelines
C9808	NERVE CRYOABLATION PROBE (E.G., CRYOICE, CRYOSPHERE, CRYOSPHERE MAX, CRYOICE CRYOSPHERE, CRYOICE CRYO2), INCLUDING PROBE AND ALL DISPOSABLE SYSTEM COMPONENTS, NON-OPIOID MEDICAL DEVICE (MUST BE A QUALIFYING MEDICARE NON-OPIOID MEDICAL DEVICE FOR POST-SURG		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
C9809	CRYOABLATION NEEDLE (E.G., IOVERA SYSTEM), INCLUDING NEEDLE/TIP AND ALL DISPOSABLE SYSTEM COMPONENTS, NON-OPIOID MEDICAL DEVICE (MUST BE A QUALIFYING MEDICARE NON-OPIOID MEDICAL DEVICE FOR POST-SURGICAL PAIN RELIEF IN ACCORDANCE WITH SECTION 4135 OF THE C		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
D0210	INTRAORAL - COMPLETE SERIES OF RADIOGRAPHIC IMAGES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D0220	INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D0230	INTRAORAL - PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D0250	EXTRAORAL - 2D PROJECTION RADIOGRAPHIC IMAGE CREATED USING A STATIONARY RADIATION SOURCE, AND DETECTO		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D0260	EXTRAORAL – EACH ADDITIONAL RADIOGRAPHIC IMAGE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D0272	BITEWINGS – FOUR RADIOGRAPHIC IMAGES – LIMIT TO 1 SERIES EVERY 6 MONTHS.		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D0273	BITEWINGS - THREE FILMS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D0274	BITEWINGS – FOUR RADIOGRAPHIC IMAGES – LIMIT TO 1 SERIES EVERY 6 MONTHS.		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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D0277	VERTICAL BITEWINGS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D5911	FACIAL MOULAGE, SECTIONAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D5912	FACIAL MOULAGE, COMPLETE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D5914	AURICULAR PROSTHESIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D5916	OCULAR PROSTHESIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D6050	SURGICAL PLACEMENT: TRANSOSTEAL IMPLANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7272	TOOTH TRANSPLANTATION (INCLUDES RE-IMPLANTATION FROM ONE SITE TO ANOTHER AND SPLINTING AND/OR STABILIZATION)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7296	CORTICOTOMY - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7297	CORTICOTOMY - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7530	REMOVAL OF FOREIGN BODY FROM MUCOSA, SKIN, OR SUBCUTANEOUS ALVEOLAR TISSUE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7540	REMOVAL OF REACTION PRODUCING FOREIGN BODIES, MUSCULOSKELETAL SYSTEM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7610	MAXILLA — OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7620	MAXILLA — CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7630	MANDIBLE — OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7640	MANDIBLE — CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7650	MALAR AND/OR ZYGOMATIC ARCH — OPEN REDUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7660	MALAR AND/OR ZYGOMATIC ARCH — CLOSED REDUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7670	ALVEOLUS — CLOSED REDUCTION, MAY INCLUDE STABILIZATION OF TEETH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7671	ALVEOLUS — OPEN REDUCTION, MAY INCLUDE STABILIZATION OF TEETH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7680	FACIAL BONES — COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7710	MAXILLA — OPEN REDUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7720	MAXILLA — CLOSED REDUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7730	MANDIBLE — OPEN REDUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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D7740	MANDIBLE — CLOSED REDUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7750	MALAR AND/OR ZYGOMATIC ARCH — OPEN REDUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7760	MALAR AND/OR ZYGOMATIC ARCH — CLOSED REDUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7770	ALVEOLUS — OPEN REDUCTION STABILIZATION OF TEETH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7771	ALVEOLUS — CLOSED REDUCTION STABILIZATION OF TEETH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7780	FACIAL BONES — COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE APPROACHES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7810	OPEN REDUCTION OF DISLOCATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7810	OPEN REDUCTION OF DISLOCATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7820	CLOSED REDUCTION OF DISLOCATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7830	MANIPULATION UNDER ANESTHESIA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7840	CONDYLECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7852	DISC REPAIR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7854	SYNOVECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7856	MYOTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7858	JOINT RECONSTRUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7860	ARTHROTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7865	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7870	ARTHROCENTESIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7871	NON-ARTHROSCOPIC LYSIS AND LAVAGE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7872	ARTHROSCOPY – DIAGNOSIS, WITH OR WITHOUT BIOPSY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7873	ARTHROSCOPY – SURGICAL: LAVAGE AND LYSIS OF ADHESIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7874	ARTHROSCOPY – SURGICAL: DISC REPOSITIONING AND STABILIZATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7875	ARTHROSCOPY – SURGICAL: SYNOVECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7876	ARTHROSCOPY – SURGICAL: DISCECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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D7877	ARTHROSCOPY – SURGICAL: DEBRIDEMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7899	UNSPECIFIED TMD THERAPY, BY REPORT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7911	COMPLICATED SUTURE - UP TO 5 CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7912	COMPLICATED SUTURE — GREATER THAN 5 CM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7940	OSTEOPLASTY — FOR ORTHOGNATHIC DEFORMITIES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7941	OSTEOTOMY – MANDIBULAR RAMI		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7943	OSTEOTOMY – MANDIBULAR RAMI WITH BONE GRAFT; INCLUDES OBTAINING THE GRAFT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7944	OSTEOTOMY – SEGMENTED OR SUBAPICAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7945	OSTEOTOMY – BODY OF MANDIBLE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7946	LEFORT I (MAXILLA – TOTAL)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7947	LEFORT I (MAXILLA – SEGMENTED)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7948	LEFORT II OR LEFORT III (OSTEOPLASTY OF FACIAL BONES FOR MIDFACE HYPOPLASIA OR RETRUSION)-WITHOUT BONE GRAFT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7949	LEFORT II OR LEFORT III – WITH BONE GRAFT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7950	OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR FACIAL BONES — AUTOGENEOUS OR NONAUTOGENEOUS, BY REPORT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7951	SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7952	SINUS AUGUMENTATION VIA A VERTICAL APPROACH.		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7955	REPAIR OF MAXILLOFACIAL SOFT AND/OR HARD TISSUE DEFECT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7991	CORONOIDECTOMY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7995	SYNTHETIC GRAFT - MANDIBLE OR FACIAL BONES, BY REPORT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D7996	IMPLANT-MANDIBLE FOR AUGMENTATION PURPOSES (EXCLUDING ALVEOLAR RIDGE), BY REPORT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D9210	LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D9211	REGIONAL BLOCK ANESTHESIA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
D9212	TRIGEMINAL DIVISION BLOCK ANESTHESIA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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D9215	LOCAL ANESTHESIA IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0181	POWERED PRESSURE REDUCING MATTRESS OVERLAY/PAD, ALTERNATING, WITH PUMP, INCLUDES HEAVY DUTY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0182	PUMP FOR ALTERNATING PRESSURE PAD, FOR REPLACEMENT ONLY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0187	WATER PRESSURE MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0193	POWERED AIR FLOTATION BED (LOW AIR LOSS THERAPY)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0194	AIR FLUIDIZED BED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0196	GEL PRESSURE MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0197	AIR PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0198	WATER PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0199	DRY PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0202	PHOTOTHERAPY (BILIRUBIN) LIGHT WITH PHOTOMETER	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0236	PUMP FOR WATER CIRCULATING PAD	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0239	HYDROCOLLATOR UNIT, PORTABLE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0249	PAD FOR WATER CIRCULATING HEAT UNIT, FOR REPLACEMENT ONLY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0250	HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE SIDE RAILS, WITH MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0251	HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0255	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITH MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0256	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0260	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITH MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0261	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
E0265	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITH MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0266	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0270	HOSPITAL BED, INSTITUTIONAL TYPE INCLUDES: OSCILLATING, CIRCULATING AND STRYKER FRAME, WITH MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0290	HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITH MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0291	HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITHOUT MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0292	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITH MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0293	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITHOUT MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0294	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITH MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0295	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITHOUT MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0296	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITHOUT SIDE RAILS, WITH MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0297	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITHOUT SIDE RAILS, WITHOUT MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0300	PEDIATRIC CRIB, HOSPITAL GRADE, FULLY ENCLOSED, WITH OR WITHOUT TOP ENCLOSURE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0301	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0302	HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0303	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 350 POUNDS, BUT LESS THAN OR EQUAL TO 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITH MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0304	HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITH MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0305	BED SIDE RAILS, HALF LENGTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0310	BED SIDE RAILS, FULL LENGTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0315	BED ACCESSORY: BOARD, TABLE, OR SUPPORT DEVICE, ANY TYPE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0316	SAFETY ENCLOSURE FRAME/CANOPY FOR USE WITH HOSPITAL BED, ANY TYPE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
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	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0350	CONTROL UNIT FOR ELECTRONIC BOWEL IRRIGATION/EVACUATION SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0352	DISPOSABLE PACK (WATER RESERVOIR BAG, SPECULUM, VALVING MECHANISM AND COLLECTION BAG/BOX) FOR USE WITH THE ELECTRONIC BOWEL IRRIGATION/EVACUATION SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0370	AIR PRESSURE ELEVATOR FOR HEEL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0371	NONPOWERED ADVANCED PRESSURE REDUCING OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0372	POWERED AIR OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0373	NONPOWERED ADVANCED PRESSURE REDUCING MATTRESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0424	STATIONARY COMPRESSED GASEOUS OXYGEN SYSTEM, RENTAL; INCLUDES CONTAINER, CONTENTS, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0425	STATIONARY COMPRESSED GAS SYSTEM, PURCHASE; INCLUDES REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0430	PORTABLE GASEOUS OXYGEN SYSTEM, PURCHASE; INCLUDES REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0431	PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL; INCLUDES PORTABLE CONTAINER, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0433	PORTABLE LIQUID OXYGEN SYSTEM, RENTAL; HOME LIQUEFIER USED TO FILL PORTABLE LIQUID OXYGEN CONTAINERS, INCLUDES PORTABLE CONTAINERS, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK AND TUBING, WITH OR WITHOUT SUPPLY RESERVOIR AND CONTENTS GAUGE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0434	PORTABLE LIQUID OXYGEN SYSTEM, RENTAL; INCLUDES PORTABLE CONTAINER, SUPPLY RESERVOIR, HUMIDIFIER, FLOWMETER, REFILL ADAPTOR, CONTENTS GAUGE, CANNULA OR MASK, AND TUBING	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0435	PORTABLE LIQUID OXYGEN SYSTEM, PURCHASE; INCLUDES PORTABLE CONTAINER, SUPPLY RESERVOIR, FLOWMETER, HUMIDIFIER, CONTENTS GAUGE, CANNULA OR MASK, TUBING AND REFILL ADAPTOR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0439	STATIONARY LIQUID OXYGEN SYSTEM, RENTAL; INCLUDES CONTAINER, CONTENTS, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, & TUBING	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0440	STATIONARY LIQUID OXYGEN SYSTEM, PURCHASE; INCLUDES USE OF RESERVOIR, CONTENTS INDICATOR, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0441	STATIONARY OXYGEN CONTENTS, GASEOUS, 1 MONTH'S SUPPLY = 1 UNIT	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0442	STATIONARY OXYGEN CONTENTS, LIQUID, 1 MONTH'S SUPPLY = 1 UNIT	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
E0443	PORTABLE OXYGEN CONTENTS, GASEOUS, 1 MONTH'S SUPPLY = 1 UNIT	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0444	PORTABLE OXYGEN CONTENTS, LIQUID, 1 MONTH'S SUPPLY = 1 UNIT	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0445	OXIMETER DEVICE FOR MEASURING BLOOD OXYGEN LEVELS NON-INVASIVELY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0446	TOPICAL OXYGEN DELIVERY SYSTEM, NOT OTHERWISE SPECIFIED, INCLUDES ALL SUPPLIES AND ACCESSORIES		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0446	TOPICAL OXYGEN DELIVERY SYSTEM, NOT OTHERWISE SPECIFIED, INCLUDES ALL SUPPLIES AND ACCESSORIES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0447	PORTABLE OXYGEN CONTENTS, LIQUID, 1 MONTH'S SUPPLY = 1 UNIT, PRESCRIBED AMOUNT AT REST OR NIGHTTIME EXCEEDS 4 LITERS PER MINUTE (LPM)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0455	OXYGEN TENT, EXCLUDING CROUP OR PEDIATRIC TENTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0457	CHEST SHELL (CUIRASS)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0459	CHEST WRAP	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0462	ROCKING BED WITH OR WITHOUT SIDE RAILS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0465	HOME VENTILATOR, ANY TYPE, USED WITH INVASIVE INTERFACE, (E.G., TRACHEOSTOMY TUBE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0466	HOME VENTILATOR, ANY TYPE, USED WITH NON-INVASIVE INTERFACE, (E.G., MASK, CHEST SHELL)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0467	HOME VENTILATOR, MULTI-FUNCTION RESPIRATORY DEVICE, ALSO PERFORMS ANY OR ALL OF THE ADDITIONAL FUNCTIONS OF OXYGEN CONCENTRATION, DRUG NEBULIZATION, ASPIRATION, AND COUGH STIMULATION, INCLUDES ALL ACCESSORIES, COMPONENTS AND SUPPLIES FOR ALL FUNCTIONS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0468	HOME VENTILATOR, DUAL-FUNCTION RESPIRATORY DEVICE, ALSO PERFORMS ADDITIONAL FUNCTION OF COUGH STIMULATION, INCLUDES ALL ACCESSORIES, COMPONENTS AND SUPPLIES FOR ALL FUNCTIONS	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
E0470	RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITHOUT BACKUP RATE FEATURE, USED WITH NONINVASIVE INTERFACE, E.G., NASAL OR FACIAL MASK (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0471	RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITH BACK-UP RATE FEATURE, USED WITH NONINVASIVE INTERFACE, E.G., NASAL OR FACIAL MASK (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0472	RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITH BACKUP RATE FEATURE, USED WITH INVASIVE INTERFACE, E.G., TRACHEOSTOMY TUBE (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0480	PERCUSSOR, ELECTRIC OR PNEUMATIC, HOME MODEL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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E0481	INTRAPULMONARY PERCUSSIVE VENTILATION SYSTEM AND RELATED ACCESSORIES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0482	COUGH STIMULATING DEVICE, ALTERNATING POSITIVE AND NEGATIVE AIRWAY PRESSURE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0483	HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM, WITH FULL ANTERIOR AND/OR POSTERIOR THORACIC REGION RECEIVING SIMULTANEOUS EXTERNAL OSCILLATION, INCLUDES ALL ACCESSORIES AND SUPPLIES, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0484	OSCILLATORY POSITIVE EXPIRATORY PRESSURE DEVICE, NON-ELECTRIC, ANY TYPE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0485	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0486	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0487	SPIROMETER, ELECTRONIC, INCLUDES ALL ACCESSORIES		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0487	SPIROMETER, ELECTRONIC, INCLUDES ALL ACCESSORIES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0492	POWER SOURCE AND CONTROL ELECTRONICS UNIT FOR ORAL DEVICE/APPLIANCE FOR NEUROMUSCULAR ELECTRICAL STIMULATION OF THE TONGUE MUSCLE, CONTROLLED BY PHONE APPLICATION	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
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	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
E0500	IPPB MACHINE, ALL TYPES, WITH BUILT-IN NEBULIZATION; MANUAL OR AUTOMATIC VALVES; INTERNAL OR EXTERNAL POWER SOURCE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0550	HUMIDIFIER, DURABLE FOR EXTENSIVE SUPPLEMENTAL HUMIDIFICATION DURING IPPB TREATMENTS OR OXYGEN DELIVERY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0555	HUMIDIFIER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGULATOR OR FLOWMETER	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0560	HUMIDIFIER, DURABLE FOR SUPPLEMENTAL HUMIDIFICATION DURING IPPB TREATMENT OR OXYGEN DELIVERY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0561	HUMIDIFIER, NON-HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0562	HUMIDIFIER, HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0565	COMPRESSOR, AIR POWER SOURCE FOR EQUIPMENT WHICH IS NOT SELF-CONTAINED OR CYLINDER DRIVEN	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0570	NEBULIZER, WITH COMPRESSOR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0572	AEROSOL COMPRESSOR, ADJUSTABLE PRESSURE, LIGHT DUTY FOR INTERMITTENT USE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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E0574	ULTRASONIC/ELECTRONIC AEROSOL GENERATOR WITH SMALL VOLUME NEBULIZER	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0575	NEBULIZER, ULTRASONIC, LARGE VOLUME	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0580	NEBULIZER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC, BOTTLE TYPE, FOR USE WITH REGULATOR OR FLOWMETER	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0585	NEBULIZER, WITH COMPRESSOR AND HEATER	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0600	RESPIRATORY SUCTION PUMP, HOME MODEL, PORTABLE OR STATIONARY, ELECTRIC	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0605	VAPORIZER, ROOM TYPE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0607	HOME BLOOD GLUCOSE MONITOR	No authorization required for a diagnosis of diabetes. All other diagnoses require preauthorization.	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0615	PACEMAKER MONITOR, SELF CONTAINED, CHECKS BATTERY DEPLETION AND OTHER PACEMAKER COMPONENTS, INCLUDES DIGITAL/VISIBLE CHECK SYSTEMS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0616	IMPLANTABLE CARDIAC EVENT RECORDER WITH MEMORY, ACTIVATOR AND PROGRAMMER	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0616	IMPLANTABLE CARDIAC EVENT RECORDER WITH MEMORY, ACTIVATOR AND PROGRAMMER	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0617	EXTERNAL DEFIBRILLATOR WITH INTEGRATED ELECTROCARDIOGRAM ANALYSIS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0618	APNEA MONITOR, WITHOUT RECORDING FEATURE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0619	APNEA MONITOR, WITH RECORDING FEATURE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0620	SKIN PIERCING DEVICE FOR COLLECTION OF CAPILLARY BLOOD, LASER, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0621	SLING OR SEAT, PATIENT LIFT, CANVAS OR NYLON	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0625	PATIENT LIFT, BATHROOM OR TOILET, NOT OTHERWISE CLASSIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0627	SEAT LIFT MECHANISM, ELECTRIC, ANY TYPE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0629	SEAT LIFT MECHANISM, NON-ELECTRIC, ANY TYPE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0630	PATIENT LIFT, HYDRAULIC OR MECHANICAL, INCLUDES ANY SEAT, SLING, STRAP(S) OR PAD(S)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0635	PATIENT LIFT, ELECTRIC WITH SEAT OR SLING	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
E0636	MULTIPOSITIONAL PATIENT SUPPORT SYSTEM, WITH INTEGRATED LIFT, PATIENT ACCESSIBLE CONTROLS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0637	COMBINATION SIT TO STAND FRAME/TABLE SYSTEM, ANY SIZE INCLUDING PEDIATRIC, WITH SEAT LIFT FEATURE, WITH OR WITHOUT WHEELS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0638	STANDING FRAME/TABLE SYSTEM, ONE POSITION (E.G., UPRIGHT, SUPINE OR PRONE STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0639	PATIENT LIFT, MOVEABLE FROM ROOM TO ROOM WITH DISASSEMBLY AND REASSEMBLY, INCLUDES ALL COMPONENTS/ACCESSORIES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0640	PATIENT LIFT, FIXED SYSTEM, INCLUDES ALL COMPONENTS/ACCESSORIES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0641	STANDING FRAME/TABLE SYSTEM, MULTI-POSITION (E.G., THREE-WAY STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0642	STANDING FRAME/TABLE SYSTEM, MOBILE (DYNAMIC STANDER), ANY SIZE INCLUDING PEDIATRIC	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0650	PNEUMATIC COMPRESSOR, NON-SEGMENTAL HOME MODEL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0651	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITHOUT CALIBRATED GRADIENT PRESSURE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0652	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITH CALIBRATED GRADIENT PRESSURE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0655	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF ARM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0656	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, TRUNK	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0657	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, CHEST	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0660	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0665	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0666	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0667	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0668	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0669	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0670	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, INTEGRATED, 2 FULL LEGS AND TRUNK	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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E0671	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, FULL LEG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0672	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, FULL ARM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0673	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, HALF LEG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0675	PNEUMATIC COMPRESSION DEVICE, HIGH PRESSURE, RAPID INFLATION/DEFLATION CYCLE, FOR ARTERIAL INSUFFICIENCY (UNILATERAL OR BILATERAL SYSTEM)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0675	PNEUMATIC COMPRESSION DEVICE, HIGH PRESSURE, RAPID INFLATION/DEFLATION CYCLE, FOR ARTERIAL INSUFFICIENCY (UNILATERAL OR BILATERAL SYSTEM)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0676	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0677	NON-PNEUMATIC SEQUENTIAL COMPRESSION GARMENT, TRUNK	Preauthorization required when billed charges exceed $500 per line item	8/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
E0682	NON-PNEUMATIC SEQUENTIAL COMPRESSION GARMENT, FULL ARM		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0683	NON-PNEUMATIC, NON-SEQUENTIAL, PERISTALTIC WAVE COMPRESSION PUMP	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
E0691	ULTRAVIOLET LIGHT THERAPY SYSTEM, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION; TREATMENT AREA 2 SQUARE FEET OR LESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0692	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION, 4 FOOT PANEL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0693	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION, 6 FOOT PANEL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0694	ULTRAVIOLET MULTIDIRECTIONAL LIGHT THERAPY SYSTEM IN 6 FOOT CABINET, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0700	SAFETY EQUIPMENT, DEVICE OR ACCESSORY, ANY TYPE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0720	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, TWO LEAD, LOCALIZED STIMULATION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0721	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR FOR NERVES IN THE AURICULAR REGION	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
E0730	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, FOUR OR MORE LEADS, FOR MULTIPLE NERVE STIMULATION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0731	FORM FITTING CONDUCTIVE GARMENT FOR DELIVERY OF TENS OR NMES (WITH CONDUCTIVE FIBERS SEPARATED FROM THE PATIENT'S SKIN BY LAYERS OF FABRIC)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0732	CRANIAL ELECTROTHERAPY STIMULATION (CES) SYSTEM, ANY TYPE		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0733	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR FOR ELECTRICAL STIMULATION OF THE TRIGEMINAL NERVE	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	

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E0734	EXTERNAL UPPER LIMB TREMOR STIMULATOR OF THE PERIPHERAL NERVES OF THE WRIST	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
E0735	NON-INVASIVE VAGUS NERVE STIMULATOR	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
E0736	TRANSCUTANEOUS TIBIAL NERVE STIMULATOR		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
E0737	TRANSCUTANEOUS TIBIAL NERVE STIMULATOR, CONTROLLED BY PHONE APPLICATION	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
E0738	UPPER EXTREMITY REHABILITATION SYSTEM PROVIDING ACTIVE ASSISTANCE TO FACILITATE MUSCLE RE-EDUCATION, INCLUDE MICROPROCESSOR, ALL COMPONENTS AND ACCESSORIES		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	InterQual® Evidence-Based Criteria & Guidelines
E0739	REHABILITATION SYSTEM WITH INTERACTIVE INTERFACE PROVIDING ACTIVE ASSISTANCE IN REHABILITATION THERAPY, INCLUDES ALL COMPONENTS AND ACCESSORIES, MOTORS, MICROPROCESSORS, SENSORS		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	InterQual® Evidence-Based Criteria & Guidelines
E0740	NON-IMPLANTED PELVIC FLOOR ELECTRICAL STIMULATOR, COMPLETE SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0740	NON-IMPLANTED PELVIC FLOOR ELECTRICAL STIMULATOR, COMPLETE SYSTEM		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0743	EXTERNAL LOWER EXTREMITY NERVE STIMULATOR FOR RESTLESS LEGS SYNDROME, EACH	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
E0744	NEUROMUSCULAR STIMULATOR FOR SCOLIOSIS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0744	NEUROMUSCULAR STIMULATOR FOR SCOLIOSIS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0745	NEUROMUSCULAR STIMULATOR, ELECTRONIC SHOCK UNIT	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0746	ELECTROMYOGRAPHY (EMG), BIOFEEDBACK DEVICE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0746	ELECTROMYOGRAPHY (EMG), BIOFEEDBACK DEVICE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0747	OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, OTHER THAN SPINAL APPLICATIONS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0748	OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, SPINAL APPLICATIONS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0749	OSTEOGENESIS STIMULATOR, ELECTRICAL, SURGICALLY IMPLANTED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0755	ELECTRONIC SALIVARY REFLEX STIMULATOR (INTRA-ORAL/NON-INVASIVE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0760	OSTEOGENESIS STIMULATOR, LOW INTENSITY ULTRASOUND, NON-INVASIVE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0761	NON-THERMAL PULSED HIGH FREQUENCY RADIOWAVES, HIGH PEAK POWER ELECTROMAGNETIC ENERGY TREATMENT DEVICE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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E0761	NON-THERMAL PULSED HIGH FREQUENCY RADIOWAVES, HIGH PEAK POWER ELECTROMAGNETIC ENERGY TREATMENT DEVICE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0762	TRANSCUTANEOUS ELECTRICAL JOINT STIMULATION DEVICE SYSTEM, INCLUDES ALL ACCESSORIES		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0765	FDA APPROVED NERVE STIMULATOR, WITH REPLACEABLE BATTERIES, FOR TREATMENT OF NAUSEA AND VOMITING	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0766	ELECTRICAL STIMULATION DEVICE USED FOR CANCER TREATMENT, INCLUDES ALL ACCESSORIES, ANY TYPE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0767	INTRABUCCAL, SYSTEMIC DELIVERY OF AMPLITUDE-MODULATED, RADIOFREQUENCY ELECTROMAGNETIC FIELD DEVICE, FOR CANCER TREATMENT, INCLUDES ALL ACCESSORIES		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0769	ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE, NOT OTHERWISE CLASSIFIED		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0769	ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE, NOT OTHERWISE CLASSIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0779	AMBULATORY INFUSION PUMP, MECHANICAL, REUSABLE, FOR INFUSION 8 HOURS OR GREATER	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0780	AMBULATORY INFUSION PUMP, MECHANICAL, REUSABLE, FOR INFUSION LESS THAN 8 HOURS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0781	AMBULATORY INFUSION PUMP, SINGLE OR MULTIPLE CHANNELS, ELECTRIC OR BATTERY OPERATED, WITH ADMINISTRATIVE EQUIPMENT, WORN BY PATIENT	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0782	INFUSION PUMP, IMPLANTABLE, NON-PROGRAMMABLE (INCLUDES ALL COMPONENTS, E.G., PUMP, CATHETER, CONNECTORS, ETC.)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0782	INFUSION PUMP, IMPLANTABLE, NON-PROGRAMMABLE (INCLUDES ALL COMPONENTS, E.G., PUMP, CATHETER, CONNECTORS, ETC.)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0783	INFUSION PUMP SYSTEM, IMPLANTABLE, PROGRAMMABLE (INCLUDES ALL COMPONENTS, E.G., PUMP, CATHETER, CONNECTORS, ETC.)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0783	INFUSION PUMP SYSTEM, IMPLANTABLE, PROGRAMMABLE (INCLUDES ALL COMPONENTS, E.G., PUMP, CATHETER, CONNECTORS, ETC.)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0784	EXTERNAL AMBULATORY INFUSION PUMP, INSULIN	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0785	IMPLANTABLE INTRASPINAL (EPIDURAL/INTRATHECAL) CATHETER USED WITH IMPLANTABLE INFUSION PUMP, REPLACEMENT	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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E0786	IMPLANTABLE PROGRAMMABLE INFUSION PUMP, REPLACEMENT (EXCLUDES IMPLANTABLE INTRASPINAL CATHETER)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0786	IMPLANTABLE PROGRAMMABLE INFUSION PUMP, REPLACEMENT (EXCLUDES IMPLANTABLE INTRASPINAL CATHETER)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0787	EXTERNAL AMBULATORY INFUSION PUMP, INSULIN, DOSAGE RATE ADJUSTMENT USING THERAPEUTIC CONTINUOUS GLUCOSE SENSING	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0791	PARENTERAL INFUSION PUMP, STATIONARY, SINGLE OR MULTI-CHANNEL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0830	AMBULATORY TRACTION DEVICE, ALL TYPES, EACH		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0830	AMBULATORY TRACTION DEVICE, ALL TYPES, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0840	TRACTION FRAME, ATTACHED TO HEADBOARD, CERVICAL TRACTION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0840	TRACTION FRAME, ATTACHED TO HEADBOARD, CERVICAL TRACTION		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0849	TRACTION EQUIPMENT, CERVICAL, FREE-STANDING STAND/FRAME, PNEUMATIC, APPLYING TRACTION FORCE TO OTHER THAN MANDIBLE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0849	TRACTION EQUIPMENT, CERVICAL, FREE-STANDING STAND/FRAME, PNEUMATIC, APPLYING TRACTION FORCE TO OTHER THAN MANDIBLE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0850	TRACTION STAND, FREE STANDING, CERVICAL TRACTION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0850	TRACTION STAND, FREE STANDING, CERVICAL TRACTION		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0855	CERVICAL TRACTION EQUIPMENT NOT REQUIRING ADDITIONAL STAND OR FRAME	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0855	CERVICAL TRACTION EQUIPMENT NOT REQUIRING ADDITIONAL STAND OR FRAME		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0856	CERVICAL TRACTION DEVICE, WITH INFLATABLE AIR BLADDER(S)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0856	CERVICAL TRACTION DEVICE, WITH INFLATABLE AIR BLADDER(S)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0860	TRACTION EQUIPMENT, OVERDOOR, CERVICAL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0860	TRACTION EQUIPMENT, OVERDOOR, CERVICAL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0870	TRACTION FRAME, ATTACHED TO FOOTBOARD, EXTREMITY TRACTION, (E.G., BUCK'S)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0880	TRACTION STAND, FREE STANDING, EXTREMITY TRACTION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0890	TRACTION FRAME, ATTACHED TO FOOTBOARD, PELVIC TRACTION		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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E0890	TRACTION FRAME, ATTACHED TO FOOTBOARD, PELVIC TRACTION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0900	TRACTION STAND, FREE STANDING, PELVIC TRACTION, (E.G., BUCK'S)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0910	TRAPEZE BARS, A/K/A PATIENT HELPER, ATTACHED TO BED, WITH GRAB BAR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0911	TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 POUNDS, ATTACHED TO BED, WITH GRAB BAR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0912	TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 POUNDS, FREE STANDING, COMPLETE WITH GRAB BAR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0920	FRACTURE FRAME, ATTACHED TO BED, INCLUDES WEIGHTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0930	FRACTURE FRAME, FREE STANDING, INCLUDES WEIGHTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0935	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE ON KNEE ONLY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0936	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE OTHER THAN KNEE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0940	TRAPEZE BAR, FREE STANDING, COMPLETE WITH GRAB BAR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0941	GRAVITY ASSISTED TRACTION DEVICE, ANY TYPE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0942	CERVICAL HEAD HARNESS/HALTER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0942	CERVICAL HEAD HARNESS/HALTER	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0944	PELVIC BELT/HARNESS/BOOT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0944	PELVIC BELT/HARNESS/BOOT	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E0945	EXTREMITY BELT/HARNESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0946	FRACTURE, FRAME, DUAL WITH CROSS BARS, ATTACHED TO BED, (E.G., BALKEN, 4 POSTER)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0947	FRACTURE FRAME, ATTACHMENTS FOR COMPLEX PELVIC TRACTION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0948	FRACTURE FRAME, ATTACHMENTS FOR COMPLEX CERVICAL TRACTION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0950	WHEELCHAIR ACCESSORY, TRAY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0953	WHEELCHAIR ACCESSORY, LATERAL THIGH OR KNEE SUPPORT, ANY TYPE INCLUDING FIXED MOUNTING HARDWARE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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E0954	WHEELCHAIR ACCESSORY, FOOT BOX, ANY TYPE, INCLUDES ATTACHMENT AND MOUNTING HARDWARE, EACH FOOT	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0955	WHEELCHAIR ACCESSORY, HEADREST, CUSHIONED, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0956	WHEELCHAIR ACCESSORY, LATERAL TRUNK OR HIP SUPPORT, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0957	WHEELCHAIR ACCESSORY, MEDIAL THIGH SUPPORT, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0958	MANUAL WHEELCHAIR ACCESSORY, ONE-ARM DRIVE ATTACHMENT, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0959	MANUAL WHEELCHAIR ACCESSORY, ADAPTER FOR AMPUTEE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0960	WHEELCHAIR ACCESSORY, SHOULDER HARNESS/STRAPS OR CHEST STRAP, INCLUDING ANY TYPE MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0961	MANUAL WHEELCHAIR ACCESSORY, WHEEL LOCK BRAKE EXTENSION (HANDLE), EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0966	MANUAL WHEELCHAIR ACCESSORY, HEADREST EXTENSION, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0967	MANUAL WHEELCHAIR ACCESSORY, HAND RIM WITH PROJECTIONS, ANY TYPE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0968	COMMODE SEAT, WHEELCHAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0969	NARROWING DEVICE, WHEELCHAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0970	NO. 2 FOOTPLATES, EXCEPT FOR ELEVATING LEG REST	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0971	MANUAL WHEELCHAIR ACCESSORY, ANTI-TIPPING DEVICE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0973	WHEELCHAIR ACCESSORY, ADJUSTABLE HEIGHT, DETACHABLE ARMREST, COMPLETE ASSEMBLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0974	MANUAL WHEELCHAIR ACCESSORY, ANTI-ROLLBACK DEVICE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0978	WHEELCHAIR ACCESSORY, POSITIONING BELT/SAFETY BELT/PELVIC STRAP, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0980	SAFETY VEST, WHEELCHAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0981	WHEELCHAIR ACCESSORY, SEAT UPHOLSTERY, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0982	WHEELCHAIR ACCESSORY, BACK UPHOLSTERY, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
E0983	MANUAL WHEELCHAIR ACCESSORY, POWER ADD-ON TO CONVERT MANUAL WHEELCHAIR TO MOTORIZED WHEELCHAIR, JOYSTICK CONTROL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0984	MANUAL WHEELCHAIR ACCESSORY, POWER ADD-ON TO CONVERT MANUAL WHEELCHAIR TO MOTORIZED WHEELCHAIR, TILLER CONTROL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0985	WHEELCHAIR ACCESSORY, SEAT LIFT MECHANISM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0986	MANUAL WHEELCHAIR ACCESSORY, PUSH-RIM ACTIVATED POWER ASSIST SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0988	MANUAL WHEELCHAIR ACCESSORY, LEVER-ACTIVATED, WHEEL DRIVE, PAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0990	WHEELCHAIR ACCESSORY, ELEVATING LEG REST, COMPLETE ASSEMBLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0992	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT INSERT	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0994	ARM REST, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E0995	WHEELCHAIR ACCESSORY, CALF REST/PAD, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1002	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, TILT ONLY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1003	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, RECLINE ONLY, WITHOUT SHEAR REDUCTION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1004	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, RECLINE ONLY, WITH MECHANICAL SHEAR REDUCTION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1005	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, RECLINE ONLY, WITH POWER SHEAR REDUCTION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1006	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITHOUT SHEAR REDUCTION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1007	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITH MECHANICAL SHEAR REDUCTION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1008	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITH POWER SHEAR REDUCTION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1009	WHEELCHAIR ACCESSORY, ADDITION TO POWER SEATING SYSTEM, MECHANICALLY LINKED LEG ELEVATION SYSTEM, INCLUDING PUSHROD AND LEG REST, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1010	WHEELCHAIR ACCESSORY, ADDITION TO POWER SEATING SYSTEM, POWER LEG ELEVATION SYSTEM, INCLUDING LEG REST, PAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1011	MODIFICATION TO PEDIATRIC SIZE WHEELCHAIR, WIDTH ADJUSTMENT PACKAGE (NOT TO BE DISPENSED WITH INITIAL CHAIR)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1012	WHEELCHAIR ACCESSORY, ADDITION TO POWER SEATING SYSTEM, CENTER MOUNT POWER ELEVATING LEG REST/PLATFORM, COMPLETE SYSTEM, ANY TYPE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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E1014	RECLINING BACK, ADDITION TO PEDIATRIC SIZE WHEELCHAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1015	SHOCK ABSORBER FOR MANUAL WHEELCHAIR, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1016	SHOCK ABSORBER FOR POWER WHEELCHAIR, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1017	HEAVY DUTY SHOCK ABSORBER FOR HEAVY DUTY OR EXTRA HEAVY DUTY MANUAL WHEELCHAIR, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1018	HEAVY DUTY SHOCK ABSORBER FOR HEAVY DUTY OR EXTRA HEAVY DUTY POWER WHEELCHAIR, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1020	RESIDUAL LIMB SUPPORT SYSTEM FOR WHEELCHAIR, ANY TYPE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1022	WHEELCHAIR TRANSPORTATION SECUREMENT SYSTEM, ANY TYPE INCLUDES ALL COMPONENTS AND ACCESSORIES	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	
E1023	WHEELCHAIR TRANSIT SECUREMENT SYSTEM, INCLUDES ALL COMPONENTS AND ACCESSORIES	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	
E1028	WHEELCHAIR ACCESSORY, MANUAL SWINGAWAY, RETRACTABLE OR REMOVABLE MOUNTING HARDWARE FOR JOYSTICK, OTHER CONTROL INTERFACE OR POSITIONING ACCESSORY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1029	WHEELCHAIR ACCESSORY, VENTILATOR TRAY, FIXED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1030	WHEELCHAIR ACCESSORY, VENTILATOR TRAY, GIMBALED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1031	ROLLABOUT CHAIR, ANY AND ALL TYPES WITH CASTERS 5" OR GREATER	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1032	WHEELCHAIR ACCESSORY, MANUAL SWINGAWAY, RETRACTABLE OR REMOVABLE MOUNTING HARDWARE USED WITH JOYSTICK OR OTHER DRIVE CONTROL INTERFACE	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
E1033	WHEELCHAIR ACCESSORY, MANUAL SWINGAWAY, RETRACTABLE OR REMOVABLE MOUNTING HARDWARE FOR HEADREST, CUSHIONED, ANY TYPE	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
E1034	WHEELCHAIR ACCESSORY, MANUAL SWINGAWAY, RETRACTABLE OR REMOVABLE MOUNTING HARDWARE FOR LATERAL TRUNK OR HIP SUPPORT, ANY TYPE	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
E1035	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, WITH INTEGRATED SEAT, OPERATED BY CARE GIVER, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 LBS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1036	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, EXTRA-WIDE, WITH INTEGRATED SEAT, OPERATED BY CAREGIVER, PATIENT WEIGHT CAPACITY GREATER THAN 300 LBS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1037	TRANSPORT CHAIR, PEDIATRIC SIZE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1038	TRANSPORT CHAIR, ADULT SIZE, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1039	TRANSPORT CHAIR, ADULT SIZE, HEAVY DUTY, PATIENT WEIGHT CAPACITY GREATER THAN 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
E1050	FULLY-RECLINING WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1060	FULLY-RECLINING WHEELCHAIR, DETACHABLE ARMS, DESK OR FULL LENGTH, SWING AWAY DETACHABLE ELEVATING LEGRESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1070	FULLY-RECLINING WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE FOOTREST	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1083	HEMI-WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG REST	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1084	HEMI-WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1085	HEMI-WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOT RESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1086	HEMI-WHEELCHAIR DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY DETACHABLE FOOTRESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1087	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1088	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY DETACHABLE ELEVATING LEG RESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1089	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, FIXED LENGTH ARMS, SWING AWAY DETACHABLE FOOTREST	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1090	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY DETACHABLE FOOT RESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1092	WIDE HEAVY DUTY WHEEL CHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH), SWING AWAY DETACHABLE ELEVATING LEG RESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1093	WIDE HEAVY DUTY WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOTRESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1100	SEMI-RECLINING WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1110	SEMI-RECLINING WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) ELEVATING LEG REST	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1130	STANDARD WHEELCHAIR, FIXED FULL LENGTH ARMS, FIXED OR SWING AWAY DETACHABLE FOOTRESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1140	WHEELCHAIR, DETACHABLE ARMS, DESK OR FULL LENGTH, SWING AWAY DETACHABLE FOOTRESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1150	WHEELCHAIR, DETACHABLE ARMS, DESK OR FULL LENGTH SWING AWAY DETACHABLE ELEVATING LEGRESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1160	WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
E1161	MANUAL ADULT SIZE WHEELCHAIR, INCLUDES TILT IN SPACE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1170	AMPUTEE WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1171	AMPUTEE WHEELCHAIR, FIXED FULL LENGTH ARMS, WITHOUT FOOTRESTS OR LEGREST	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1172	AMPUTEE WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) WITHOUT FOOTRESTS OR LEGREST	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1180	AMPUTEE WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE FOOTRESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1190	AMPUTEE WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE ELEVATING LEGRESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1195	HEAVY DUTY WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1200	AMPUTEE WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOTREST	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1220	WHEELCHAIR; SPECIALLY SIZED OR CONSTRUCTED, (INDICATE BRAND NAME, MODEL NUMBER, IF ANY) AND JUSTIFICATION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1221	WHEELCHAIR WITH FIXED ARM, FOOTRESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1222	WHEELCHAIR WITH FIXED ARM, ELEVATING LEGRESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1223	WHEELCHAIR WITH DETACHABLE ARMS, FOOTRESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1224	WHEELCHAIR WITH DETACHABLE ARMS, ELEVATING LEGRESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1225	WHEELCHAIR ACCESSORY, MANUAL SEMI-RECLINING BACK, (RECLINE GREATER THAN 15 DEGREES, BUT LESS THAN 80 DEGREES), EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1226	WHEELCHAIR ACCESSORY, MANUAL FULLY RECLINING BACK, (RECLINE GREATER THAN 80 DEGREES), EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1227	SPECIAL HEIGHT ARMS FOR WHEELCHAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1228	SPECIAL BACK HEIGHT FOR WHEELCHAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1229	WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1230	POWER OPERATED VEHICLE (THREE OR FOUR WHEEL NONHIGHWAY) SPECIFY BRAND NAME AND MODEL NUMBER	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1231	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, RIGID, ADJUSTABLE, WITH SEATING SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
E1232	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, FOLDING, ADJUSTABLE, WITH SEATING SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1233	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, RIGID, ADJUSTABLE, WITHOUT SEATING SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1234	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, FOLDING, ADJUSTABLE, WITHOUT SEATING SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1235	WHEELCHAIR, PEDIATRIC SIZE, RIGID, ADJUSTABLE, WITH SEATING SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1236	WHEELCHAIR, PEDIATRIC SIZE, FOLDING, ADJUSTABLE, WITH SEATING SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1237	WHEELCHAIR, PEDIATRIC SIZE, RIGID, ADJUSTABLE, WITHOUT SEATING SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1238	WHEELCHAIR, PEDIATRIC SIZE, FOLDING, ADJUSTABLE, WITHOUT SEATING SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1239	POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1240	LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS, (DESK OR FULL LENGTH) SWING AWAY DETACHABLE, ELEVATING LEGREST	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1250	LIGHTWEIGHT WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOTREST	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1260	LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE FOOTREST	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1270	LIGHTWEIGHT WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1280	HEAVY DUTY WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) ELEVATING LEGRESTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1285	HEAVY DUTY WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOTREST	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1290	HEAVY DUTY WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE FOOTREST	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1295	HEAVY DUTY WHEELCHAIR, FIXED FULL LENGTH ARMS, ELEVATING LEGREST	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1296	SPECIAL WHEELCHAIR SEAT HEIGHT FROM FLOOR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1297	SPECIAL WHEELCHAIR SEAT DEPTH, BY UPHOLSTERY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1298	SPECIAL WHEELCHAIR SEAT DEPTH AND/OR WIDTH, BY CONSTRUCTION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1301	WHIRLPOOL TUB, WALK-IN, PORTABLE	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
E1352	OXYGEN ACCESSORY, FLOW REGULATOR CAPABLE OF POSITIVE INSPIRATORY PRESSURE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1353	REGULATOR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1354	OXYGEN ACCESSORY, WHEELED CART FOR PORTABLE CYLINDER OR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1355	STAND/RACK	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1356	OXYGEN ACCESSORY, BATTERY PACK/CARTRIDGE FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1357	OXYGEN ACCESSORY, BATTERY CHARGER FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1358	OXYGEN ACCESSORY, DC POWER ADAPTER FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1372	IMMERSION EXTERNAL HEATER FOR NEBULIZER	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1390	OXYGEN CONCENTRATOR, SINGLE DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1391	OXYGEN CONCENTRATOR, DUAL DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1392	PORTABLE OXYGEN CONCENTRATOR, RENTAL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1399	DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1405	OXYGEN AND WATER VAPOR ENRICHING SYSTEM WITH HEATED DELIVERY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1406	OXYGEN AND WATER VAPOR ENRICHING SYSTEM WITHOUT HEATED DELIVERY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1570	ADJUSTABLE CHAIR, FOR ESRD PATIENTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1575	TRANSDUCER PROTECTORS/FLUID BARRIERS, FOR HEMODIALYSIS, ANY SIZE, PER 10	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1580	UNIPUNCTURE CONTROL SYSTEM FOR HEMODIALYSIS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1590	HEMODIALYSIS MACHINE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1594	CYCLER DIALYSIS MACHINE FOR PERITONEAL DIALYSIS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1610	REVERSE OSMOSIS WATER PURIFICATION SYSTEM, FOR HEMODIALYSIS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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E1615	DEIONIZER WATER PURIFICATION SYSTEM, FOR HEMODIALYSIS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1629	TABLO HEMODIALYSIS SYSTEM FOR THE BILLABLE DIALYSIS SERVICE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1630	RECIPROCATING PERITONEAL DIALYSIS SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1632	WEARABLE ARTIFICIAL KIDNEY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1635	COMPACT (PORTABLE) TRAVEL HEMODIALYZER SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1636	SORBENT CARTRIDGES, FOR HEMODIALYSIS, PER 10	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1699	DIALYSIS EQUIPMENT, NOT OTHERWISE SPECIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1700	JAW MOTION REHABILITATION SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1701	REPLACEMENT CUSHIONS FOR JAW MOTION REHABILITATION SYSTEM, PKG. OF 6	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1702	REPLACEMENT MEASURING SCALES FOR JAW MOTION REHABILITATION SYSTEM, PKG. OF 200	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1800	DYNAMIC ADJUSTABLE ELBOW EXTENSION AND FLEXION DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1801	STATIC PROGRESSIVE STRETCH ELBOW DEVICE, EXTENSION AND/OR FLEXION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E1802	DYNAMIC ADJUSTABLE FOREARM PRONATION/SUPINATION DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1803	DYNAMIC ADJUSTABLE ELBOW EXTENSION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
E1804	DYNAMIC ADJUSTABLE ELBOW FLEXION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
E1805	DYNAMIC ADJUSTABLE WRIST EXTENSION AND FLEXION DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1806	STATIC PROGRESSIVE STRETCH WRIST DEVICE, FLEXION AND/OR EXTENSION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E1807	DYNAMIC ADJUSTABLE WRIST EXTENSION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
E1808	DYNAMIC ADJUSTABLE WRIST FLEXION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
E1810	DYNAMIC ADJUSTABLE KNEE EXTENSION AND FLEXION DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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E1811	STATIC PROGRESSIVE STRETCH KNEE DEVICE, EXTENSION AND/OR FLEXION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E1812	DYNAMIC KNEE, EXTENSION/FLEXION DEVICE WITH ACTIVE RESISTANCE CONTROL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1813	DYNAMIC ADJUSTABLE KNEE EXTENSION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
E1814	DYNAMIC ADJUSTABLE KNEE FLEXION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
E1815	DYNAMIC ADJUSTABLE ANKLE EXTENSION AND FLEXION DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1816	STATIC PROGRESSIVE STRETCH ANKLE DEVICE, FLEXION AND/OR EXTENSION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E1816	STATIC PROGRESSIVE STRETCH ANKLE DEVICE, FLEXION AND/OR EXTENSION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E1818	STATIC PROGRESSIVE STRETCH FOREARM PRONATION / SUPINATION DEVICE, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E1818	STATIC PROGRESSIVE STRETCH FOREARM PRONATION / SUPINATION DEVICE, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E1820	REPLACEMENT SOFT INTERFACE MATERIAL, DYNAMIC ADJUSTABLE EXTENSION/FLEXION DEVICE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1821	REPLACEMENT SOFT INTERFACE MATERIAL/CUFFS FOR BI-DIRECTIONAL STATIC PROGRESSIVE STRETCH DEVICE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1822	DYNAMIC ADJUSTABLE ANKLE EXTENSION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
E1823	DYNAMIC ADJUSTABLE ANKLE FLEXION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
E1825	DYNAMIC ADJUSTABLE FINGER EXTENSION AND FLEXION DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1826	DYNAMIC ADJUSTABLE FINGER EXTENSION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
E1827	DYNAMIC ADJUSTABLE FINGER FLEXION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
E1828	DYNAMIC ADJUSTABLE TOE EXTENSION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
E1829	DYNAMIC ADJUSTABLE TOE FLEXION ONLY DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
E1830	DYNAMIC ADJUSTABLE TOE EXTENSION AND FLEXION DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1831	STATIC PROGRESSIVE STRETCH TOE DEVICE, EXTENSION AND/OR FLEXION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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E1831	STATIC PROGRESSIVE STRETCH TOE DEVICE, EXTENSION AND/OR FLEXION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E1832	STATIC PROGRESSIVE STRETCH FINGER DEVICE, EXTENSION AND/OR FLEXION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	
E1840	DYNAMIC ADJUSTABLE SHOULDER FLEXION / ABDUCTION / ROTATION DEVICE, INCLUDES SOFT INTERFACE MATERIAL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1841	STATIC PROGRESSIVE STRETCH SHOULDER DEVICE, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E1841	STATIC PROGRESSIVE STRETCH SHOULDER DEVICE, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E1902	COMMUNICATION BOARD, NON-ELECTRONIC AUGMENTATIVE OR ALTERNATIVE COMMUNICATION DEVICE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E1905	VIRTUAL REALITY COGNITIVE BEHAVIORAL THERAPY DEVICE (CBT), INCLUDING PRE-PROGRAMMED THERAPY SOFTWARE		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
E2000	GASTRIC SUCTION PUMP, HOME MODEL, PORTABLE OR STATIONARY, ELECTRIC	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2001	SUCTION PUMP, HOME MODEL, PORTABLE OR STATIONARY, ELECTRIC, ANY TYPE, FOR USE WITH EXTERNAL URINE AND/OR FECAL MANAGEMENT SYSTEM	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
E2100	BLOOD GLUCOSE MONITOR WITH INTEGRATED VOICE SYNTHESIZER	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2101	BLOOD GLUCOSE MONITOR WITH INTEGRATED LANCING/BLOOD SAMPLE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2103	NON-ADJUNCTIVE, NON-IMPLANTED CONTINUOUS GLUCOSE MONITOR OR RECEIVER	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
E2120	PULSE GENERATOR SYSTEM FOR TYMPANIC TREATMENT OF INNER EAR ENDOLYMPHATIC FLUID	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2201	MANUAL WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME, WIDTH GREATER THAN OR EQUAL TO 20 INCHES AND LESS THAN 24 INCHES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2202	MANUAL WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME WIDTH, 24-27 INCHES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2203	MANUAL WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME DEPTH, 20 TO LESS THAN 22 INCHES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2204	MANUAL WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME DEPTH, 22 TO 25 INCHES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2205	MANUAL WHEELCHAIR ACCESSORY, HANDRIM WITHOUT PROJECTIONS (INCLUDES ERGONOMIC OR CONTOURED), ANY TYPE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2206	MANUAL WHEELCHAIR ACCESSORY, WHEEL LOCK ASSEMBLY, COMPLETE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2207	WHEELCHAIR ACCESSORY, CRUTCH AND CANE HOLDER, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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E2208	WHEELCHAIR ACCESSORY, CYLINDER TANK CARRIER, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2209	ACCESSORY, ARM TROUGH, WITH OR WITHOUT HAND SUPPORT, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2210	WHEELCHAIR ACCESSORY, BEARINGS, ANY TYPE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2211	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2212	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2213	MANUAL WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC PROPULSION TIRE (REMOVABLE), ANY TYPE, ANY SIZE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2214	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2215	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2216	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED PROPULSION TIRE, ANY SIZE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2217	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2218	MANUAL WHEELCHAIR ACCESSORY, FOAM PROPULSION TIRE, ANY SIZE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2219	MANUAL WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2220	MANUAL WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) PROPULSION TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2221	MANUAL WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE (REMOVABLE), ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2222	MANUAL WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATED WHEEL, ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2224	MANUAL WHEELCHAIR ACCESSORY, PROPULSION WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2225	MANUAL WHEELCHAIR ACCESSORY, CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2226	MANUAL WHEELCHAIR ACCESSORY, CASTER FORK, ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2227	MANUAL WHEELCHAIR ACCESSORY, GEAR REDUCTION DRIVE WHEEL, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2228	MANUAL WHEELCHAIR ACCESSORY, WHEEL BRAKING SYSTEM AND LOCK, COMPLETE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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E2230	MANUAL WHEELCHAIR ACCESSORY, MANUAL STANDING SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2231	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT), INCLUDES ANY TYPE MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2291	BACK, PLANAR, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2292	SEAT, PLANAR, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2293	BACK, CONTOURED, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2294	SEAT, CONTOURED, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2295	MANUAL WHEELCHAIR ACCESSORY, FOR PEDIATRIC SIZE WHEELCHAIR, DYNAMIC SEATING FRAME, ALLOWS COORDINATED MOVEMENT OF MULTIPLE POSITIONING FEATURES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2298	COMPLEX REHABILITATIVE POWER WHEELCHAIR ACCESSORY, POWER SEAT ELEVATION SYSTEM, ANY TYPE	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
E2301	WHEELCHAIR ACCESSORY, POWER STANDING SYSTEM, ANY TYPE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2311	POWER WHEELCHAIR ACCESSORY, ELECTRONIC CONNECTION BETWEEN WHEELCHAIR CONTROLLER AND TWO OR MORE POWER SEATING SYSTEM MOTORS, INCLUDING ALL RELATED ELECTRONICS, INDICATOR FEATURE, MECHANICAL FUNCTION SELECTION SWITCH, AND FIXED MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2312	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, MINI-PROPORTIONAL REMOTE JOYSTICK, PROPORTIONAL, INCLUDING FIXED MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2313	POWER WHEELCHAIR ACCESSORY, HARNESS FOR UPGRADE TO EXPANDABLE CONTROLLER, INCLUDING ALL FASTENERS, CONNECTORS AND MOUNTING HARDWARE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2321	POWER WHEELCHAIR ACCESSORY, HAND CONTROL INTERFACE, REMOTE JOYSTICK, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, AND FIXED MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2322	POWER WHEELCHAIR ACCESSORY, HAND CONTROL INTERFACE, MULTIPLE MECHANICAL SWITCHES, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, AND FIXED MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2323	POWER WHEELCHAIR ACCESSORY, SPECIALTY JOYSTICK HANDLE FOR HAND CONTROL INTERFACE, PREFABRICATED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2324	POWER WHEELCHAIR ACCESSORY, CHIN CUP FOR CHIN CONTROL INTERFACE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2325	POWER WHEELCHAIR ACCESSORY, SIP AND PUFF INTERFACE, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, AND MANUAL SWINGAWAY MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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E2326	POWER WHEELCHAIR ACCESSORY, BREATH TUBE KIT FOR SIP AND PUFF INTERFACE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2327	POWER WHEELCHAIR ACCESSORY, HEAD CONTROL INTERFACE, MECHANICAL, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL DIRECTION CHANGE SWITCH, AND FIXED MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2328	POWER WHEELCHAIR ACCESSORY, HEAD CONTROL OR EXTREMITY CONTROL INTERFACE, ELECTRONIC, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2329	POWER WHEELCHAIR ACCESSORY, HEAD CONTROL INTERFACE, CONTACT SWITCH MECHANISM, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, MECHANICAL DIRECTION CHANGE SWITCH, HEAD ARRAY, AND FIXED MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2330	POWER WHEELCHAIR ACCESSORY, HEAD CONTROL INTERFACE, PROXIMITY SWITCH MECHANISM, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, MECHANICAL DIRECTION CHANGE SWITCH, HEAD ARRAY, AND FIXED MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2331	POWER WHEELCHAIR ACCESSORY, ATTENDANT CONTROL, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2340	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME WIDTH, 20-23 INCHES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2341	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME WIDTH, 24-27 INCHES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2342	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME DEPTH, 20 OR 21 INCHES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2343	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME DEPTH, 22-25 INCHES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2351	POWER WHEELCHAIR ACCESSORY, ELECTRONIC INTERFACE TO OPERATE SPEECH GENERATING DEVICE USING POWER WHEELCHAIR CONTROL INTERFACE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2358	POWER WHEELCHAIR ACCESSORY, GROUP 34 NON-SEALED LEAD ACID BATTERY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2359	POWER WHEELCHAIR ACCESSORY, GROUP 34 SEALED LEAD ACID BATTERY, EACH (E.G., GEL CELL, ABSORBED GLASSMAT)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2360	POWER WHEELCHAIR ACCESSORY, 22NF NON-SEALED LEAD ACID BATTERY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2361	POWER WHEELCHAIR ACCESSORY, 22NF SEALED LEAD ACID BATTERY, EACH, (E.G., GEL CELL, ABSORBED GLASSMAT)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2362	POWER WHEELCHAIR ACCESSORY, GROUP 24 NON-SEALED LEAD ACID BATTERY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2363	POWER WHEELCHAIR ACCESSORY, GROUP 24 SEALED LEAD ACID BATTERY, EACH (E.G., GEL CELL, ABSORBED GLASSMAT)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2364	POWER WHEELCHAIR ACCESSORY, U-1 NON-SEALED LEAD ACID BATTERY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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E2365	POWER WHEELCHAIR ACCESSORY, U-1 SEALED LEAD ACID BATTERY, EACH (E.G., GEL CELL, ABSORBED GLASSMAT)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2366	POWER WHEELCHAIR ACCESSORY, BATTERY CHARGER, SINGLE MODE, FOR USE WITH ONLY ONE BATTERY TYPE, SEALED OR NON-SEALED, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2367	POWER WHEELCHAIR ACCESSORY, BATTERY CHARGER, DUAL MODE, FOR USE WITH EITHER BATTERY TYPE, SEALED OR NON-SEALED, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2368	POWER WHEELCHAIR COMPONENT, DRIVE WHEEL MOTOR, REPLACEMENT ONLY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2369	POWER WHEELCHAIR COMPONENT, DRIVE WHEEL GEAR BOX, REPLACEMENT ONLY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2370	POWER WHEELCHAIR COMPONENT, INTEGRATED DRIVE WHEEL MOTOR AND GEAR BOX COMBINATION, REPLACEMENT ONLY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2371	POWER WHEELCHAIR ACCESSORY, GROUP 27 SEALED LEAD ACID BATTERY, (E.G., GEL CELL, ABSORBED GLASSMAT), EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2372	POWER WHEELCHAIR ACCESSORY, GROUP 27 NON-SEALED LEAD ACID BATTERY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2373	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, COMPACT REMOTE JOYSTICK, PROPORTIONAL, INCLUDING FIXED MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2374	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, STANDARD REMOTE JOYSTICK (NOT INCLUDING CONTROLLER), PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE, REPLACEMENT ONLY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2375	POWER WHEELCHAIR ACCESSORY, NON-EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2376	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2377	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, UPGRADE PROVIDED AT INITIAL ISSUE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2378	POWER WHEELCHAIR COMPONENT, ACTUATOR, REPLACEMENT ONLY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2381	POWER WHEELCHAIR ACCESSORY, PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2382	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2383	POWER WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC DRIVE WHEEL TIRE (REMOVABLE), ANY TYPE, ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2384	POWER WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2385	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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E2386	POWER WHEELCHAIR ACCESSORY, FOAM FILLED DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2387	POWER WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2388	POWER WHEELCHAIR ACCESSORY, FOAM DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2389	POWER WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2390	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2391	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE (REMOVABLE), ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2392	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATED WHEEL, ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2394	POWER WHEELCHAIR ACCESSORY, DRIVE WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2395	POWER WHEELCHAIR ACCESSORY, CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2396	POWER WHEELCHAIR ACCESSORY, CASTER FORK, ANY SIZE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2397	POWER WHEELCHAIR ACCESSORY, LITHIUM-BASED BATTERY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2398	WHEELCHAIR ACCESSORY, DYNAMIC POSITIONING HARDWARE FOR BACK	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2500	SPEECH GENERATING DEVICE, DIGITIZED SPEECH, USING PRE-RECORDED MESSAGES, LESS THAN OR EQUAL TO 8 MINUTES RECORDING TIME	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2502	SPEECH GENERATING DEVICE, DIGITIZED SPEECH, USING PRE-RECORDED MESSAGES, GREATER THAN 8 MINUTES BUT LESS THAN OR EQUAL TO 20 MINUTES RECORDING TIME	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2504	SPEECH GENERATING DEVICE, DIGITIZED SPEECH, USING PRE-RECORDED MESSAGES, GREATER THAN 20 MINUTES BUT LESS THAN OR EQUAL TO 40 MINUTES RECORDING TIME	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2506	SPEECH GENERATING DEVICE, DIGITIZED SPEECH, USING PRE-RECORDED MESSAGES, GREATER THAN 40 MINUTES RECORDING TIME	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2508	SPEECH GENERATING DEVICE, SYNTHESIZED SPEECH, REQUIRING MESSAGE FORMULATION BY SPELLING AND ACCESS BY PHYSICAL CONTACT WITH THE DEVICE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2510	SPEECH GENERATING DEVICE, SYNTHESIZED SPEECH, PERMITTING MULTIPLE METHODS OF MESSAGE FORMULATION AND MULTIPLE METHODS OF DEVICE ACCESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2511	SPEECH GENERATING SOFTWARE PROGRAM, FOR PERSONAL COMPUTER OR PERSONAL DIGITAL ASSISTANT	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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E2512	ACCESSORY FOR SPEECH GENERATING DEVICE, MOUNTING SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2599	ACCESSORY FOR SPEECH GENERATING DEVICE, NOT OTHERWISE CLASSIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2601	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2602	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2603	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2604	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2605	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2606	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2607	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2608	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2609	CUSTOM FABRICATED WHEELCHAIR SEAT CUSHION, ANY SIZE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2610	WHEELCHAIR SEAT CUSHION, POWERED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2611	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2612	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2613	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2614	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2615	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2616	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2617	CUSTOM FABRICATED WHEELCHAIR BACK CUSHION, ANY SIZE, INCLUDING ANY TYPE MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2619	REPLACEMENT COVER FOR WHEELCHAIR SEAT CUSHION OR BACK CUSHION, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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E2620	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2621	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2622	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2623	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2624	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2625	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2626	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2627	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE RANCHO TYPE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2628	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, RECLINING	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2629	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, FRICTION ARM SUPPORT (FRICTION DAMPENING TO PROXIMAL AND DISTAL JOINTS)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2630	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT, MONOSUSPENSION ARM AND HAND SUPPORT, OVERHEAD ELBOW FOREARM HAND SLING SUPPORT, YOKE TYPE SUSPENSION SUPPORT	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2631	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, ELEVATING PROXIMAL ARM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2632	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE CONTROL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E2633	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, SUPINATOR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E3000	SPEECH VOLUME MODULATION SYSTEM, ANY TYPE, INCLUDING ALL COMPONENTS AND ACCESSORIES	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
E3200	GAIT MODULATION SYSTEM, RHYTHMIC AUDITORY STIMULATION, INCLUDING RESTRICTED THERAPY SOFTWARE, ALL COMPONENTS AND ACCESSORIES, PRESCRIPTION ONLY	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
E8000	GAIT TRAINER, PEDIATRIC SIZE, POSTERIOR SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E8001	GAIT TRAINER, PEDIATRIC SIZE, UPRIGHT SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
E8002	GAIT TRAINER, PEDIATRIC SIZE, ANTERIOR SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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G0138	INTRAVENOUS INFUSION OF CIPAGLUCOSIDASE ALFA-ATGA, INCLUDING PROVIDER/SUPPLIER ACQUISITION AND CLINICAL SUPERVISION OF ORAL ADMINISTRATION OF MIGLUSTAT IN PREPARATION OF RECEIPT OF CIPAGLUCOSIDASE ALFA-ATGA	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
G0151	SERVICES PERFORMED BY A QUALIFIED PHYSICAL THERAPIST IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0152	SERVICES PERFORMED BY A QUALIFIED OCCUPATIONAL THERAPIST IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0153	SERVICES PERFORMED BY A QUALIFIED SPEECH-LANGUAGE PATHOLOGIST IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0155	SERVICES OF CLINICAL SOCIAL WORKER IN HOME HEALTH OR HOSPICE SETTINGS, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0156	SERVICES OF HOME HEALTH/HOSPICE AIDE IN HOME HEALTH OR HOSPICE SETTINGS, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0157	SERVICES PERFORMED BY A QUALIFIED PHYSICAL THERAPIST ASSISTANT IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0158	SERVICES PERFORMED BY A QUALIFIED OCCUPATIONAL THERAPIST ASSISTANT IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0159	SERVICES PERFORMED BY A QUALIFIED PHYSICAL THERAPIST, IN THE HOME HEALTH SETTING, IN THE ESTABLISHMENT OR DELIVERY OF A SAFE AND EFFECTIVE PHYSICAL THERAPY MAINTENANCE PROGRAM, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0160	SERVICES PERFORMED BY A QUALIFIED OCCUPATIONAL THERAPIST, IN THE HOME HEALTH SETTING, IN THE ESTABLISHMENT OR DELIVERY OF A SAFE AND EFFECTIVE OCCUPATIONAL THERAPY MAINTENANCE PROGRAM, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0161	SERVICES PERFORMED BY A QUALIFIED SPEECH-LANGUAGE PATHOLOGIST, IN THE HOME HEALTH SETTING, IN THE ESTABLISHMENT OR DELIVERY OF A SAFE AND EFFECTIVE SPEECH-LANGUAGE PATHOLOGY MAINTENANCE PROGRAM, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0166	EXTERNAL COUNTERPULSATION, PER TREATMENT SESSION		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
G0181	PHYSICIAN OR ALLOWED PRACTITIONER SUPERVISION OF A PATIENT RECEIVING MEDICARE-COVERED SERVICES PROVIDED BY A PARTICIPATING HOME HEALTH AGENCY (PATIENT NOT PRESENT) REQUIRING COMPLEX AND MULTIDISCIPLINARY CARE MODALITIES INVOLVING REGULAR PHYSICIAN OR ALLO		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0182	PHYSICIAN SUPERVISION OF A PATIENT UNDER A MEDICARE-APPROVED HOSPICE (PATIENT NOT PRESENT) REQUIRING COMPLEX AND MULTIDISCIPLINARY CARE MODALITIES INVOLVING REGULAR PHYSICIAN DEVELOPMENT AND/OR REVISION OF CARE PLANS, REVIEW OF SUBSEQUENT REPORTS OF PATIE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0219	PET IMAGING WHOLE BODY; MELANOMA FOR NON-COVERED INDICATIONS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0235	PET IMAGING, ANY SITE, NOT OTHERWISE SPECIFIED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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G0255	CURRENT PERCEPTION THRESHOLD/SENSORY NERVE CONDUCTION TEST, (SNCT) PER LIMB, ANY NERVE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
G0259	INJECTION PROCEDURE FOR SACROILIAC JOINT; ARTHROGRAPHY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0260	INJECTION PROCEDURE FOR SACROILIAC JOINT; PROVISION OF ANESTHETIC, STEROID AND/OR OTHER THERAPEUTIC AGENT, WITH OR WITHOUT ARTHROGRAPHY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0276	BLINDED PROCEDURE FOR LUMBAR STENOSIS, PERCUTANEOUS IMAGE-GUIDED LUMBAR DECOMPRESSION (PILD) OR PLACEBO-CONTROL, PERFORMED IN AN APPROVED COVERAGE WITH EVIDENCE DEVELOPMENT (CED) CLINICAL TRIAL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
G0281	ELECTRICAL STIMULATION, (UNATTENDED), TO ONE OR MORE AREAS, FOR CHRONIC STAGE III AND STAGE IV PRESSURE ULCERS, ARTERIAL ULCERS, DIABETIC ULCERS, AND VENOUS STASIS ULCERS NOT DEMONSTRATING MEASURABLE SIGNS OF HEALING AFTER 30 DAYS OF CONVENTIONAL CARE, AS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
G0282	ELECTRICAL STIMULATION, (UNATTENDED), TO ONE OR MORE AREAS, FOR WOUND CARE OTHER THAN DESCRIBED IN G0281		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
G0283	ELECTRICAL STIMULATION (UNATTENDED), TO ONE OR MORE AREAS FOR INDICATION(S) OTHER THAN WOUND CARE, AS PART OF A THERAPY PLAN OF CARE	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/7/2020	InterQual® Evidence-Based Criteria & Guidelines	
G0295	ELECTROMAGNETIC THERAPY, TO ONE OR MORE AREAS, FOR WOUND CARE OTHER THAN DESCRIBED IN G0329 OR FOR OTHER USES		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
G0299	DIRECT SKILLED NURSING SERVICES OF A REGISTERED NURSE (RN) IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0299	DIRECT SKILLED NURSING SERVICES OF A REGISTERED NURSE (RN) IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0300	DIRECT SKILLED NURSING SERVICES OF A LICENSED PRACTICAL NURSE (LPN) IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0300	DIRECT SKILLED NURSING SERVICES OF A LICENSED PRACTICAL NURSE (LPN) IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0329	ELECTROMAGNETIC THERAPY, TO ONE OR MORE AREAS FOR CHRONIC STAGE III AND STAGE IV PRESSURE ULCERS, ARTERIAL ULCERS, DIABETIC ULCERS AND VENOUS STASIS ULCERS NOT DEMONSTRATING MEASURABLE SIGNS OF HEALING AFTER 30 DAYS OF CONVENTIONAL CARE AS PART OF A THERA		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
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		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
G0337	HOSPICE EVALUATION AND COUNSELING SERVICES, PRE-ELECTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0341	PERCUTANEOUS ISLET CELL TRANSPLANT, INCLUDES PORTAL VEIN CATHETERIZATION AND INFUSION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0342	LAPAROSCOPY FOR ISLET CELL TRANSPLANT, INCLUDES PORTAL VEIN CATHETERIZATION AND INFUSION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0343	LAPAROTOMY FOR ISLET CELL TRANSPLANT, INCLUDES PORTAL VEIN CATHETERIZATION AND INFUSION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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G0428	COLLAGEN MENISCUS IMPLANT PROCEDURE FOR FILLING MENISCAL DEFECTS (E.G., CMI, COLLAGEN SCAFFOLD, MENAFLEX)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
G0460	AUTOLOGOUS PLATELET RICH PLASMA OR OTHER BLOOD-DERIVED PRODUCT FOR NON-DIABETIC CHRONIC WOUNDS/ULCERS, INCLUDING AS APPLICABLE PHLEBOTOMY, CENTRIFUGATION OR MIXING, AND ALL OTHER PREPARATORY PROCEDURES, ADMINISTRATION AND DRESSINGS, PER TREATMENT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
G0465	AUTOLOGOUS PLATELET RICH PLASMA (PRP) OR OTHER BLOOD-DERIVED PRODUCT FOR DIABETIC CHRONIC WOUNDS/ULCERS, USING AN FDA-CLEARED DEVICE FOR THIS INDICATION, (INCLUDES AS APPLICABLE ADMINISTRATION, DRESSINGS, PHLEBOTOMY, CENTRIFUGATION OR MIXING, AND ALL OTHE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
G0493	SKILLED SERVICES OF A REGISTERED NURSE (RN) FOR THE OBSERVATION AND ASSESSMENT OF THE PATIENT'S CONDITION, EACH 15 MINUTES (THE CHANGE IN THE PATIENT'S CONDITION REQUIRES SKILLED NURSING PERSONNEL TO IDENTIFY AND EVALUATE THE PATIENT'S NEED FOR POSSIBLE M		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G0533	MEDICATION ASSISTED TREATMENT, BUPRENORPHINE (INJECTABLE) ADMINISTERED ON A WEEKLY BASIS; WEEKLY BUNDLE INCLUDING DISPENSING AND/OR ADMINISTRATION, SUBSTANCE USE COUNSELING, INDIVIDUAL AND GROUP THERAPY, AND TOXICOLOGY TESTING IF PERFORMED (PROVISION OF T	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
G0555	PROVISION OF REPLACEMENT PATIENT ELECTRONICS SYSTEM (E.G., SYSTEM PILLOW, HANDHELD READER) FOR HOME PULMONARY ARTERY PRESSURE MONITORING	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
G0562	THERAPEUTIC RADIOLOGY SIMULATION-AIDED FIELD SETTING; COMPLEX, INCLUDING ACQUISITION OF PET AND CT IMAGING DATA REQUIRED FOR RADIOPHARMACEUTICAL-DIRECTED RADIATION THERAPY TREATMENT PLANNING (I.E., MODELING)		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	
G0563	STEREOTACTIC BODY RADIATION THERAPY, TREATMENT DELIVERY, PER FRACTION TO 1 OR MORE LESIONS, INCLUDING IMAGE GUIDANCE AND REAL-TIME POSITRON EMISSIONS-BASED DELIVERY ADJUSTMENTS TO 1 OR MORE LESIONS, ENTIRE COURSE NOT TO EXCEED 5 FRACTIONS		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	
G9012	OTHER SPECIFIED CASE MANAGEMENT SERVICE NOT ELSEWHERE CLASSIFIED		4/15/2020	InterQual® Evidence-Based Criteria & Guidelines	
G9143	WARFARIN RESPONSIVENESS TESTING BY GENETIC TECHNIQUE USING ANY METHOD, ANY NUMBER OF SPECIMEN(S)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
G9147	OUTPATIENT INTRAVENOUS INSULIN TREATMENT (OIVIT) EITHER PULSATILE OR CONTINUOUS, BY ANY MEANS, GUIDED BY THE RESULTS OF MEASUREMENTS FOR: RESPIRATORY QUOTIENT; AND/OR, URINE UREA NITROGEN (UUN); AND/OR, ARTERIAL, VENOUS OR CAPILLARY GLUCOSE; AND/OR POTASS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
G9473	SERVICES PERFORMED BY CHAPLAIN IN THE HOSPICE SETTING, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G9474	SERVICES PERFORMED BY DIETARY COUNSELOR IN THE HOSPICE SETTING, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G9475	SERVICES PERFORMED BY OTHER COUNSELOR IN THE HOSPICE SETTING, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G9476	SERVICES PERFORMED BY VOLUNTEER IN THE HOSPICE SETTING, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G9477	SERVICES PERFORMED BY CARE COORDINATOR IN THE HOSPICE SETTING, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G9478	SERVICES PERFORMED BY OTHER QUALIFIED THERAPIST IN THE HOSPICE SETTING, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G9479	SERVICES PERFORMED BY QUALIFIED PHARMACIST IN THE HOSPICE SETTING, EACH 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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G9524	PATIENT WAS REFERRED TO HOSPICE CARE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G9525	DOCUMENTATION OF PATIENT REASON(S) FOR NOT REFERRING TO HOSPICE CARE (E.G., PATIENT DECLINED, OTHER PATIENT REASONS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
G9526	PATIENT WAS NOT REFERRED TO HOSPICE CARE, REASON NOT GIVEN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
H0010	ALCOHOL AND/OR DRUG SERVICES; SUB-ACUTE DETOXIFICATION (RESIDENTIAL ADDICTION PROGRAM INPATIENT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
H0011	ALCOHOL AND/OR DRUG SERVICES; ACUTE DETOXIFICATION (RESIDENTIAL ADDICTION PROGRAM INPATIENT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
H0012	ALCOHOL AND/OR DRUG SERVICES; SUB-ACUTE DETOXIFICATION (RESIDENTIAL ADDICTION PROGRAM OUTPATIENT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
H0015	ALCOHOL AND/OR DRUG SERVICES; INTENSIVE OUTPATIENT (TREATMENT PROGRAM THAT OPERATES AT LEAST 3 HOURS/DAY AND AT LEAST 3 DAYS/WEEK AND IS BASED ON AN INDIVIDUALIZED TREATMENT PLAN), INCLUDING ASSESSMENT, COUNSELING; CRISIS INTERVENTION, AND ACTIVITY THERAP		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
H0017	BEHAVIORAL HEALTH; RESIDENTIAL (HOSPITAL RESIDENTIAL TREATMENT PROGRAM), WITHOUT ROOM AND BOARD, PER DIEM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
H0018	BEHAVIORAL HEALTH; SHORT-TERM RESIDENTIAL (NON-HOSPITAL RESIDENTIAL TREATMENT PROGRAM), WITHOUT ROOM AND BOARD, PER DIEM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
H0031	MENTAL HEALTH ASSESSMENT, BY NON-PHYSICIAN		4/15/2020	InterQual® Evidence-Based Criteria & Guidelines	
H0031	MENTAL HEALTH ASSESSMENT, BY NON-PHYSICIAN		4/15/2020	InterQual® Evidence-Based Criteria & Guidelines	
H0032	MENTAL HEALTH SERVICE PLAN DEVELOPMENT BY NON-PHYSICIAN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
H0035	MENTAL HEALTH PARTIAL HOSPITALIZATION, TREATMENT, LESS THAN 24 HOURS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
H0047	ALCOHOL AND/OR OTHER DRUG ABUSE SERVICES, NOT OTHERWISE SPECIFIED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
H2014	SKILLS TRAINING AND DEVELOPMENT, PER 15 MINUTES		4/15/2020	InterQual® Evidence-Based Criteria & Guidelines	
H2019	THERAPEUTIC BEHAVIORAL SERVICES, PER 15 MINUTES		4/15/2020	InterQual® Evidence-Based Criteria & Guidelines	
H2035	ALCOHOL AND/OR OTHER DRUG TREATMENT PROGRAM, PER HOUR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0129	INJECTION, ABATACEPT, 10 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER THE DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN DRUG IS SELF ADMINISTERED)	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	Sendero internal medical policy RX.001 "Biologic and Special ty Treatments for Autoimmune Diseases"	InterQual® Evidence-Based Criteria & Guidelines
J0135	INJECTION, ADALIMUMAB, 20 MG	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	Sendero internal medical policy RX.001 "Biologic and Special ty Treatments for Autoimmune Diseases"	InterQual® Evidence-Based Criteria & Guidelines
J0139	INJECTION, ADALIMUMAB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J0172	INJECTION, ADUCANUMAB-AVWA, 2 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
J0174	INJECTION, LECANEMAB-IRMB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J0175	INJECTION, DONANEMAB-AZBT, 2 MG	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J0177	INJECTION, AFLIBERCEPT HD, 1 MG	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J0178	INJECTION, AFLIBERCEPT, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0179	INJECTION, BROLUCIZUMAB-DBLL, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0180	INJECTION, AGALSIDASE BETA, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0202	INJECTION, ALEMTUZUMAB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	8/15/2018	InterQual® Evidence-Based Criteria & Guidelines	
J0217	INJECTION, VELMANASE ALFA-TYCV, 1 MG	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J0218	INJECTION, OLIPUDASE ALFA-RPCP, 1 MG	Preauthorization required when billed charges exceed $500 per line item	8/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
J0220	INJECTION, ALGLUCOSIDASE ALFA, 10 MG, NOT OTHERWISE SPECIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0221	INJECTION, ALGLUCOSIDASE ALFA, (LUMIZYME), 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0222	INJECTION, PATISIRAN, 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0223	INJECTION, GIVOSIRAN, 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0224	INJECTION, LUMASIRAN, 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0225	INJECTION, VUTRISIRAN, 1 MG	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
J0256	INJECTION, ALPHA 1 PROTEINASE INHIBITOR (HUMAN), NOT OTHERWISE SPECIFIED, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0257	INJECTION, ALPHA 1 PROTEINASE INHIBITOR (HUMAN), (GLASSIA), 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0364	INJECTION, APOMORPHINE HYDROCHLORIDE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0402	INJECTION, ARIPIPRAZOLE (ABILIFY ASIMTUFII), 1 MG	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J0490	INJECTION, BELIMUMAB, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
J0491	INJECTION, ANIFROLUMAB-FNIA, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0517	INJECTION, BENRALIZUMAB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0567	INJECTION, CERLIPONASE ALFA, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0584	INJECTION, BUROSUMAB-TWZA 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0585	INJECTION, ONABOTULINUMTOXINA, 1 UNIT	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0585	INJECTION, ONABOTULINUMTOXINA, 1 UNIT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0586	INJECTION, ABOBOTULINUMTOXINA, 5 UNITS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0586	INJECTION, ABOBOTULINUMTOXINA, 5 UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0587	INJECTION, RIMABOTULINUMTOXINB, 100 UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
j0587	INJECTION, RIMABOTULINUMTOXINB, 100 UNITS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0588	INJECTION, INCOBOTULINUMTOXIN A, 1 UNIT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0589	INJECTION, DAXIBOTULINUMTOXINA-LANM, 1 UNIT		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J0593	INJECTION, LANADELUMAB-FLYO, 1 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN DRUG IS SELF-ADMINISTERED)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0596	INJECTION, C1 ESTERASE INHIBITOR (RECOMBINANT), RUCONEST, 10 UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0597	INJECTION, C-1 ESTERASE INHIBITOR (HUMAN), BERINERT, 10 UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0598	INJECTION, C-1 ESTERASE INHIBITOR (HUMAN), CINRYZE, 10 UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0599	INJECTION, C-1 ESTERASE INHIBITOR (HUMAN), (HAEGARDA), 10 UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0606	INJECTION, ETELCALCETIDE, 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0630	INJECTION, CALCITONIN SALMON, UP TO 400 UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0638	INJECTION, CANAKINUMAB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0641	INJECTION, LEVOLEUCOVORIN, NOT OTHERWISE SPECIFIED, 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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J0642	INJECTION, LEVOLEUCOVORIN (KHAPZORY), 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0666	INJECTION, BUPIVACAINE LIPOSOME, 1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J0717	INJECTION, CERTOLIZUMAB PEGOL, 1 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER THE DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN DRUG IS SELF ADMINISTERED)	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	Sendero internal medical policy RX.001 "Biologic and Special	InterQual® Evidence-Based Criteria & Guidelines
J0725	INJECTION, CHORIONIC GONADOTROPIN, PER 1,000 USP UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0775	INJECTION, COLLAGENASE, CLOSTRIDIUM HISTOLYTICUM, 0.01 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0791	INJECTION, CRIZANLIZUMAB-TMCA, 5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0799	FDA APPROVED PRESCRIPTION DRUG, ONLY FOR USE AS HIV PRE-EXPOSURE PROPHYLAXIS (NOT FOR USE AS TREATMENT OF HIV), NOT OTHERWISE CLASSIFIED	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J0800	INJECTION, CORTICOTROPIN, UP TO 40 UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0870	INJECTION, IMETELSTAT, 1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J0877	INJECTION, DAPTOMYCIN (HOSPIRA), NOT THERAPEUTICALLY EQUIVALENT TO J0878, 1 MG	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
J0881	INJECTION, DARBEPOETIN ALFA, 1 MICROGRAM (NON-ESRD USE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0882	INJECTION, DARBEPOETIN ALFA, 1 MICROGRAM (FOR ESRD ON DIALYSIS)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0885	INJECTION, EPOETIN ALFA, (FOR NON-ESRD USE), 1000 UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0887	INJECTION, EPOETIN BETA, 1 MICROGRAM, (FOR ESRD ON DIALYSIS)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0888	INJECTION, EPOETIN BETA, 1 MICROGRAM, (FOR NON ESRD USE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0890	INJECTION, PEGINESATIDE, 0.1 MG (FOR ESRD ON DIALYSIS)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0891	INJECTION, ARGATROBAN (ACCORD), NOT THERAPEUTICALLY EQUIVALENT TO J0883, 1 MG (FOR NON-ESRD USE)	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
J0892	INJECTION, ARGATROBAN (ACCORD), NOT THERAPEUTICALLY EQUIVALENT TO J0884, 1 MG (FOR ESRD ON DIALYSIS)	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
J0893	INJECTION, DECITABINE (SUN PHARMA), NOT THERAPEUTICALLY EQUIVALENT TO J0894, 1 MG	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
J0896	INJECTION, LUSPATERCEPT-AAMT, 0.25 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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J0897	INJECTION, DENOSUMAB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J0898	INJECTION, ARGATROBAN (AUROMEDICS), NOT THERAPEUTICALLY EQUIVALENT TO J0883, 1 MG (FOR NON-ESRD USE)	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
J0899	INJECTION, ARGATROBAN (AUROMEDICS), NOT THERAPEUTICALLY EQUIVALENT TO J0884, 1 MG (FOR ESRD ON DIALYSIS)	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
J0901	VADADUSTAT, ORAL, 1 MG (FOR ESRD ON DIALYSIS)	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
J1202	MIGLUSTAT, ORAL, 65 MG	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J1203	INJECTION, CIPAGLUCOSIDASE ALFA-ATGA, 5 MG	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J1260	INJECTION, DOLASETRON MESYLATE, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1290	INJECTION, ECALLANTIDE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1299	INJECTION, DENILEUKIN DIFTITOX-CXDL, 1 MCG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J1300	INJECTION, ECULIZUMAB, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1301	INJECTION, EDARAVONE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1303	INJECTION, RAVULIZUMAB-CWVZ, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1304	INJECTION, TOFERSEN, 1 MG	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J1305	INJECTION, EVINACUMAB-DGNB, 5MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1306	INJECTION, INCLISIRAN, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1307	INJECTION, CROVALIMAB-AKKZ, 10 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J1322	INJECTION, ELOSULFASE ALFA, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1323	INJECTION, ELRANATAMAB-BCMM, 1 MG	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	OncoHealth Global Medical Necessity Review criteria	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications
J1325	INJECTION, EPOPROSTENOL, 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1411	INJECTION, ETRANACOGENE DEZAPARVOVEC-DRLB, PER THERAPEUTIC DOSE	Preauthorization required when billed charges exceed $500 per line item	8/15/2023	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
J1412	INJECTION, VALOCTOCOGENE ROXAPARVOVEC-RVOX, PER ML, CONTAINING NOMINAL 2 X 10^13 VECTOR GENOMES	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J1413	INJECTION, DELANDISTROGENE MOXEPARVOVEC-ROKL, PER THERAPEUTIC DOSE	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J1414	INJECTION, FIDANACOGENE ELAPARVOVEC-DZKT, PER THERAPEUTIC DOSE		6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J1426	INJECTION, CASIMERSEN, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1427	INJECTION, VILTOLARSEN, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1428	INJECTION, ETEPLIRSEN, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1429	INJECTION, GOLODIRSEN, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1438	INJECTION, ETANERCEPT, 25 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER THE DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN DRUG IS SELF ADMINISTERED)	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	Sendero internal medical policy RX.001 "Biologic and Special ty Treatments for Autoimmune Diseases"	InterQual® Evidence-Based Criteria & Guidelines
J1439	INJECTION, FERRIC CARBOXYMALTOSE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1442	INJECTION, FILGRASTIM (G-CSF), EXCLUDES BIOSIMILARS, 1 MICROGRAM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1447	INJECTION, TBO-FILGRASTIM, 1 MICROGRAM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1448	INJECTION, TRILACICLIB, 1MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1449	INJECTION, EFLAPEGRASTIM-XNST, 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	8/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
J1456	INJECTION, FOSAPREPITANT (TEVA), NOT THERAPEUTICALLY EQUIVALENT TO J1453, 1 MG	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
J1458	INJECTION, GALSULFASE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1459	INJECTION, IMMUNE GLOBULIN (PRIVIGEN), INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), 500 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1460	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 1 CC	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1551	INJECTION, IMMUNE GLOBULIN (CUTAQUIG), 100 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1552	INJECTION, IMMUNE GLOBULIN (ALYGLO), 500 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J1555	INJECTION, IMMUNE GLOBULIN (CUVITRU), 100 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
J1556	INJECTION, IMMUNE GLOBULIN (BIVIGAM), 500 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1557	INJECTION, IMMUNE GLOBULIN, (GAMMAPLEX), INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), 500 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1558	INJECTION, IMMUNE GLOBULIN (XEMBIFY), 100 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1559	INJECTION, IMMUNE GLOBULIN (HIZENTRA), 100 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1560	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, OVER 10 CC	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1561	INJECTION, IMMUNE GLOBULIN, (GAMUNEX-C/GAMMAKED), NON-LYOPHILIZED (E.G., LIQUID), 500 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1566	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G., POWDER), NOT OTHERWISE SPECIFIED, 500 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1568	INJECTION, IMMUNE GLOBULIN, (OCTAGAM), INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), 500 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1569	INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), NON-LYOPHILIZED, (E.G., LIQUID), 500 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1572	INJECTION, IMMUNE GLOBULIN, (FLEBOGAMMA/FLEBOGAMMA DIF), INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), 500 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1573	INJECTION, HEPATITIS B IMMUNE GLOBULIN (HEPAGAM B), INTRAVENOUS, 0.5 ML	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1574	INJECTION, GANCICLOVIR SODIUM (EXELA), NOT THERAPEUTICALLY EQUIVALENT TO J1570, 500 MG	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
J1575	INJECTION, IMMUNE GLOBULIN/HYALURONIDASE, (HYQVIA), 100 MG IMMUNEGLOBULIN	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1576	INJECTION, IMMUNE GLOBULIN (PANZYGA), INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), 500 MG	Preauthorization required when billed charges exceed $500 per line item	7/1/2023	InterQual® Evidence-Based Criteria & Guidelines	
J1599	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), NOT OTHERWISE SPECIFIED, 500 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1602	INJECTION, GOLIMUMAB, 1 MG, FOR INTRAVENOUS USE	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	Sendero internal medical policy RX.001 "Biologic and Special [illegible]"	InterQual® Evidence-Based Criteria & Guidelines
J1628	INJECTION, GUSELKUMAB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	Sendero internal medical policy RX.001 "Biologic and Special [illegible]"	
J1675	INJECTION, HISTRELIN ACETATE, 10 MICROGRAMS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1740	INJECTION, IBANDRONATE SODIUM, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1743	INJECTION, IDURSULFASE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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J1744	INJECTION, ICATIBANT, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1745	INJECTION, INFLIXIMAB, EXCLUDES BIOSIMILAR, 10 MG	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	Sendero internal medical policy RX.001 "Biologic and Special	InterQual® Evidence-Based Criteria & Guidelines
J1747	INJECTION, SPESOLIMAB-SBZO, 1 MG		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J1748	INJECTION, INFLIXIMAB-DYYB (ZYMFENTRA), 10 MG	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J1749	INJECTION, ILOPROST, 0.1 MCG	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
J1786	INJECTION, IMIGLUCERASE, 10 UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1823	INJECTION, INEBILIZUMAB-CDON, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1826	INJECTION, INTERFERON BETA-1A, 30 MCG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1830	INJECTION, INTERFERON BETA-1B, 0.25 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER THE DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN DRUG IS SELF ADMINISTERED)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1930	INJECTION, LANREOTIDE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1931	INJECTION, LARONIDASE, 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1952	LEUPROLIDE INJECTABLE, CAMCEVI, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J1954	INJECTION, LEUPROLIDE ACETATE FOR DEPOT SUSPENSION (CIPLA), 7.5 MG	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
J2021	INJECTION, LINEZOLID (HOSPIRA), NOT THERAPEUTICALLY EQUIVALENT TO J2020, 200 MG	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
J2182	INJECTION, MEPOLIZUMAB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2267	INJECTION, MIRIKIZUMAB-MRKZ, 1 MG		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J2277	INJECTION, MOTIXAFORTIDE, 0.25 MG	Preauthorization required when billed charges exceed $500 per line item	11/26/2024	OncoHealth Global Medical Necessity Review criteria	InterQual® Evidence-Based Criteria & Guidelines
J2320	INJECTION, NANDROLONE DECANOATE, UP TO 50 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2323	INJECTION, NATALIZUMAB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	Sendero internal medical policy RX.001 "Biologic and Special	InterQual® Evidence-Based Criteria & Guidelines
J2326	INJECTION, NUSINERSEN, 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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J2327	INJECTION, RISANKIZUMAB-RZAA, INTRAVENOUS, 1 MG	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	Sendero internal medical policy RX.001 "Biologic and Special	InterQual® Evidence-Based Criteria & Guidelines
J2329	INJECTION, UBLITUXIMAB-XIIY, 1MG	Preauthorization required when billed charges exceed $500 per line item	7/1/2023	InterQual® Evidence-Based Criteria & Guidelines	
J2350	INJECTION, OCRELIZUMAB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2351	INJECTION, OCRELIZUMAB, 1 MG AND HYALURONIDASE-OCSQ	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J2353	INJECTION, OCTREOTIDE, DEPOT FORM FOR INTRAMUSCULAR INJECTION, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2354	INJECTION, OCTREOTIDE, NON-DEPOT FORM FOR SUBCUTANEOUS OR INTRAVENOUS INJECTION, 25 MCG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2356	INJECTION, TEZEPELUMAB-EKKO, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2357	INJECTION, OMALIZUMAB, 5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2427	INJECTION, PALIPERIDONE PALMITATE EXTENDED RELEASE (INVEGA HAFYERA, OR INVEGA TRINZA), 1 MG	Preauthorization required when billed charges exceed $500 per line item	7/1/2023	InterQual® Evidence-Based Criteria & Guidelines	
J2428	INJECTION, PALIPERIDONE PALMITATE EXTENDED RELEASE (ERZOFRI), 1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J2469	INJECTION, PALONOSETRON HCL, 25 MCG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2502	INJECTION, PASIREOTIDE LONG ACTING, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2503	INJECTION, PEGAPTANIB SODIUM, 0.3 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2504	INJECTION, PEGADEMASE BOVINE, 25 IU	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2505	INJECTION, PEGFILGRASTIM, 6 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2506	INJECTION, PEGFILGRASTIM, EXCLUDES BIOSIMILAR, 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2507	INJECTION, PEGLOTICASE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2508	INJECTION, PEGUNIGALSIDASE ALFA-IWXJ, 1 MG	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
J2545	PENTAMIDINE ISETHIONATE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MG	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J2778	INJECTION, RANIBIZUMAB, 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2779	INJECTION, RANIBIZUMAB, VIA INTRAVITREAL IMPLANT (SUSVIMO), 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2786	INJECTION, RESLIZUMAB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2798	INJECTION, RISPERIDONE, (PERSERIS), 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J2799	INJECTION, RISPERIDONE (UZEDY), 1 MG	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J2801	INJECTION, RISPERIDONE (RYKINDO), 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	11/26/2024	InterQual® Evidence-Based Criteria & Guidelines	
J2802	INJECTION, ROMIPLOSTIM, 1 MICROGRAM	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J2820	INJECTION, SARGRAMOSTIM (GM-CSF), 50 MCG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2840	INJECTION, SEBELIPASE ALFA, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2941	INJECTION, SOMATROPIN, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J2998	INJECTION, PLASMINOGEN, HUMAN-TVMH, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J3010	INJECTION, FENTANYL CITRATE, 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J3032	INJECTION, EPTINEZUMAB-JJMR, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J3060	INJECTION, TALIGLUCERASE ALFA, 10 UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J3110	INJECTION, TERIPARATIDE, 10 MCG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J3111	INJECTION, ROMOSOZUMAB-AQQG, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
J3145	INJECTION, TESTOSTERONE UNDECANOATE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J3241	INJECTION, TEPROTUMUMAB-TRBW, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J3245	INJECTION, TILDRAKIZUMAB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	InterQual® Evidence-Based Criteria & Guidelines	
J3247	INJECTION, SECUKINUMAB, INTRAVENOUS, 1 MG	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J3262	INJECTION, TOCILIZUMAB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	Sendero internal medical policy RX.001 "Biologic and Special	InterQual® Evidence-Based Criteria & Guidelines
J3263	INJECTION, TORIPALIMAB-TPZI, 1 MG	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J3285	INJECTION, TREPROSTINIL, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J3315	INJECTION, TRIPTORELIN PAMOATE, 3.75 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J3357	USTEKINUMAB, FOR SUBCUTANEOUS INJECTION, 1 MG	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	Sendero internal medical policy RX.001 "Biologic and Special	InterQual® Evidence-Based Criteria & Guidelines
J3358	USTEKINUMAB, FOR INTRAVENOUS INJECTION, 1 MG	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	Sendero internal medical policy RX.001 "Biologic and Special	InterQual® Evidence-Based Criteria & Guidelines
J3380	INJECTION, VEDOLIZUMAB, INTRAVENOUS, 1 MG	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	Sendero internal medical policy RX.001 "Biologic and Special	InterQual® Evidence-Based Criteria & Guidelines
J3385	INJECTION, VELAGLUCERASE ALFA, 100 UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J3392	INJECTION, EXAGAMGLOGENE AUTOTEMCEL, PER TREATMENT		6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J3393	INJECTION, BETIBEGLOGENE AUTOTEMCEL, PER TREATMENT		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	InterQual® Evidence-Based Criteria & Guidelines
J3394	INJECTION, LOVOTIBEGLOGENE AUTOTEMCEL, PER TREATMENT	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J3397	INJECTION, VESTRONIDASE ALFA-VJBK, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J3398	INJECTION, VORETIGENE NEPARVOVEC-RZYL, 1 BILLION VECTOR GENOMES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J3399	INJECTION, ONASEMNOGENE ABEPARVOVEC-XIOI, PER TREATMENT, UP TO 5X10^15 VECTOR GENOMES		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
J3401	BEREMAGENE GEPERPAVEC-SVDT FOR TOPICAL ADMINISTRATION, CONTAINING NOMINAL 5 X 10^9 PFU/ML VECTOR GENOMES, PER 0.1 ML	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J3489	INJECTION, ZOLEDRONIC ACID, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J3490	UNCLASSIFIED DRUGS	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	Policy/Guideline depends on the specific drug being request	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
J3590	UNCLASSIFIED BIOLOGICS	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	Depends on which drug is requested. Sendero internal medic al policy PX.001 "Biologics and Specialty Treatments for Autoi	InterQual® Evidence-Based Criteria & Guidelines
J7170	INJECTION, EMICIZUMAB-KXWH, 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7171	INJECTION, ADAMTS13, RECOMBINANT-KRHN, 10 IU		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J7175	INJECTION, FACTOR X, (HUMAN), 1 I.U.	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7177	INJECTION, HUMAN FIBRINOGEN CONCENTRATE (FIBRYGA), 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7178	INJECTION, HUMAN FIBRINOGEN CONCENTRATE, NOT OTHERWISE SPECIFIED, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7179	INJECTION, VON WILLEBRAND FACTOR (RECOMBINANT), (VONVENDI), 1 I.U. VWF:RCO	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7180	INJECTION, FACTOR XIII (ANTIHEMOPHILIC FACTOR, HUMAN), 1 I.U.	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7181	INJECTION, FACTOR XIII A-SUBUNIT, (RECOMBINANT), PER IU	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7182	INJECTION, FACTOR VIII, (ANTIHEMOPHILIC FACTOR, RECOMBINANT), (NOVOEIGHT), PER IU	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7183	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, 1 I.U. VWF:RCO	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7184	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, PER 100 IU VWF:RCO	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7185	INJECTION, FACTOR VIII (ANTIHEMOPHILIC FACTOR, RECOMBINANT) (XYNTHA), PER I.U.	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7186	INJECTION, ANTIHEMOPHILIC FACTOR VIII/VON WILLEBRAND FACTOR COMPLEX (HUMAN), PER FACTOR VIII I.U.	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7187	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMATE-P), PER IU VWF:RCO	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7188	INJECTION, FACTOR VIII (ANTIHEMOPHILIC FACTOR, RECOMBINANT), (OBIZUR), PER I.U.	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7189	FACTOR VIIA (ANTIHEMOPHILIC FACTOR, RECOMBINANT), (NOVOSEVEN RT), 1 MICROGRAM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7190	FACTOR VIII (ANTIHEMOPHILIC FACTOR, HUMAN) PER I.U.	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7191	FACTOR VIII (ANTIHEMOPHILIC FACTOR (PORCINE)), PER I.U.	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7192	FACTOR VIII (ANTIHEMOPHILIC FACTOR, RECOMBINANT) PER I.U., NOT OTHERWISE SPECIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7193	FACTOR IX (ANTIHEMOPHILIC FACTOR, PURIFIED, NON-RECOMBINANT) PER I.U.	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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J7194	FACTOR IX, COMPLEX, PER I.U.	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7195	INJECTION, FACTOR IX (ANTIHEMOPHILIC FACTOR, RECOMBINANT) PER IU, NOT OTHERWISE SPECIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7196	INJECTION, ANTITHROMBIN RECOMBINANT, 50 I.U.	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7197	ANTITHROMBIN III (HUMAN), PER I.U.	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7198	ANTI-INHIBITOR, PER I.U.	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7199	HEMOPHILIA CLOTTING FACTOR, NOT OTHERWISE CLASSIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7200	INJECTION, FACTOR IX, (ANTIHEMOPHILIC FACTOR, RECOMBINANT), RIXUBIS, PER IU	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7201	INJECTION, FACTOR IX, FC FUSION PROTEIN, (RECOMBINANT), ALPROLIX, 1 I.U.	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7202	INJECTION, FACTOR IX, ALBUMIN FUSION PROTEIN, (RECOMBINANT), IDELVION, 1 I.U.	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7203	INJECTION FACTOR IX, (ANTIHEMOPHILIC FACTOR, RECOMBINANT), GLYCOPEGYLATED, (REBINYN), 1 IU	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7204	INJECTION, FACTOR VIII, ANTIHEMOPHILIC FACTOR (RECOMBINANT), (ESPEROCT), GLYCOPEGYLATED-EXEI, PER IU	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7205	INJECTION, FACTOR VIII FC FUSION PROTEIN (RECOMBINANT), PER IU	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7207	INJECTION, FACTOR VIII, (ANTIHEMOPHILIC FACTOR, RECOMBINANT), PEGYLATED, 1 I.U.	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7208	INJECTION, FACTOR VIII, (ANTIHEMOPHILIC FACTOR, RECOMBINANT), PEGYLATED-AUCL, (JIVI), 1 I.U.	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7209	INJECTION, FACTOR VIII, (ANTIHEMOPHILIC FACTOR, RECOMBINANT), (NUWIQ), 1 I.U.	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7210	INJECTION, FACTOR VIII, (ANTIHEMOPHILIC FACTOR, RECOMBINANT), (AFSTYLA), 1 I.U.	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7211	INJECTION, FACTOR VIII, (ANTIHEMOPHILIC FACTOR, RECOMBINANT), (KOVALTRY), 1 I.U.	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7212	FACTOR VIIA (ANTIHEMOPHILIC FACTOR, RECOMBINANT)-JNCW (SEVENFACT), 1 MICROGRAM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7320	HYALURONAN OR DERIVITIVE, GENVISC 850, FOR INTRA-ARTICULAR INJECTION, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7321	HYALURONAN OR DERIVATIVE, HYALGAN, SUPARTZ OR VISCO-3, FOR INTRA-ARTICULAR INJECTION, PER DOSE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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J7322	HYALURONAN OR DERIVATIVE, HYMOVIS, FOR INTRA-ARTICULAR INJECTION, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7323	HYALURONAN OR DERIVATIVE, EUFLEXXA, FOR INTRA-ARTICULAR INJECTION, PER DOSE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7324	HYALURONAN OR DERIVATIVE, ORTHOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7325	HYALURONAN OR DERIVATIVE, SYNVISC OR SYNVISC-ONE, FOR INTRA-ARTICULAR INJECTION, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7326	HYALURONAN OR DERIVATIVE, GEL-ONE, FOR INTRA-ARTICULAR INJECTION, PER DOSE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7327	HYALURONAN OR DERIVATIVE, MONOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7328	HYALURONAN OR DERIVATIVE, GELSYN-3, FOR INTRA-ARTICULAR INJECTION, 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7329	HYALURONAN OR DERIVATIVE, TRIVISC, FOR INTRA-ARTICULAR INJECTION, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7330	AUTOLOGOUS CULTURED CHONDROCYTES, IMPLANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7331	HYALURONAN OR DERIVATIVE, SYNOJOYNT, FOR INTRA-ARTICULAR INJECTION, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7332	HYALURONAN OR DERIVATIVE, TRILURON, FOR INTRA-ARTICULAR INJECTION, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J7354	CANTHARIDIN FOR TOPICAL ADMINISTRATION, 0.7%, SINGLE UNIT DOSE APPLICATOR (3.2 MG)	Topical drug authorized through the Pharmacy benefit. Submit request to Navitus PBM.	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J7355	INJECTION, TRAVOPROST, INTRACAMERAL IMPLANT, 1 MICROGRAM		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J7376	INJECTION, POZELIMAB-BBFG, 1 MG	Preauthorization required when billed charges exceed $500 per line item	11/26/2024	InterQual® Evidence-Based Criteria & Guidelines	
J7514	MYCOPHENOLATE MOFETIL (MYHIBBIN), ORAL SUSPENSION, 100 MG	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
J7601	ENSIFENTRINE, INHALATION SUSPENSION, FDA APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 3 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J7605	ARFORMOTEROL, INHALATION SOLUTION, FDA APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 15 MICROGRAMS	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Otherwise considered nvestigational/Experimental and thus, requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
J7606	FORMOTEROL FUMARATE, INHALATION SOLUTION, FDA APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 20 MICROGRAMS	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Otherwise considered nvestigational/Experimental and thus, requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7607	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Otherwise considered nvestigational/Experimental and thus, requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7608	ACETYLCYSTEINE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER GRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Otherwise considered nvestigational/Experimental and thus, requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7609	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 1 MG	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Otherwise considered nvestigational/Experimental and thus, requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7610	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1 MG	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Otherwise considered nvestigational/Experimental and thus, requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7615	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Otherwise considered nvestigational/Experimental and thus, requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7620	ALBUTEROL, UP TO 2.5 MG AND IPRATROPIUM BROMIDE, UP TO 0.5 MG, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME	Pays without authorization or Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Otherwise considered nvestigational/Experimental and thus, requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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J7622	BECLOMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Otherwise considered nvestigational/Experimental and thus, requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7626	BUDESONIDE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 0.5 MG	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Otherwise considered nvestigational/Experimental and thus, requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7627	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 0.5 MG	Pays without authorization for age 6 through 17 for Dx J45.40-J45.52 Pys without authorization for ages 12 through 17 years for Dx. L50.8 Pays without authorization for ages 18 yrs and older for Dx. D47.02, J33.0 - J33.9, J45.40 - J45.52, L50.8 Otherwise considered nvestigational/Experimental and thus, requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7628	BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Otherwise considered nvestigational/Experimental and thus, requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7629	BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Otherwise considered nvestigational/Experimental and thus, requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7631	CROMOLYN SODIUM, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Otherwise considered nvestigational/Experimental and thus, requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7632	CROMOLYN SODIUM, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS	Pays without auth for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Otherwise considered nvestigational/Experimental and thus, requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
J7633	BUDESONIDE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 0.25 MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Pasy without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7634	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 0.25 MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7635	ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7636	ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	Pays without authorization or Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7639	DORNASE ALFA, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7640	FORMOTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 12 MICROGRAMS	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
J7641	FLUNISOLIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, PER MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7642	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7643	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization..	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7644	IPRATROPIUM BROMIDE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7645	IPRATROPIUM BROMIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	Pays without authorization or Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7647	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7648	ISOETHARINE HCL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
J7649	ISOETHARINE HCL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7650	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7657	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7659	ISOPROTERENOL HCL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7660	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7667	METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, CONCENTRATED FORM, PER 10 MILLIGRAMS	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7669	METAPROTERENOL SULFATE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
J7670	METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7676	PENTAMIDINE ISETHIONATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MG	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7682	TOBRAMYCIN, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, UNIT DOSE FORM, ADMINISTERED THROUGH DME, PER 300 MILLIGRAMS	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7683	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7684	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7685	TOBRAMYCIN, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MILLIGRAMS	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7686	TREPROSTINIL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 1.74 MG	Pays without authorization for Dx B20, B59, B96.5, E84.0 - E84.9, I27.0, I27.20 - I27.29, J05.0, J15.1, J40 - J47.9, J95.00 - J95.09, Q33.4, R09.3, T86.00 - T86.99, Z43.0, Z93.0, E75.242, J98.11, J98.19, R05.1 - R05.9, Z43.0, Z94.2. Investigational /Experimental for all other diagnoses and thus requires preauthorization.	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J7699	NOC DRUGS, INHALATION SOLUTION ADMINISTERED THROUGH DME	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
J7999	COMPOUNDED DRUG, NOT OTHERWISE CLASSIFIED	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
J8522	CAPECITABINE, ORAL, 50 MG	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J8611	METHOTREXATE (JYLAMVO), ORAL, 2.5 MG	Submit request through Navitus	7/1/2024	OncoHealth global Medical Necessity Criteria	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications
J8612	METHOTREXATE (XATMEP), ORAL, 2.5 MG	Submit request through Navitus	7/1/2024	OncoHealth global Medical Necessity Criteria	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications
J8700	TEMOZOLOMIDE, ORAL, 5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9000	INJECTION, DOXORUBICIN HYDROCHLORIDE, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9015	INJECTION, ALDESLEUKIN, PER SINGLE USE VIAL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9017	INJECTION, ARSENIC TRIOXIDE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9019	INJECTION, ASPARAGINASE (ERWINAZE), 1,000 IU	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9020	INJECTION, ASPARAGINASE, NOT OTHERWISE SPECIFIED, 10,000 UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9022	INJECTION, ATEZOLIZUMAB, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9023	INJECTION, AVELUMAB, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9024	INJECTION, ATEZOLIZUMAB, 5 MG AND HYALURONIDASE-TQJS	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J9025	INJECTION, AZACITIDINE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9026	INJECTION, TARLATAMAB-DLLE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J9027	INJECTION, CLOFARABINE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9028	INJECTION, NOGAPENDEKIN ALFA INBAKICEPT-PMLN, FOR INTRAVESICAL USE, 1 MICROGRAM	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J9029	INTRAVESICAL INSTILLATION, NADOFARAGENE FIRADENOVEC-VNCG, PER THERAPEUTIC DOSE	Preauthorization required when billed charges exceed $500 per line item	7/1/2023	InterQual® Evidence-Based Criteria & Guidelines	
J9031	BCG (INTRAVESICAL) PER INSTILLATION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9032	INJECTION, BELINOSTAT, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9033	INJECTION, BENDAMUSTINE HYDROCHLORIDE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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J9034	INJECTION, BENDAMUSTINE HCL (BENDEKA), 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9035	INJECTION, BEVACIZUMAB, 10 MG	Pays without authorization for Ophthalmic condition Dx codes listed here when delivered by Providers in the Sendero network. Requires preauthorization for any other condition when billed charges exceed $500 per line item or when administered by a provider that is not part of the Sendero provider network. Diagnosis codes: B39.9, E08.311, E08.321, E08.331, E08.39, E08.341 through E08.359, E09.311, E09.321, E09.331, E09.39, E09.341 through E09.359, E10.311 through E10.39, E11.311 through E11.39, E13.311, E13.321, E13.331, E13.34, E13.341 through E13.359, H21.1X1, H21.1X2, H21.1X3, H21.1X9, H34.811 through H34.9, H35.00 through H35.9, H40.5, H40.89, H43.1, H44.2A1 through H44.2A9, and H54.0X33 through H54.8.	1/1/2022	OncolHealth medical policy, "Bevacizumab: Alymsys, Avastin [illegible]"	InterQual® Evidence-Based Criteria & Guidelines [illegible]
J9036	INJECTION, BENDAMUSTINE HYDROCHLORIDE, (BELRAPZO/BENDAMUSTINE), 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9037	INJECTION, BELANTAMAB MAFODOTIN-BLMF, 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9038	INJECTION, AXATILIMAB-CSFR, 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J9039	INJECTION, BLINATUMOMAB, 1 MICROGRAM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9040	INJECTION, BLEOMYCIN SULFATE, 15 UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9041	INJECTION, BORTEZOMIB, 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9042	INJECTION, BRENTUXIMAB VEDOTIN, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9043	INJECTION, CABAZITAXEL, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9045	INJECTION, CARBOPLATIN, 50 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9046	INJECTION, BORTEZOMIB (DR. REDDY'S), NOT THERAPEUTICALLY EQUIVALENT TO J9041, 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
J9047	INJECTION, CARFILZOMIB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9048	INJECTION, BORTEZOMIB (FRESENIUS KABI), NOT THERAPEUTICALLY EQUIVALENT TO J9041, 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
J9049	INJECTION, BORTEZOMIB (HOSPIRA), NOT THERAPEUTICALLY EQUIVALENT TO J9041, 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	

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J9050	INJECTION, CARMUSTINE, 100 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9052	INJECTION, CARMUSTINE (ACCORD), NOT THERAPEUTICALLY EQUIVALENT TO J9050, 100 MG	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J9054	INJECTION, BORTEZOMIB (BORUZU), 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J9055	INJECTION, CETUXIMAB, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9056	INJECTION, BENDAMUSTINE HYDROCHLORIDE (VIVIMUSTA), 1 MG	Preauthorization required when billed charges exceed $500 per line item	7/1/2023	InterQual® Evidence-Based Criteria & Guidelines	
J9058	INJECTION, BENDAMUSTINE HYDROCHLORIDE (APOTEX), 1 MG	Preauthorization required when billed charges exceed $500 per line item	7/1/2023	InterQual® Evidence-Based Criteria & Guidelines	
J9059	INJECTION, BENDAMUSTINE HYDROCHLORIDE (BAXTER), 1 MG	Preauthorization required when billed charges exceed $500 per line item	7/1/2023	InterQual® Evidence-Based Criteria & Guidelines	
J9060	INJECTION, CISPLATIN, POWDER OR SOLUTION, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9061	INJECTION, AMIVANTAMAB-VMJW, 2 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9063	INJECTION, MIRVETUXIMAB SORAVTANSINE-GYNX, 1 MG	Preauthorization required when billed charges exceed $500 per line item	7/1/2023	InterQual® Evidence-Based Criteria & Guidelines	
J9065	INJECTION, CLADRIBINE, PER 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9070	CYCLOPHOSPHAMIDE, 100 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9072	INJECTION, CYCLOPHOSPHAMIDE (AVYXA), 5 MG	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J9073	INJECTION, CYCLOPHOSPHAMIDE (INGENUS), 5 MG	Preauthorization required when billed charges exceed $500 per line item	11/26/2024	InterQual® Evidence-Based Criteria & Guidelines	
J9074	INJECTION, CYCLOPHOSPHAMIDE (SANDOZ), 5 MG	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J9075	INJECTION, CYCLOPHOSPHAMIDE, NOT OTHERWISE SPECIFIED, 5 MG	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J9076	INJECTION, CYCLOPHOSPHAMIDE (BAXTER), 5 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J9098	INJECTION, CYTARABINE LIPOSOME, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9100	INJECTION, CYTARABINE, 100 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9119	INJECTION, CEMIPLIMAB-RWLC, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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J9120	INJECTION, DACTINOMYCIN, 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9130	DACARBAZINE, 100 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9144	INJECTION, DARATUMUMAB, 10 MG AND HYALURONIDASE-FIHJ	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9145	INJECTION, DARATUMUMAB, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9150	INJECTION, DAUNORUBICIN, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9151	INJECTION, DAUNORUBICIN CITRATE, LIPOSOMAL FORMULATION, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9155	INJECTION, DEGARELIX, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9161	INJECTION, DENILEUKIN DIFTITOX-CXDL, 1 MCG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J9165	INJECTION, DIETHYLSTILBESTROL DIPHOSPHATE, 250 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9171	INJECTION, DOCETAXEL, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	OncoHealth Medical Policy, "Paclitaxel Protein Bound: Abraxane"	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications
J9172	INJECTION, DOCETAXEL (DOCIVYX), 1 MG	Includes step therapy requirements through either biosimilars or therapeutically similar medications for the below medications only when used for cancer/chemotherapy indications. Prequthorization required for all uses.	4/1/2024	OncoHealth Medical Policy, "Paclitaxel Protein Bound: Abraxane"	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications
J9173	INJECTION, DURVALUMAB, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9175	INJECTION, ELLIOTTS' B SOLUTION, 1 ML	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9176	INJECTION, ELOTUZUMAB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9177	INJECTION, ENFORTUMAB VEDOTIN-EJFV, 0.25 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9178	INJECTION, EPIRUBICIN HCL, 2 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9179	INJECTION, ERIBULIN MESYLATE, 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9181	INJECTION, ETOPOSIDE, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9185	INJECTION, FLUDARABINE PHOSPHATE, 50 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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J9190	INJECTION, FLUOROURACIL, 500 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9200	INJECTION, FLOXURIDINE, 500 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9201	INJECTION, GEMCITABINE HYDROCHLORIDE, NOT OTHERWISE SPECIFIED, 200 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9202	GOSERELIN ACETATE IMPLANT, PER 3.6 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9206	INJECTION, IRINOTECAN, 20 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9207	INJECTION, IXABEPILONE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9208	INJECTION, IFOSFAMIDE, 1 GRAM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9209	INJECTION, MESNA, 200 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9211	INJECTION, IDARUBICIN HYDROCHLORIDE, 5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9212	INJECTION, INTERFERON ALFACON-1, RECOMBINANT, 1 MICROGRAM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9213	INJECTION, INTERFERON, ALFA-2A, RECOMBINANT, 3 MILLION UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9214	INJECTION, INTERFERON, ALFA-2B, RECOMBINANT, 1 MILLION UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9215	INJECTION, INTERFERON, ALFA-N3, (HUMAN LEUKOCYTE DERIVED), 250,000 IU	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9216	INJECTION, INTERFERON, GAMMA 1-B, 3 MILLION UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9217	LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), 7.5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9218	LEUPROLIDE ACETATE, PER 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9219	LEUPROLIDE ACETATE IMPLANT, 65 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9225	HISTRELIN IMPLANT (VANTAS), 50 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9226	HISTRELIN IMPLANT (SUPPRELIN LA), 50 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9227	INJECTION, ISATUXIMAB-IRFC, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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J9228	INJECTION, IPILIMUMAB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9229	INJECTION, INOTUZUMAB OZOGAMICIN, 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9230	INJECTION, MECHLORETHAMINE HYDROCHLORIDE, (NITROGEN MUSTARD), 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9245	INJECTION, MELPHALAN HYDROCHLORIDE, NOT OTHERWISE SPECIFIED, 50 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9247	INJECTION, MELPHALAN FLUFENAMIDE, 1MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9248	INJECTION, MELPHALAN (HEPZATO), 1 MG	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	OncoHealth Global Medical Necessity Review criteria	InterQual® Evidence-Based Criteria & Guidelines
J9249	INJECTION, MELPHALAN (APOTEX), 1 MG	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J9250	METHOTREXATE SODIUM, 5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9255	INJECTION, METHOTREXATE (ACCORD), NOT THERAPEUTICALLY EQUIVALENT TO J9260, 50 MG	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	OncoHealth Global Medical Necessity Review criteria	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications
J9258	INJECTION, PACLITAXEL PROTEIN-BOUND PARTICLES (TEVA), NOT THERAPEUTICALLY EQUIVALENT TO J9264, 1 MG	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J9259	INJECTION, PACLITAXEL PROTEIN-BOUND PARTICLES (AMERICAN REGENT), NOT THERAPEUTICALLY EQUIVALENT TO J9264, 1 MG	Includes step therapy requirements through either biosimilars or therapeutically similar medications for the below medications only when used for cancer/chemotherapy indications. Prequthorization required for all uses.	7/1/2023	Sendero Internal medical policy	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications
J9260	INJECTION, METHOTREXATE SODIUM, 50 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9261	INJECTION, NELARABINE, 50 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9262	INJECTION, OMACETAXINE MEPESUCCINATE, 0.01 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9263	INJECTION, OXALIPLATIN, 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9264	INJECTION, PACLITAXEL PROTEIN-BOUND PARTICLES, 1 MG	Includes step therapy requirements through either biosimilars or therapeutically similar medications for the below medications only when used for cancer/chemotherapy indications. Preauthorization required for all uses when billed charges exceed $500 per line item.	1/1/2022	OncoHealth Medical Policy, "Paclitaxel Protein Bound: Abraxane"	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications
J9266	INJECTION, PEGASPARGASE, PER SINGLE DOSE VIAL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9267	INJECTION, PACLITAXEL, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	OncoHealth Medical Policy, "Paclitaxel Protein Bound: Abraxane"	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications

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J9268	INJECTION, PENTOSTATIN, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9270	INJECTION, PLICAMYCIN, 2.5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9271	INJECTION, PEMBROLIZUMAB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9272	INJECTION, DOSTARLIMAB-GXLY, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9280	INJECTION, MITOMYCIN, 5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9281	MITOMYCIN PYELOCALYCEAL INSTILLATION, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9285	INJECTION, OLARATUMAB, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9286	INJECTION, GLOFITAMAB-GXBM, 2.5 MG	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J9292	INJECTION, PEMETREXED (AVYXA), NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
J9293	INJECTION, MITOXANTRONE HYDROCHLORIDE, PER 5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9294	INJECTION, PEMETREXED (HOSPIRA), NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG	Preauthorization required when billed charges exceed $500 per line item	8/15/2023	OncoHealth Medical Policy, "Pemetrexed: Alimta, Pemfexy, Pemrydi PTH"	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications
J9296	INJECTION, PEMETREXED (ACCORD), NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG	Preauthorization required when billed charges exceed $500 per line item	8/15/2023	OncoHealth Medical Policy, "Pemetrexed: Alimta, Pemfexy, Pemrydi PTH"	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications
J9297	INJECTION, PEMETREXED (SANDOZ), NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG	Preauthorization required when billed charges exceed $500 per line item	8/15/2023	OncoHealth Medical Policy, "Pemetrexed: Alimta, Pemfexy, Pemrydi PTH"	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications
J9299	INJECTION, NIVOLUMAB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9301	INJECTION, OBINUTUZUMAB, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9302	INJECTION, OFATUMUMAB, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9303	INJECTION, PANITUMUMAB, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9304	INJECTION, PEMETREXED (PEMFEXY), 10 MG	Includes step therapy requirements through either biosimilars or therapeutically similar medications for the below medications only when used for cancer/chemotherapy indications. Prequthorization required for all uses.	1/1/2025	Sendero Internal medical policy	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications

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J9305	INJECTION, PEMETREXED, NOT OTHERWISE SPECIFIED, 10 MG	Includes step therapy requirements through either biosimilars or therapeutically similar medications for the below medications only when used for cancer/chemotherapy indications. Preauthorization required for all uses when billed charges exceed $500 per line item.	1/1/2022	OncoHealth Medical Policy, "Pemetrexed: Alimta, Pemfexy, Pemrydi PTH"	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications
J9306	INJECTION, PERTUZUMAB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9307	INJECTION, PRALATREXATE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9308	INJECTION, RAMUCIRUMAB, 5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9309	INJECTION, POLATUZUMAB VEDOTIN-PIIQ, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9310	INJECTION, RITUXIMAB, 100 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9311	INJECTION, RITUXIMAB 10 MG AND HYALURONIDASE	Includes step therapy requirements through either biosimilars or therapeutically similar medications for the below medications only when used for cancer/chemotherapy indications. Preauthorization required for all uses when billed charges exceed $500 per line item.	2/28/2021	OncoHealth Medical Policy, "Rituximab: Riabni, Rituxan, Ritu van Ukoola, Ruxience, Truxima"	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications
J9312	INJECTION, RITUXIMAB, 10 MG	Includes step therapy requirements through either biosimilars or therapeutically similar medications for the below medications only when used for cancer/chemotherapy indications. Preauthorization required for all uses when billed charges exceed $500 per line item.	2/28/2021	OncoHealth Medical Policy, "Rituximab: Riabni, Rituxan, Ritu van Ukoola, Ruxience, Truxima"	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications
J9313	INJECTION, MOXETUMOMAB PASUDOTOX-TDFK, 0.01 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9314	INJECTION, PEMETREXED (TEVA), NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	OncoHealth Medical Policy, "Pemetrexed: Alimta, Pemfexy, Pemrydi PTH"	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications
J9315	INJECTION, ROMIDEPSIN, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9316	INJECTION, PERTUZUMAB, TRASTUZUMAB, AND HYALURONIDASE-ZZXF, PER 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9317	INJECTION, SACITUZUMAB GOVITECAN-HZIY, 2.5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9320	INJECTION, STREPTOZOCIN, 1 GRAM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9321	INJECTION, EPCORITAMAB-BYSP, 0.16 MG	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J9322	INJECTION, PEMETREXED (BLUEPOINT), NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG	Preauthorization required when billed charges exceed $500 per line item	7/1/2023	OncoHealth Medical Policy, "Pemetrexed: Alimta, Pemfexy, Pemrydi PTH"	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications

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J9323	INJECTION, PEMETREXED DITROMETHAMINE, 10 MG	Preauthorization required when billed charges exceed $500 per line item	7/1/2023	OncoHealth Medical Policy, "Pemetrexed: Alimta, Pemfexy, Pemrydi RTU"	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications
J9324	INJECTION, PEMETREXED (PEMRYDI RTU), 10 MG	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	OncoHealth Medical Policy, "Pemetrexed: Alimta, Pemfexy, Pemrydi RTU"	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications
J9325	INJECTION, TALIMOGENE LAHERPAREPVEC, PER 1 MILLION PLAQUE FORMING UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9328	INJECTION, TEMOZOLOMIDE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9329	INJECTION, TISLELIZUMAB-JSGR, 1MG	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
J9330	INJECTION, TEMSIROLIMUS, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9331	INJECTION, SIROLIMUS PROTEIN-BOUND PARTICLES, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9332	INJECTION, EFGARTIGIMOD ALFA-FCAB, 2MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9333	INJECTION, ROZANOLIXIZUMAB-NOLI, 1 MG	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J9334	INJECTION, EFGARTIGIMOD ALFA, 2 MG AND HYALURONIDASE-QVFC	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
J9340	INJECTION, THIOTEPA, 15 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9347	INJECTION, TREMELIMUMAB-ACTL, 1 MG	Preauthorization required when billed charges exceed $500 per line item	7/1/2023	InterQual® Evidence-Based Criteria & Guidelines	
J9348	INJECTION, NAXITAMAB-GQGK, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9349	INJECTION, TAFASITAMAB-CXIX, 2 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9350	INJECTION, MOSUNETUZUMAB-AXGB, 1 MG	Preauthorization required when billed charges exceed $500 per line item	7/1/2023	InterQual® Evidence-Based Criteria & Guidelines	
J9351	INJECTION, TOPOTECAN, 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9353	INJECTION, MARGETUXIMAB-CMKB, 5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9354	INJECTION, ADO-TRASTUZUMAB EMTANSINE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9355	INJECTION, TRASTUZUMAB, EXCLUDES BIOSIMILAR, 10 MG	Includes step therapy requirements through either biosimilars or therapeutically similar medications for the below medications only when used for cancer/chemotherapy indications. Preauthorization required for all uses when billed charges exceed $500 per line item.	1/1/2022	OncoHealth Medical Policy, "Trastuzumab: Herceptin, Herceptin Hylecta, Herzuma, Kanjinti, Ogivri, Ontruzant"	InterQual® Evidence-Based Criteria & Guidelines for non-cancer indications

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J9356	INJECTION, TRASTUZUMAB, 10 MG AND HYALURONIDASE-OYSK	Includes step therapy requirements through either biosimilars or therapeutically similar medications for the below medications only when used for cancer/chemotherapy indications. Preauthorization required for all uses when billed charges exceed $500 per line item.	1/1/2022	OncoHealth Medical Policy, "Trastuzumab: Herceptin, Herce	InterQual® Evidence-Based Criteria & Guidelines
J9357	INJECTION, VALRUBICIN, INTRAVESICAL, 200 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9358	INJECTION, FAM-TRASTUZUMAB DERUXTECAN-NXKI, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9360	INJECTION, VINBLASTINE SULFATE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9361	INJECTION, EFBEMALENOGRASTIM ALFA-VUXW, 0.5 MG		9/1/2024	OncoHealth Global Medical Necessity Review criteria	InterQual® Evidence-Based Criteria & Guidelines
J9370	VINCRISTINE SULFATE, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9371	INJECTION, VINCRISTINE SULFATE LIPOSOME, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9376	INJECTION, POZELIMAB-BBFG, 1 MG	Preauthorization required when billed charges exceed $500 per line item	11/26/2024	InterQual® Evidence-Based Criteria & Guidelines	
J9380	INJECTION, TECLISTAMAB-CQYV, 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	7/1/2023	InterQual® Evidence-Based Criteria & Guidelines	
J9381	INJECTION, TEPLIZUMAB-MZWV, 5 MCG	Preauthorization required when billed charges exceed $500 per line item	7/1/2023	InterQual® Evidence-Based Criteria & Guidelines	
J9390	INJECTION, VINORELBINE TARTRATE, 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9393	INJECTION, FULVESTRANT (TEVA), NOT THERAPEUTICALLY EQUIVALENT TO J9395, 25 MG	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
J9394	INJECTION, FULVESTRANT (FRESENIUS KABI) NOT THERAPEUTICALLY EQUIVALENT TO J9395, 25 MG	Preauthorization required when billed charges exceed $500 per line item	5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
J9395	INJECTION, FULVESTRANT, 25 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9400	INJECTION, ZIV-AFLIBERCEPT, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9600	INJECTION, PORFIMER SODIUM, 75 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
J9999	NOT OTHERWISE CLASSIFIED, ANTINEOPLASTIC DRUGS	Includes step therapy requirements through either biosimilars or therapeutically similar medications for the below medications only when used for cancer/chemotherapy indications. Preauthorization required for all uses when billed charges exceed $500 per line item.	2/28/2021	Depends on the drug being requested: OncoHealth Medical	InterQual® Evidence-Based Criteria & Guidelines
K0001	STANDARD WHEELCHAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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K0002	STANDARD HEMI (LOW SEAT) WHEELCHAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0003	LIGHTWEIGHT WHEELCHAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0004	HIGH STRENGTH, LIGHTWEIGHT WHEELCHAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0005	ULTRALIGHTWEIGHT WHEELCHAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0006	HEAVY DUTY WHEELCHAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0007	EXTRA HEAVY DUTY WHEELCHAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0008	CUSTOM MANUAL WHEELCHAIR/BASE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0009	OTHER MANUAL WHEELCHAIR/BASE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0010	STANDARD - WEIGHT FRAME MOTORIZED/POWER WHEELCHAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0011	STANDARD - WEIGHT FRAME MOTORIZED/POWER WHEELCHAIR WITH PROGRAMMABLE CONTROL PARAMETERS FOR SPEED ADJUSTMENT, TREMOR DAMPENING, ACCELERATION CONTROL AND BRAKING	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0012	LIGHTWEIGHT PORTABLE MOTORIZED/POWER WHEELCHAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0013	CUSTOM MOTORIZED/POWER WHEELCHAIR BASE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0014	OTHER MOTORIZED/POWER WHEELCHAIR BASE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0015	DETACHABLE, NON-ADJUSTABLE HEIGHT ARMREST, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0017	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, BASE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0018	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, UPPER PORTION, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0019	ARM PAD, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0020	FIXED, ADJUSTABLE HEIGHT ARMREST, PAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0037	HIGH MOUNT FLIP-UP FOOTREST, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0038	LEG STRAP, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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K0039	LEG STRAP, H STYLE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0040	ADJUSTABLE ANGLE FOOTPLATE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0041	LARGE SIZE FOOTPLATE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0042	STANDARD SIZE FOOTPLATE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0043	FOOTREST, LOWER EXTENSION TUBE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0044	FOOTREST, UPPER HANGER BRACKET, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0045	FOOTREST, COMPLETE ASSEMBLY, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0046	ELEVATING LEGREST, LOWER EXTENSION TUBE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0047	ELEVATING LEGREST, UPPER HANGER BRACKET, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0050	RATCHET ASSEMBLY, REPLACEMENT ONLY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0051	CAM RELEASE ASSEMBLY, FOOTREST OR LEGREST, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0052	SWINGAWAY, DETACHABLE FOOTRESTS, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0053	ELEVATING FOOTRESTS, ARTICULATING (TELESCOPING), EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0056	SEAT HEIGHT LESS THAN 17" OR EQUAL TO OR GREATER THAN 21" FOR A HIGH STRENGTH, LIGHTWEIGHT, OR ULTRALIGHTWEIGHT WHEELCHAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0065	SPOKE PROTECTORS, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0069	REAR WHEEL ASSEMBLY, COMPLETE, WITH SOLID TIRE, SPOKES OR MOLDED, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0070	REAR WHEEL ASSEMBLY, COMPLETE, WITH PNEUMATIC TIRE, SPOKES OR MOLDED, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0071	FRONT CASTER ASSEMBLY, COMPLETE, WITH PNEUMATIC TIRE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0072	FRONT CASTER ASSEMBLY, COMPLETE, WITH SEMI-PNEUMATIC TIRE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0073	CASTER PIN LOCK, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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K0077	FRONT CASTER ASSEMBLY, COMPLETE, WITH SOLID TIRE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0098	DRIVE BELT FOR POWER WHEELCHAIR, REPLACEMENT ONLY	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0108	WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0195	ELEVATING LEG RESTS, PAIR (FOR USE WITH CAPPED RENTAL WHEELCHAIR BASE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0455	INFUSION PUMP USED FOR UNINTERRUPTED PARENTERAL ADMINISTRATION OF MEDICATION, (E.G., EPOPROSTENOL OR TREPROSTINOL)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0462	TEMPORARY REPLACEMENT FOR PATIENT OWNED EQUIPMENT BEING REPAIRED, ANY TYPE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0552	SUPPLIES FOR EXTERNAL NON-INSULIN DRUG INFUSION PUMP, SYRINGE TYPE CARTRIDGE, STERILE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0601	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, SILVER OXIDE, 1.5 VOLT, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0602	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, SILVER OXIDE, 3 VOLT, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0603	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, ALKALINE, 1.5 VOLT, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0604	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, LITHIUM, 3.6 VOLT, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0605	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, LITHIUM, 4.5 VOLT, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0606	AUTOMATIC EXTERNAL DEFIBRILLATOR, WITH INTEGRATED ELECTROCARDIOGRAM ANALYSIS, GARMENT TYPE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0607	REPLACEMENT BATTERY FOR AUTOMATED EXTERNAL DEFIBRILLATOR, GARMENT TYPE ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0608	REPLACEMENT GARMENT FOR USE WITH AUTOMATED EXTERNAL DEFIBRILLATOR, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0609	REPLACEMENT ELECTRODES FOR USE WITH AUTOMATED EXTERNAL DEFIBRILLATOR, GARMENT TYPE ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0669	WHEELCHAIR ACCESSORY, WHEELCHAIR SEAT OR BACK CUSHION, DOES NOT MEET SPECIFIC CODE CRITERIA OR NO WRITTEN CODING VERIFICATION FROM DME PDAC	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0672	ADDITION TO LOWER EXTREMITY ORTHOSIS, REMOVABLE SOFT INTERFACE, ALL COMPONENTS, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0733	POWER WHEELCHAIR ACCESSORY, 12 TO 24 AMP HOUR SEALED LEAD ACID BATTERY, EACH (E.G., GEL CELL, ABSORBED GLASSMAT)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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K0738	PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL; HOME COMPRESSOR USED TO FILL PORTABLE OXYGEN CYLINDERS; INCLUDES PORTABLE CONTAINERS, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0739	REPAIR OR NONROUTINE SERVICE FOR DURABLE MEDICAL EQUIPMENT OTHER THAN OXYGEN EQUIPMENT REQUIRING THE SKILL OF A TECHNICIAN, LABOR COMPONENT, PER 15 MINUTES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0740	REPAIR OR NONROUTINE SERVICE FOR OXYGEN EQUIPMENT REQUIRING THE SKILL OF A TECHNICIAN, LABOR COMPONENT, PER 15 MINUTES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0743	SUCTION PUMP, HOME MODEL, PORTABLE, FOR USE ON WOUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0744	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE 16 SQUARE INCHES OR LESS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0745	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE MORE THAN 16 SQUARE INCHES BUT LESS THAN OR EQUAL TO 48 SQUARE INCHES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0746	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE GREATER THAN 48 SQUARE INCHES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0800	POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0802	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0812	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT 601 POUNDS OR MORE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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K0843	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0851	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0852	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0855	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0857	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 301 TO 450 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0859	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0862	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0863	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0864	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0868	POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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K0869	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0870	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0871	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0877	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0878	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0879	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0880	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0884	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0885	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0886	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0890	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0891	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0898	POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0899	POWER MOBILITY DEVICE, NOT CODED BY DME PDAC OR DOES NOT MEET CRITERIA	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0900	CUSTOMIZED DURABLE MEDICAL EQUIPMENT, OTHER THAN WHEELCHAIR	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0901	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	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K0902	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	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
K1002	CRANIAL ELECTROTHERAPY STIMULATION (CES) SYSTEM, ANY TYPE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
K1004	LOW FREQUENCY ULTRASONIC DIATHERMY TREATMENT DEVICE FOR HOME USE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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L0112	CRANIAL CERVICAL ORTHOSIS, CONGENITAL TORTICOLLIS TYPE, WITH OR WITHOUT SOFT INTERFACE MATERIAL, ADJUSTABLE RANGE OF MOTION JOINT, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0113	CRANIAL CERVICAL ORTHOSIS, TORTICOLLIS TYPE, WITH OR WITHOUT JOINT, WITH OR WITHOUT SOFT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0120	CERVICAL, FLEXIBLE, NON-ADJUSTABLE, PREFABRICATED, OFF-THE-SHELF (FOAM COLLAR)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0130	CERVICAL, FLEXIBLE, THERMOPLASTIC COLLAR, MOLDED TO PATIENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0140	CERVICAL, SEMI-RIGID, ADJUSTABLE (PLASTIC COLLAR)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0150	CERVICAL, SEMI-RIGID, ADJUSTABLE MOLDED CHIN CUP (PLASTIC COLLAR WITH MANDIBULAR/OCCIPITAL PIECE)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0160	CERVICAL, SEMI-RIGID, WIRE FRAME OCCIPITAL/MANDIBULAR SUPPORT, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0170	CERVICAL, COLLAR, MOLDED TO PATIENT MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0172	CERVICAL, COLLAR, SEMI-RIGID THERMOPLASTIC FOAM, TWO-PIECE, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0174	CERVICAL, COLLAR, SEMI-RIGID, THERMOPLASTIC FOAM, TWO PIECE WITH THORACIC EXTENSION, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0180	CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0190	CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE CERVICAL BARS (SOMI, GUILFORD, TAYLOR TYPES)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0200	CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE CERVICAL BARS, AND THORACIC EXTENSION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0220	THORACIC, RIB BELT, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0450	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, UPPER THORACIC REGION, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L0452	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, UPPER THORACIC REGION, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0454	TLSO FLEXIBLE, PROVIDES TRUNK SUPPORT, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO ABOVE T-9 VERTEBRA, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S),	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0456	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, THORACIC REGION, RIGID POSTERIOR PANEL AND SOFT ANTERIOR APRON, EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUC	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0458	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, TWO RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE XIPHOID, SOFT LINER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0460	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, TWO RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE STERNAL NOTCH, SOFT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0462	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, THREE RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE STERNAL NOTCH, SO	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0464	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, FOUR RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO THE STERNAL NOTCH, SOFT LINER, RES	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0466	TLSO, SAGITTAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, PREFABRICATED ITEM TH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0470	TLSO, TRIPLANAR CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO SCAPULA, LATERAL STRENGTH PROVIDED BY PELVIC, THORACIC, AND LATERAL FRAME PIECES, ROTATIONAL STRENGT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0472	TLSO, TRIPLANAR CONTROL, HYPEREXTENSION, RIGID ANTERIOR AND LATERAL FRAME EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH WITH TWO ANTERIOR COMPONENTS (ONE PUBIC AND ONE STERNAL), POSTERIOR AND LATERAL PADS WITH STRAPS AND CLOSURES, LIMITS SPINAL FLEXION, R	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0480	TLSO, TRIPLANAR CONTROL, ONE PIECE RIGID PLASTIC SHELL WITHOUT INTERFACE LINER, WITH MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0482	TLSO, TRIPLANAR CONTROL, ONE PIECE RIGID PLASTIC SHELL WITH INTERFACE LINER, MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTC	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0484	TLSO, TRIPLANAR CONTROL, TWO PIECE RIGID PLASTIC SHELL WITHOUT INTERFACE LINER, WITH MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L0486	TLSO, TRIPLANAR CONTROL, TWO PIECE RIGID PLASTIC SHELL WITH INTERFACE LINER, MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTC	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0488	TLSO, TRIPLANAR CONTROL, ONE PIECE RIGID PLASTIC SHELL WITH INTERFACE LINER, MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTC	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0490	TLSO, SAGITTAL-CORONAL CONTROL, ONE PIECE RIGID PLASTIC SHELL, WITH OVERLAPPING REINFORCED ANTERIOR, WITH MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES AT OR BEFORE THE T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMP	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0491	TLSO, SAGITTAL-CORONAL CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, TWO RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE XIPHOID, SOF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0492	TLSO, SAGITTAL-CORONAL CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, THREE RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE XIPHOID, S	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0621	SACROILIAC ORTHOSIS, FLEXIBLE, PROVIDES PELVIC-SACRAL SUPPORT, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0622	SACROILIAC ORTHOSIS, FLEXIBLE, PROVIDES PELVIC-SACRAL SUPPORT, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0623	SACROILIAC ORTHOSIS, PROVIDES PELVIC-SACRAL SUPPORT, WITH RIGID OR SEMI-RIGID PANELS OVER THE SACRUM AND ABDOMEN, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0624	SACROILIAC ORTHOSIS, PROVIDES PELVIC-SACRAL SUPPORT, WITH RIGID OR SEMI-RIGID PANELS PLACED OVER THE SACRUM AND ABDOMEN, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0625	LUMBAR ORTHOSIS, FLEXIBLE, PROVIDES LUMBAR SUPPORT, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, SHOULDER STR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0626	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0627	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOU	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0628	LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVIDES LUMBO-SACRAL SUPPORT, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE STAYS, SHOU	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L0629	LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVIDES LUMBO-SACRAL SUPPORT, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE STAYS, SHOU	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0630	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0631	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0632	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0633	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0634	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANEL(S), PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOA	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0635	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, LUMBAR FLEXION, RIGID POSTERIOR FRAME/PANEL(S), LATERAL ARTICULATING DESIGN TO FLEX THE LUMBAR SPINE, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0636	LUMBAR SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, LUMBAR FLEXION, RIGID POSTERIOR FRAME/PANELS, LATERAL ARTICULATING DESIGN TO FLEX THE LUMBAR SPINE, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERA	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0637	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO R	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0638	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO R	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0639	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0640	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L0700	CERVICAL-THORACIC-LUMBAR-SACRAL-ORTHOSES (CTLSO), ANTERIOR-POSTERIOR-LATERAL CONTROL, MOLDED TO PATIENT MODEL, (MINERVA TYPE)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0710	CTLSO, ANTERIOR-POSTERIOR-LATERAL-CONTROL, MOLDED TO PATIENT MODEL, WITH INTERFACE MATERIAL, (MINERVA TYPE)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0720	CERVICAL-THORACIC-LUMBAR-SACRAL-ORTHOSES (CTLSO), ANTERIOR-POSTERIOR-LATERAL CONTROL, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	Preauthorization required when purchase price exceeds $500 per line item	6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	
L0810	HALO PROCEDURE, CERVICAL HALO INCORPORATED INTO JACKET VEST	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0820	HALO PROCEDURE, CERVICAL HALO INCORPORATED INTO PLASTER BODY JACKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0830	HALO PROCEDURE, CERVICAL HALO INCORPORATED INTO MILWAUKEE TYPE ORTHOSIS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0859	ADDITION TO HALO PROCEDURE, MAGNETIC RESONANCE IMAGE COMPATIBLE SYSTEMS, RINGS AND PINS, ANY MATERIAL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0861	ADDITION TO HALO PROCEDURE, REPLACEMENT LINER/INTERFACE MATERIAL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0970	TLSO, CORSET FRONT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0972	LSO, CORSET FRONT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0974	TLSO, FULL CORSET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0976	LSO, FULL CORSET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0978	AXILLARY CRUTCH EXTENSION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0980	PERONEAL STRAPS, PREFABRICATED, OFF-THE-SHELF, PAIR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0982	STOCKING SUPPORTER GRIPS, PREFABRICATED, OFF-THE-SHELF, SET OF FOUR (4)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L0984	PROTECTIVE BODY SOCK, PREFABRICATED, OFF-THE-SHELF, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L0999	ADDITION TO SPINAL ORTHOSIS, NOT OTHERWISE SPECIFIED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1000	CERVICAL-THORACIC-LUMBAR-SACRAL ORTHOSIS (CTLSO) (MILWAUKEE), INCLUSIVE OF FURNISHING INITIAL ORTHOSIS, INCLUDING MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1001	CERVICAL THORACIC LUMBAR SACRAL ORTHOSIS, IMMOBILIZER, INFANT SIZE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1005	TENSION BASED SCOLIOSIS ORTHOSIS AND ACCESSORY PADS, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1006	SCOLIOSIS ORTHOSIS, SAGITTAL-CORONAL CONTROL PROVIDED BY A RIGID LATERAL FRAME, EXTENDS FROM AXILLA TO TROCHANTER, INCLUDES ALL ACCESSORY PADS, STRAPS AND INTERFACE, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZE	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
L1010	ADDITION TO CERVICAL-THORACIC-LUMBAR-SACRAL ORTHOSIS (CTLSO) OR SCOLIOSIS ORTHOSIS, AXILLA SLING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1020	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, KYPHOSIS PAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1025	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, KYPHOSIS PAD, FLOATING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1030	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, LUMBAR BOLSTER PAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1040	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, LUMBAR OR LUMBAR RIB PAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1050	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, STERNAL PAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1060	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, THORACIC PAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1070	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, TRAPEZIUS SLING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1080	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, OUTRIGGER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L1085	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, OUTRIGGER, BILATERAL WITH VERTICAL EXTENSIONS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1090	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, LUMBAR SLING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1100	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, RING FLANGE, PLASTIC OR LEATHER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1110	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, RING FLANGE, PLASTIC OR LEATHER, MOLDED TO PATIENT MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1120	ADDITION TO CTLSO, SCOLIOSIS ORTHOSIS, COVER FOR UPRIGHT, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1200	THORACIC-LUMBAR-SACRAL-ORTHOSIS (TLSO), INCLUSIVE OF FURNISHING INITIAL ORTHOSIS ONLY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1210	ADDITION TO TLSO, (LOW PROFILE), LATERAL THORACIC EXTENSION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1220	ADDITION TO TLSO, (LOW PROFILE), ANTERIOR THORACIC EXTENSION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1230	ADDITION TO TLSO, (LOW PROFILE), MILWAUKEE TYPE SUPERSTRUCTURE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1240	ADDITION TO TLSO, (LOW PROFILE), LUMBAR DEROTATION PAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1250	ADDITION TO TLSO, (LOW PROFILE), ANTERIOR ASIS PAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1260	ADDITION TO TLSO, (LOW PROFILE), ANTERIOR THORACIC DEROTATION PAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1270	ADDITION TO TLSO, (LOW PROFILE), ABDOMINAL PAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1280	ADDITION TO TLSO, (LOW PROFILE), RIB GUSSET (ELASTIC), EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1290	ADDITION TO TLSO, (LOW PROFILE), LATERAL TROCHANTERIC PAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L1300	OTHER SCOLIOSIS PROCEDURE, BODY JACKET MOLDED TO PATIENT MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1310	OTHER SCOLIOSIS PROCEDURE, POST-OPERATIVE BODY JACKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1320	THORACIC, PECTUS CARINATUM ORTHOSIS, STERNAL COMPRESSION, RIGID CIRCUMFERENTIAL FRAME WITH ANTERIOR AND POSTERIOR RIGID PADS, CUSTOM FABRICATED	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
L1499	SPINAL ORTHOSIS, NOT OTHERWISE SPECIFIED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1600	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, FREJKA TYPE WITH COVER, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INIDIVIDUAL WITH EXPERTISE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1610	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, (FREJKA COVER ONLY), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1620	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, (PAVLIK HARNESS), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1630	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, SEMI-FLEXIBLE (VON ROSEN TYPE), CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1640	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, STATIC, PELVIC BAND OR SPREADER BAR, THIGH CUFFS, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1650	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, STATIC, ADJUSTABLE, (ILFLED TYPE), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1652	HIP ORTHOSIS, BILATERAL THIGH CUFFS WITH ADJUSTABLE ABDUCTOR SPREADER BAR, ADULT SIZE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1653	HIP ORTHOSIS, BILATERAL THIGH CUFFS WITH ADJUSTABLE ABDUCTOR SPREADER BAR, ADULT SIZE, PREFABRICATED, OFF THE SHELF	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
L1660	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, STATIC, PLASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1680	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, DYNAMIC, PELVIC CONTROL, ADJUSTABLE HIP MOTION CONTROL, THIGH CUFFS (RANCHO HIP ACTION TYPE), CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1685	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINT, POSTOPERATIVE HIP ABDUCTION TYPE, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L1686	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINT, POSTOPERATIVE HIP ABDUCTION TYPE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1690	COMBINATION, BILATERAL, LUMBO-SACRAL, HIP, FEMUR ORTHOSIS PROVIDING ADDUCTION AND INTERNAL ROTATION CONTROL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1700	LEGG PERTHES ORTHOSIS, (TORONTO TYPE), CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1710	LEGG PERTHES ORTHOSIS, (NEWINGTON TYPE), CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1720	LEGG PERTHES ORTHOSIS, TRILATERAL, (TACHDIJAN TYPE), CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1730	LEGG PERTHES ORTHOSIS, (SCOTTISH RITE TYPE), CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1755	LEGG PERTHES ORTHOSIS, (PATTEN BOTTOM TYPE), CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1820	KNEE ORTHOSIS, ELASTIC WITH CONDYLAR PADS AND JOINTS, WITH OR WITHOUT PATELLAR CONTROL, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1821	KNEE ORTHOSIS, ELASTIC WITH CONDYLAR PADS AND JOINTS, WITH OR WITHOUT PATELLAR CONTROL, PREFABRICATED, OFF THE SHELF	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
L1830	KNEE ORTHOSIS, IMMOBILIZER, CANVAS LONGITUDINAL, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1831	KNEE ORTHOSIS, LOCKING KNEE JOINT(S), POSITIONAL ORTHOSIS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1834	KNEE ORTHOSIS, WITHOUT KNEE JOINT, RIGID, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1836	KNEE ORTHOSIS, RIGID, WITHOUT JOINT(S), INCLUDES SOFT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L1840	KNEE ORTHOSIS, DEROTATION, MEDIAL-LATERAL, ANTERIOR CRUCIATE LIGAMENT, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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, A	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1844	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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, A	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1846	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1850	KNEE ORTHOSIS, SWEDISH TYPE, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1860	KNEE ORTHOSIS, MODIFICATION OF SUPRACONDYLAR PROSTHETIC SOCKET, CUSTOM FABRICATED (SK)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1900	ANKLE FOOT ORTHOSIS, SPRING WIRE, DORSIFLEXION ASSIST CALF BAND, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1902	ANKLE ORTHOSIS, ANKLE GAUNTLET OR SIMILAR, WITH OR WITHOUT JOINTS, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1904	ANKLE ORTHOSIS, ANKLE GAUNTLET OR SIMILAR, WITH OR WITHOUT JOINTS, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1906	ANKLE FOOT ORTHOSIS, MULTILIGAMENTOUS ANKLE SUPPORT, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1907	ANKLE ORTHOSIS, SUPRAMALLEOLAR WITH STRAPS, WITH OR WITHOUT INTERFACE/PADS, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1910	ANKLE FOOT ORTHOSIS, POSTERIOR, SINGLE BAR, CLASP ATTACHMENT TO SHOE COUNTER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L1920	ANKLE FOOT ORTHOSIS, SINGLE UPRIGHT WITH STATIC OR ADJUSTABLE STOP (PHELPS OR PERLSTEIN TYPE), CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1930	ANKLE FOOT ORTHOSIS, PLASTIC OR OTHER MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1932	AFO, RIGID ANTERIOR TIBIAL SECTION, TOTAL CARBON FIBER OR EQUAL MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1933	ANKLE FOOT ORTHOSIS, RIGID ANTERIOR TIBIAL SECTION, TOTAL CARBON FIBER OR EQUAL MATERIAL, PREFABRICATED, OFF-THE-SHELF	Preauthorization required when purchase price exceeds $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
L1940	ANKLE FOOT ORTHOSIS, PLASTIC OR OTHER MATERIAL, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1945	ANKLE FOOT ORTHOSIS, PLASTIC, RIGID ANTERIOR TIBIAL SECTION (FLOOR REACTION), CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1950	ANKLE FOOT ORTHOSIS, SPIRAL, (INSTITUTE OF REHABILITATIVE MEDICINE TYPE), PLASTIC, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1951	ANKLE FOOT ORTHOSIS, SPIRAL, (INSTITUTE OF REHABILITATIVE MEDICINE TYPE), PLASTIC OR OTHER MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1952	ANKLE FOOT ORTHOSIS, SPIRAL, (INSTITUTE OF REHABILITATIVE MEDICINE TYPE), PLASTIC OR OTHER MATERIAL, PREFABRICATED, OFF-THE-SHELF	Preauthorization required when purchase price exceeds $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
L1960	ANKLE FOOT ORTHOSIS, POSTERIOR SOLID ANKLE, PLASTIC, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1970	ANKLE FOOT ORTHOSIS, PLASTIC WITH ANKLE JOINT, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1971	ANKLE FOOT ORTHOSIS, PLASTIC OR OTHER MATERIAL WITH ANKLE JOINT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1980	ANKLE FOOT ORTHOSIS, SINGLE UPRIGHT FREE PLANTAR DORSIFLEXION, SOLID STIRRUP, CALF BAND/CUFF (SINGLE BAR 'BK' ORTHOSIS), CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L1990	ANKLE FOOT ORTHOSIS, DOUBLE UPRIGHT FREE PLANTAR DORSIFLEXION, SOLID STIRRUP, CALF BAND/CUFF (DOUBLE BAR 'BK' ORTHOSIS), CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2000	KNEE ANKLE FOOT ORTHOSIS, SINGLE UPRIGHT, FREE KNEE, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS (SINGLE BAR 'AK' ORTHOSIS), CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L2005	KNEE ANKLE FOOT ORTHOSIS, ANY MATERIAL, SINGLE OR DOUBLE UPRIGHT, STANCE CONTROL, AUTOMATIC LOCK AND SWING PHASE RELEASE, ANY TYPE ACTIVATION, INCLUDES ANKLE JOINT, ANY TYPE, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2010	KNEE ANKLE FOOT ORTHOSIS, SINGLE UPRIGHT, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS (SINGLE BAR 'AK' ORTHOSIS), WITHOUT KNEE JOINT, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2020	KNEE ANKLE FOOT ORTHOSIS, DOUBLE UPRIGHT, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS (DOUBLE BAR 'AK' ORTHOSIS), CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2030	KNEE ANKLE FOOT ORTHOSIS, DOUBLE UPRIGHT, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS, (DOUBLE BAR 'AK' ORTHOSIS), WITHOUT KNEE JOINT, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2034	KNEE ANKLE FOOT ORTHOSIS, FULL PLASTIC, SINGLE UPRIGHT, WITH OR WITHOUT FREE MOTION KNEE, MEDIAL LATERAL ROTATION CONTROL, WITH OR WITHOUT FREE MOTION ANKLE, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2035	KNEE ANKLE FOOT ORTHOSIS, FULL PLASTIC, STATIC (PEDIATRIC SIZE), WITHOUT FREE MOTION ANKLE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2036	KNEE ANKLE FOOT ORTHOSIS, FULL PLASTIC, DOUBLE UPRIGHT, WITH OR WITHOUT FREE MOTION KNEE, WITH OR WITHOUT FREE MOTION ANKLE, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2037	KNEE ANKLE FOOT ORTHOSIS, FULL PLASTIC, SINGLE UPRIGHT, WITH OR WITHOUT FREE MOTION KNEE, WITH OR WITHOUT FREE MOTION ANKLE, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2038	KNEE ANKLE FOOT ORTHOSIS, FULL PLASTIC, WITH OR WITHOUT FREE MOTION KNEE, MULTI-AXIS ANKLE, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2040	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CONTROL, BILATERAL ROTATION STRAPS, PELVIC BAND/BELT, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2050	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CONTROL, BILATERAL TORSION CABLES, HIP JOINT, PELVIC BAND/BELT, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2060	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CONTROL, BILATERAL TORSION CABLES, BALL BEARING HIP JOINT, PELVIC BAND/ BELT, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2070	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CONTROL, UNILATERAL ROTATION STRAPS, PELVIC BAND/BELT, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2080	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CONTROL, UNILATERAL TORSION CABLE, HIP JOINT, PELVIC BAND/BELT, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2090	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CONTROL, UNILATERAL TORSION CABLE, BALL BEARING HIP JOINT, PELVIC BAND/ BELT, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L2106	ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, THERMOPLASTIC TYPE CASTING MATERIAL, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2108	ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2112	ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, TIBIAL FRACTURE ORTHOSIS, SOFT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2114	ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, TIBIAL FRACTURE ORTHOSIS, SEMI-RIGID, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2116	ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, TIBIAL FRACTURE ORTHOSIS, RIGID, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2126	KNEE ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, THERMOPLASTIC TYPE CASTING MATERIAL, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2128	KNEE ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2132	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SOFT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2134	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SEMI-RIGID, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2136	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, RIGID, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2180	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, PLASTIC SHOE INSERT WITH ANKLE JOINTS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2182	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, DROP LOCK KNEE JOINT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2184	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, LIMITED MOTION KNEE JOINT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2186	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, ADJUSTABLE MOTION KNEE JOINT, LERMAN TYPE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2188	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, QUADRILATERAL BRIM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L2190	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, WAIST BELT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2192	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, HIP JOINT, PELVIC BAND, THIGH FLANGE, AND PELVIC BELT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2200	ADDITION TO LOWER EXTREMITY, LIMITED ANKLE MOTION, EACH JOINT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2210	ADDITION TO LOWER EXTREMITY, DORSIFLEXION ASSIST (PLANTAR FLEXION RESIST), EACH JOINT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2220	ADDITION TO LOWER EXTREMITY, DORSIFLEXION AND PLANTAR FLEXION ASSIST/RESIST, EACH JOINT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2230	ADDITION TO LOWER EXTREMITY, SPLIT FLAT CALIPER STIRRUPS AND PLATE ATTACHMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2232	ADDITION TO LOWER EXTREMITY ORTHOSIS, ROCKER BOTTOM FOR TOTAL CONTACT ANKLE FOOT ORTHOSIS, FOR CUSTOM FABRICATED ORTHOSIS ONLY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2240	ADDITION TO LOWER EXTREMITY, ROUND CALIPER AND PLATE ATTACHMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2250	ADDITION TO LOWER EXTREMITY, FOOT PLATE, MOLDED TO PATIENT MODEL, STIRRUP ATTACHMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2260	ADDITION TO LOWER EXTREMITY, REINFORCED SOLID STIRRUP (SCOTT-CRAIG TYPE)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2265	ADDITION TO LOWER EXTREMITY, LONG TONGUE STIRRUP	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2270	ADDITION TO LOWER EXTREMITY, VARUS/VALGUS CORRECTION ('T') STRAP, PADDED/LINED OR MALLEOLUS PAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2275	ADDITION TO LOWER EXTREMITY, VARUS/VALGUS CORRECTION, PLASTIC MODIFICATION, PADDED/LINED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2280	ADDITION TO LOWER EXTREMITY, MOLDED INNER BOOT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2300	ADDITION TO LOWER EXTREMITY, ABDUCTION BAR (BILATERAL HIP INVOLVEMENT), JOINTED, ADJUSTABLE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L2310	ADDITION TO LOWER EXTREMITY, ABDUCTION BAR-STRAIGHT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2320	ADDITION TO LOWER EXTREMITY, NON-MOLDED LACER, FOR CUSTOM FABRICATED ORTHOSIS ONLY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2330	ADDITION TO LOWER EXTREMITY, LACER MOLDED TO PATIENT MODEL, FOR CUSTOM FABRICATED ORTHOSIS ONLY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2335	ADDITION TO LOWER EXTREMITY, ANTERIOR SWING BAND	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2340	ADDITION TO LOWER EXTREMITY, PRE-TIBIAL SHELL, MOLDED TO PATIENT MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2350	ADDITION TO LOWER EXTREMITY, PROSTHETIC TYPE, (BK) SOCKET, MOLDED TO PATIENT MODEL, (USED FOR 'PTB' 'AFO' ORTHOSES)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2360	ADDITION TO LOWER EXTREMITY, EXTENDED STEEL SHANK	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2370	ADDITION TO LOWER EXTREMITY, PATTEN BOTTOM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2375	ADDITION TO LOWER EXTREMITY, TORSION CONTROL, ANKLE JOINT AND HALF SOLID STIRRUP	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2380	ADDITION TO LOWER EXTREMITY, TORSION CONTROL, STRAIGHT KNEE JOINT, EACH JOINT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2385	ADDITION TO LOWER EXTREMITY, STRAIGHT KNEE JOINT, HEAVY DUTY, EACH JOINT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2387	ADDITION TO LOWER EXTREMITY, POLYCENTRIC KNEE JOINT, FOR CUSTOM FABRICATED KNEE ANKLE FOOT ORTHOSIS, EACH JOINT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2390	ADDITION TO LOWER EXTREMITY, OFFSET KNEE JOINT, EACH JOINT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2395	ADDITION TO LOWER EXTREMITY, OFFSET KNEE JOINT, HEAVY DUTY, EACH JOINT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2397	ADDITION TO LOWER EXTREMITY ORTHOSIS, SUSPENSION SLEEVE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L2405	ADDITION TO KNEE JOINT, DROP LOCK, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2415	ADDITION TO KNEE LOCK WITH INTEGRATED RELEASE MECHANISM (BAIL, CABLE, OR EQUAL), ANY MATERIAL, EACH JOINT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2425	ADDITION TO KNEE JOINT, DISC OR DIAL LOCK FOR ADJUSTABLE KNEE FLEXION, EACH JOINT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2430	ADDITION TO KNEE JOINT, RATCHET LOCK FOR ACTIVE AND PROGRESSIVE KNEE EXTENSION, EACH JOINT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2492	ADDITION TO KNEE JOINT, LIFT LOOP FOR DROP LOCK RING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2500	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, GLUTEAL/ ISCHIAL WEIGHT BEARING, RING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2510	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, QUADRI- LATERAL BRIM, MOLDED TO PATIENT MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2520	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, QUADRI- LATERAL BRIM, CUSTOM FITTED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2525	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, ISCHIAL CONTAINMENT/NARROW M-L BRIM MOLDED TO PATIENT MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2526	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, ISCHIAL CONTAINMENT/NARROW M-L BRIM, CUSTOM FITTED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2530	ADDITION TO LOWER EXTREMITY, THIGH-WEIGHT BEARING, LACER, NON-MOLDED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2540	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, LACER, MOLDED TO PATIENT MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2550	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, HIGH ROLL CUFF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2570	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, CLEVIS TYPE TWO POSITION JOINT, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2580	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, PELVIC SLING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L2600	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, CLEVIS TYPE, OR THRUST BEARING, FREE, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2610	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, CLEVIS OR THRUST BEARING, LOCK, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2620	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, HEAVY DUTY, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2622	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, ADJUSTABLE FLEXION, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2624	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, ADJUSTABLE FLEXION, EXTENSION, ABDUCTION CONTROL, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2627	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, PLASTIC, MOLDED TO PATIENT MODEL, RECIPROCATING HIP JOINT AND CABLES	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2628	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, METAL FRAME, RECIPROCATING HIP JOINT AND CABLES	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2630	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, BAND AND BELT, UNILATERAL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2640	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, BAND AND BELT, BILATERAL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2650	ADDITION TO LOWER EXTREMITY, PELVIC AND THORACIC CONTROL, GLUTEAL PAD, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2660	ADDITION TO LOWER EXTREMITY, THORACIC CONTROL, THORACIC BAND	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2670	ADDITION TO LOWER EXTREMITY, THORACIC CONTROL, PARASPINAL UPRIGHTS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2680	ADDITION TO LOWER EXTREMITY, THORACIC CONTROL, LATERAL SUPPORT UPRIGHTS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2750	ADDITION TO LOWER EXTREMITY ORTHOSIS, PLATING CHROME OR NICKEL, PER BAR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2755	ADDITION TO LOWER EXTREMITY ORTHOSIS, HIGH STRENGTH, LIGHTWEIGHT MATERIAL, ALL HYBRID LAMINATION/PREPREG COMPOSITE, PER SEGMENT, FOR CUSTOM FABRICATED ORTHOSIS ONLY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L2760	ADDITION TO LOWER EXTREMITY ORTHOSIS, EXTENSION, PER EXTENSION, PER BAR (FOR LINEAL ADJUSTMENT FOR GROWTH)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2768	ORTHOTIC SIDE BAR DISCONNECT DEVICE, PER BAR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2780	ADDITION TO LOWER EXTREMITY ORTHOSIS, NON-CORROSIVE FINISH, PER BAR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2785	ADDITION TO LOWER EXTREMITY ORTHOSIS, DROP LOCK RETAINER, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2795	ADDITION TO LOWER EXTREMITY ORTHOSIS, KNEE CONTROL, FULL KNEECAP	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2800	ADDITION TO LOWER EXTREMITY ORTHOSIS, KNEE CONTROL, KNEE CAP, MEDIAL OR LATERAL PULL, FOR USE WITH CUSTOM FABRICATED ORTHOSIS ONLY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2810	ADDITION TO LOWER EXTREMITY ORTHOSIS, KNEE CONTROL, CONDYLAR PAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2820	ADDITION TO LOWER EXTREMITY ORTHOSIS, SOFT INTERFACE FOR MOLDED PLASTIC, BELOW KNEE SECTION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2830	ADDITION TO LOWER EXTREMITY ORTHOSIS, SOFT INTERFACE FOR MOLDED PLASTIC, ABOVE KNEE SECTION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2840	ADDITION TO LOWER EXTREMITY ORTHOSIS, TIBIAL LENGTH SOCK, FRACTURE OR EQUAL, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2850	ADDITION TO LOWER EXTREMITY ORTHOSIS, FEMORAL LENGTH SOCK, FRACTURE OR EQUAL, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L2861	ADDITION TO LOWER EXTREMITY JOINT, KNEE OR ANKLE, CONCENTRIC ADJUSTABLE TORSION STYLE MECHANISM FOR CUSTOM FABRICATED ORTHOTICS ONLY, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3000	FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, 'UCB' TYPE, BERKELEY SHELL, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3001	FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, SPENCO, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3002	FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, PLASTAZOTE OR EQUAL, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L3003	FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, SILICONE GEL, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3010	FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, LONGITUDINAL ARCH SUPPORT, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3020	FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, LONGITUDINAL/ METATARSAL SUPPORT, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3030	FOOT, INSERT, REMOVABLE, FORMED TO PATIENT FOOT, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3031	FOOT, INSERT/PLATE, REMOVABLE, ADDITION TO LOWER EXTREMITY ORTHOSIS, HIGH STRENGTH, LIGHTWEIGHT MATERIAL, ALL HYBRID LAMINATION/PREPREG COMPOSITE, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3040	FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED, LONGITUDINAL, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3050	FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED, METATARSAL, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3060	FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED, LONGITUDINAL/ METATARSAL, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3070	FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACHED TO SHOE, LONGITUDINAL, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3080	FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACHED TO SHOE, METATARSAL, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3090	FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACHED TO SHOE, LONGITUDINAL/METATARSAL, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3100	HALLUS-VALGUS NIGHT DYNAMIC SPLINT, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3140	FOOT, ABDUCTION ROTATION BAR, INCLUDING SHOES	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3150	FOOT, ABDUCTION ROTATION BAR, WITHOUT SHOES	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3160	FOOT, ADJUSTABLE SHOE-STYLED POSITIONING DEVICE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L3161	FOOT, ADDUCTUS POSITIONING DEVICE, ADJUSTABLE	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
L3170	FOOT, PLASTIC, SILICONE OR EQUAL, HEEL STABILIZER, PREFABRICATED, OFF-THE-SHELF, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3201	ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR OR PRONATOR, INFANT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3202	ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR OR PRONATOR, CHILD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3203	ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR OR PRONATOR, JUNIOR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3204	ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR OR PRONATOR, INFANT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3206	ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR OR PRONATOR, CHILD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3207	ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR OR PRONATOR, JUNIOR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3208	SURGICAL BOOT, EACH, INFANT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3209	SURGICAL BOOT, EACH, CHILD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3211	SURGICAL BOOT, EACH, JUNIOR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3212	BENESCH BOOT, PAIR, INFANT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3213	BENESCH BOOT, PAIR, CHILD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3214	BENESCH BOOT, PAIR, JUNIOR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3215	ORTHOPEDIC FOOTWEAR, LADIES SHOE, OXFORD, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L3216	ORTHOPEDIC FOOTWEAR, LADIES SHOE, DEPTH INLAY, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3217	ORTHOPEDIC FOOTWEAR, LADIES SHOE, HIGHTOP, DEPTH INLAY, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3219	ORTHOPEDIC FOOTWEAR, MENS SHOE, OXFORD, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3221	ORTHOPEDIC FOOTWEAR, MENS SHOE, DEPTH INLAY, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3222	ORTHOPEDIC FOOTWEAR, MENS SHOE, HIGHTOP, DEPTH INLAY, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3224	ORTHOPEDIC FOOTWEAR, WOMAN'S SHOE, OXFORD, USED AS AN INTEGRAL PART OF A BRACE (ORTHOSIS)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3225	ORTHOPEDIC FOOTWEAR, MAN'S SHOE, OXFORD, USED AS AN INTEGRAL PART OF A BRACE (ORTHOSIS)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3230	ORTHOPEDIC FOOTWEAR, CUSTOM SHOE, DEPTH INLAY, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3250	ORTHOPEDIC FOOTWEAR, CUSTOM MOLDED SHOE, REMOVABLE INNER MOLD, PROSTHETIC SHOE, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3251	FOOT, SHOE MOLDED TO PATIENT MODEL, SILICONE SHOE, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3252	FOOT, SHOE MOLDED TO PATIENT MODEL, PLASTAZOTE (OR SIMILAR), CUSTOM FABRICATED, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3253	FOOT, MOLDED SHOE PLASTAZOTE (OR SIMILAR) CUSTOM FITTED, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3254	NON-STANDARD SIZE OR WIDTH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3255	NON-STANDARD SIZE OR LENGTH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3257	ORTHOPEDIC FOOTWEAR, ADDITIONAL CHARGE FOR SPLIT SIZE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L3260	SURGICAL BOOT/SHOE, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3265	PLASTAZOTE SANDAL, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3300	LIFT, ELEVATION, HEEL, TAPERED TO METATARSALS, PER INCH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3310	LIFT, ELEVATION, HEEL AND SOLE, NEOPRENE, PER INCH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3320	LIFT, ELEVATION, HEEL AND SOLE, CORK, PER INCH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3330	LIFT, ELEVATION, METAL EXTENSION (SKATE)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3332	LIFT, ELEVATION, INSIDE SHOE, TAPERED, UP TO ONE-HALF INCH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3334	LIFT, ELEVATION, HEEL, PER INCH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3340	HEEL WEDGE, SACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3350	HEEL WEDGE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3360	SOLE WEDGE, OUTSIDE SOLE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3370	SOLE WEDGE, BETWEEN SOLE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3380	CLUBFOOT WEDGE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3390	OUTFLARE WEDGE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3400	METATARSAL BAR WEDGE, ROCKER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L3410	METATARSAL BAR WEDGE, BETWEEN SOLE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3420	FULL SOLE AND HEEL WEDGE, BETWEEN SOLE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3430	HEEL, COUNTER, PLASTIC REINFORCED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3440	HEEL, COUNTER, LEATHER REINFORCED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3450	HEEL, SACH CUSHION TYPE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3455	HEEL, NEW LEATHER, STANDARD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3460	HEEL, NEW RUBBER, STANDARD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3465	HEEL, THOMAS WITH WEDGE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3470	HEEL, THOMAS EXTENDED TO BALL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3480	HEEL, PAD AND DEPRESSION FOR SPUR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3485	HEEL, PAD, REMOVABLE FOR SPUR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3500	ORTHOPEDIC SHOE ADDITION, INSOLE, LEATHER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3510	ORTHOPEDIC SHOE ADDITION, INSOLE, RUBBER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3520	ORTHOPEDIC SHOE ADDITION, INSOLE, FELT COVERED WITH LEATHER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3530	ORTHOPEDIC SHOE ADDITION, SOLE, HALF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L3540	ORTHOPEDIC SHOE ADDITION, SOLE, FULL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3550	ORTHOPEDIC SHOE ADDITION, TOE TAP STANDARD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3560	ORTHOPEDIC SHOE ADDITION, TOE TAP, HORSESHOE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3570	ORTHOPEDIC SHOE ADDITION, SPECIAL EXTENSION TO INSTEP (LEATHER WITH EYELETS)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3580	ORTHOPEDIC SHOE ADDITION, CONVERT INSTEP TO VELCRO CLOSURE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3590	ORTHOPEDIC SHOE ADDITION, CONVERT FIRM SHOE COUNTER TO SOFT COUNTER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3595	ORTHOPEDIC SHOE ADDITION, MARCH BAR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3600	TRANSFER OF AN ORTHOSIS FROM ONE SHOE TO ANOTHER, CALIPER PLATE, EXISTING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3610	TRANSFER OF AN ORTHOSIS FROM ONE SHOE TO ANOTHER, CALIPER PLATE, NEW	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3620	TRANSFER OF AN ORTHOSIS FROM ONE SHOE TO ANOTHER, SOLID STIRRUP, EXISTING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3630	TRANSFER OF AN ORTHOSIS FROM ONE SHOE TO ANOTHER, SOLID STIRRUP, NEW	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3640	TRANSFER OF AN ORTHOSIS FROM ONE SHOE TO ANOTHER, DENNIS BROWNE SPLINT (RIVETON), BOTH SHOES	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3649	ORTHOPEDIC SHOE, MODIFICATION, ADDITION OR TRANSFER, NOT OTHERWISE SPECIFIED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3650	SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIGN ABDUCTION RESTRAINER, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3660	SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIGN ABDUCTION RESTRAINER, CANVAS AND WEBBING, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L3670	SHOULDER ORTHOSIS, ACROMIO/CLAVICULAR (CANVAS AND WEBBING TYPE), PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3671	SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3674	SHOULDER ORTHOSIS, ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, WITH OR WITHOUT NONTORSION JOINT/TURNBUCKLE, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3675	SHOULDER ORTHOSIS, VEST TYPE ABDUCTION RESTRAINER, CANVAS WEBBING TYPE OR EQUAL, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3677	SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3702	ELBOW ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3710	ELBOW ORTHOSIS, ELASTIC WITH METAL JOINTS, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3720	ELBOW ORTHOSIS, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, FREE MOTION, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3730	ELBOW ORTHOSIS, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, EXTENSION/ FLEXION ASSIST, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3740	ELBOW ORTHOSIS, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, ADJUSTABLE POSITION LOCK WITH ACTIVE CONTROL, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3760	ELBOW ORTHOSIS (EO), WITH ADJUSTABLE POSITION LOCKING JOINT(S), PREFABRICATED, ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3762	ELBOW ORTHOSIS, RIGID, WITHOUT JOINTS, INCLUDES SOFT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3763	ELBOW WRIST HAND ORTHOSIS, RIGID, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3764	ELBOW WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINTS, ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3765	ELBOW WRIST HAND FINGER ORTHOSIS, RIGID, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L3766	ELBOW WRIST HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINTS, ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3806	WRIST HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3807	WRIST HAND FINGER ORTHOSIS, WITHOUT JOINT(S), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3808	WRIST HAND FINGER ORTHOSIS, RIGID WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE MATERIAL; STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3809	WRIST HAND FINGER ORTHOSIS, WITHOUT JOINT(S), PREFABRICATED, OFF-THE-SHELF, ANY TYPE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3891	ADDITION TO UPPER EXTREMITY JOINT, WRIST OR ELBOW, CONCENTRIC ADJUSTABLE TORSION STYLE MECHANISM FOR CUSTOM FABRICATED ORTHOTICS ONLY, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3900	WRIST HAND FINGER ORTHOSIS, DYNAMIC FLEXOR HINGE, RECIPROCAL WRIST EXTENSION/ FLEXION, FINGER FLEXION/EXTENSION, WRIST OR FINGER DRIVEN, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3901	WRIST HAND FINGER ORTHOSIS, DYNAMIC FLEXOR HINGE, RECIPROCAL WRIST EXTENSION/ FLEXION, FINGER FLEXION/EXTENSION, CABLE DRIVEN, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3904	WRIST HAND FINGER ORTHOSIS, EXTERNAL POWERED, ELECTRIC, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3905	WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINTS, ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3906	WRIST HAND ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3908	WRIST HAND ORTHOSIS, WRIST EXTENSION CONTROL COCK-UP, NON MOLDED, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3912	HAND FINGER ORTHOSIS (HFO), FLEXION GLOVE WITH ELASTIC FINGER CONTROL, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3913	HAND FINGER ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L3915	WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIV	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3917	HAND ORTHOSIS, METACARPAL FRACTURE ORTHOSIS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3919	HAND ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3921	HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINTS, ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3923	HAND FINGER ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3925	FINGER ORTHOSIS, PROXIMAL INTERPHALANGEAL (PIP)/DISTAL INTERPHALANGEAL (DIP), NON TORSION JOINT/SPRING, EXTENSION/FLEXION, MAY INCLUDE SOFT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3927	FINGER ORTHOSIS, PROXIMAL INTERPHALANGEAL (PIP)/DISTAL INTERPHALANGEAL (DIP), WITHOUT JOINT/SPRING, EXTENSION/FLEXION (E.G., STATIC OR RING TYPE), MAY INCLUDE SOFT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3929	HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC P	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3931	WRIST HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3933	FINGER ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3935	FINGER ORTHOSIS, NONTORSION JOINT, MAY INCLUDE SOFT INTERFACE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3956	ADDITION OF JOINT TO UPPER EXTREMITY ORTHOSIS, ANY MATERIAL; PER JOINT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3960	SHOULDER ELBOW WRIST HAND ORTHOSIS, ABDUCTION POSITIONING, AIRPLANE DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3961	SHOULDER ELBOW WRIST HAND ORTHOSIS, SHOULDER CAP DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L3962	SHOULDER ELBOW WRIST HAND ORTHOSIS, ABDUCTION POSITIONING, ERB'S PALSEY DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3967	SHOULDER ELBOW WRIST HAND ORTHOSIS, ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3971	SHOULDER ELBOW WRIST HAND ORTHOSIS, SHOULDER CAP DESIGN, INCLUDES ONE OR MORE NONTORSION JOINTS, ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3973	SHOULDER ELBOW WRIST HAND ORTHOSIS, ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, INCLUDES ONE OR MORE NONTORSION JOINTS, ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AN	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3975	SHOULDER ELBOW WRIST HAND FINGER ORTHOSIS, SHOULDER CAP DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3976	SHOULDER ELBOW WRIST HAND FINGER ORTHOSIS, ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3977	SHOULDER ELBOW WRIST HAND FINGER ORTHOSIS, SHOULDER CAP DESIGN, INCLUDES ONE OR MORE NONTORSION JOINTS, ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3978	SHOULDER ELBOW WRIST HAND FINGER ORTHOSIS, ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, INCLUDES ONE OR MORE NONTORSION JOINTS, ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FIT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3980	UPPER EXTREMITY FRACTURE ORTHOSIS, HUMERAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3982	UPPER EXTREMITY FRACTURE ORTHOSIS, RADIUS/ULNAR, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3984	UPPER EXTREMITY FRACTURE ORTHOSIS, WRIST, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3995	ADDITION TO UPPER EXTREMITY ORTHOSIS, SOCK, FRACTURE OR EQUAL, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L3999	UPPER LIMB ORTHOSIS, NOT OTHERWISE SPECIFIED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4000	REPLACE GIRDLE FOR SPINAL ORTHOSIS (CTLSO OR SO)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L4002	REPLACEMENT STRAP, ANY ORTHOSIS, INCLUDES ALL COMPONENTS, ANY LENGTH, ANY TYPE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4010	REPLACE TRILATERAL SOCKET BRIM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4020	REPLACE QUADRILATERAL SOCKET BRIM, MOLDED TO PATIENT MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4030	REPLACE QUADRILATERAL SOCKET BRIM, CUSTOM FITTED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4040	REPLACE MOLDED THIGH LACER, FOR CUSTOM FABRICATED ORTHOSIS ONLY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4045	REPLACE NON-MOLDED THIGH LACER, FOR CUSTOM FABRICATED ORTHOSIS ONLY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4050	REPLACE MOLDED CALF LACER, FOR CUSTOM FABRICATED ORTHOSIS ONLY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4055	REPLACE NON-MOLDED CALF LACER, FOR CUSTOM FABRICATED ORTHOSIS ONLY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4060	REPLACE HIGH ROLL CUFF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4070	REPLACE PROXIMAL AND DISTAL UPRIGHT FOR KAFO	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4080	REPLACE METAL BANDS KAFO, PROXIMAL THIGH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4090	REPLACE METAL BANDS KAFO-AFO, CALF OR DISTAL THIGH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4100	REPLACE LEATHER CUFF KAFO, PROXIMAL THIGH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4110	REPLACE LEATHER CUFF KAFO-AFO, CALF OR DISTAL THIGH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4130	REPLACE PRETIBIAL SHELL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L4205	REPAIR OF ORTHOTIC DEVICE, LABOR COMPONENT, PER 15 MINUTES	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4210	REPAIR OF ORTHOTIC DEVICE, REPAIR OR REPLACE MINOR PARTS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4350	ANKLE CONTROL ORTHOSIS, STIRRUP STYLE, RIGID, INCLUDES ANY TYPE INTERFACE (E.G., PNEUMATIC, GEL), PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4360	WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4361	WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4370	PNEUMATIC FULL LEG SPLINT, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4386	WALKING BOOT, NON-PNEUMATIC, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4392	REPLACEMENT, SOFT INTERFACE MATERIAL, STATIC AFO	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4394	REPLACE SOFT INTERFACE MATERIAL, FOOT DROP SPLINT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4396	STATIC OR DYNAMIC ANKLE FOOT ORTHOSIS, INCLUDING SOFT INTERFACE MATERIAL, ADJUSTABLE FOR FIT, FOR POSITIONING, MAY BE USED FOR MINIMAL AMBULATION, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4398	FOOT DROP SPLINT, RECUMBENT POSITIONING DEVICE, PREFABRICATED, OFF-THE-SHELF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L4631	ANKLE FOOT ORTHOSIS, WALKING BOOT TYPE, VARUS/VALGUS CORRECTION, ROCKER BOTTOM, ANTERIOR TIBIAL SHELL, SOFT INTERFACE, CUSTOM ARCH SUPPORT, PLASTIC OR OTHER MATERIAL, INCLUDES STRAPS AND CLOSURES, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5000	PARTIAL FOOT, SHOE INSERT WITH LONGITUDINAL ARCH, TOE FILLER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5010	PARTIAL FOOT, MOLDED SOCKET, ANKLE HEIGHT, WITH TOE FILLER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5020	PARTIAL FOOT, MOLDED SOCKET, TIBIAL TUBERCLE HEIGHT, WITH TOE FILLER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L5050	ANKLE, SYMES, MOLDED SOCKET, SACH FOOT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5060	ANKLE, SYMES, METAL FRAME, MOLDED LEATHER SOCKET, ARTICULATED ANKLE/FOOT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5100	BELOW KNEE, MOLDED SOCKET, SHIN, SACH FOOT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5105	BELOW KNEE, PLASTIC SOCKET, JOINTS AND THIGH LACER, SACH FOOT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5150	KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, EXTERNAL KNEE JOINTS, SHIN, SACH FOOT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5160	KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, BENT KNEE CONFIGURATION, EXTERNAL KNEE JOINTS, SHIN, SACH FOOT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5200	ABOVE KNEE, MOLDED SOCKET, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, SACH FOOT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5210	ABOVE KNEE, SHORT PROSTHESIS, NO KNEE JOINT ('STUBBIES'), WITH FOOT BLOCKS, NO ANKLE JOINTS, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5220	ABOVE KNEE, SHORT PROSTHESIS, NO KNEE JOINT ('STUBBIES'), WITH ARTICULATED ANKLE/FOOT, DYNAMICALLY ALIGNED, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5230	ABOVE KNEE, FOR PROXIMAL FEMORAL FOCAL DEFICIENCY, CONSTANT FRICTION KNEE, SHIN, SACH FOOT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5250	HIP DISARTICULATION, CANADIAN TYPE; MOLDED SOCKET, HIP JOINT, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, SACH FOOT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5270	HIP DISARTICULATION, TILT TABLE TYPE; MOLDED SOCKET, LOCKING HIP JOINT, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, SACH FOOT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5280	HEMIPELVECTOMY, CANADIAN TYPE; MOLDED SOCKET, HIP JOINT, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, SACH FOOT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5301	BELOW KNEE, MOLDED SOCKET, SHIN, SACH FOOT, ENDOSKELETAL SYSTEM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5312	KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, SINGLE AXIS KNEE, PYLON, SACH FOOT, ENDOSKELETAL SYSTEM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L5321	ABOVE KNEE, MOLDED SOCKET, OPEN END, SACH FOOT, ENDOSKELETAL SYSTEM, SINGLE AXIS KNEE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5331	HIP DISARTICULATION, CANADIAN TYPE, MOLDED SOCKET, ENDOSKELETAL SYSTEM, HIP JOINT, SINGLE AXIS KNEE, SACH FOOT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5341	HEMIPELVECTOMY, CANADIAN TYPE, MOLDED SOCKET, ENDOSKELETAL SYSTEM, HIP JOINT, SINGLE AXIS KNEE, SACH FOOT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5400	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING, ALIGNMENT, SUSPENSION, AND ONE CAST CHANGE, BELOW KNEE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5410	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING, ALIGNMENT AND SUSPENSION, BELOW KNEE, EACH ADDITIONAL CAST CHANGE AND REALIGNMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5420	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING, ALIGNMENT AND SUSPENSION AND ONE CAST CHANGE 'AK' OR KNEE DISARTICULATION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5430	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCL. FITTING, ALIGNMENT AND SUPENSION, 'AK' OR KNEE DISARTICULATION, EACH ADDITIONAL CAST CHANGE AND REALIGNMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5450	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF NON-WEIGHT BEARING RIGID DRESSING, BELOW KNEE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5460	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF NON-WEIGHT BEARING RIGID DRESSING, ABOVE KNEE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5500	INITIAL, BELOW KNEE 'PTB' TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, PLASTER SOCKET, DIRECT FORMED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5505	INITIAL, ABOVE KNEE - KNEE DISARTICULATION, ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, PLASTER SOCKET, DIRECT FORMED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5510	PREPARATORY, BELOW KNEE 'PTB' TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, PLASTER SOCKET, MOLDED TO MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5520	PREPARATORY, BELOW KNEE 'PTB' TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, THERMOPLASTIC OR EQUAL, DIRECT FORMED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5530	PREPARATORY, BELOW KNEE 'PTB' TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, THERMOPLASTIC OR EQUAL, MOLDED TO MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5535	PREPARATORY, BELOW KNEE 'PTB' TYPE SOCKET, NON-ALIGNABLE SYSTEM, NO COVER, SACH FOOT, PREFABRICATED, ADJUSTABLE OPEN END SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L5540	PREPARATORY, BELOW KNEE 'PTB' TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, LAMINATED SOCKET, MOLDED TO MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5560	PREPARATORY, ABOVE KNEE- KNEE DISARTICULATION, ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, PLASTER SOCKET, MOLDED TO MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5570	PREPARATORY, ABOVE KNEE - KNEE DISARTICULATION, ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, THERMOPLASTIC OR EQUAL, DIRECT FORMED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5580	PREPARATORY, ABOVE KNEE - KNEE DISARTICULATION ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, THERMOPLASTIC OR EQUAL, MOLDED TO MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5585	PREPARATORY, ABOVE KNEE - KNEE DISARTICULATION, ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, PREFABRICATED ADJUSTABLE OPEN END SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5590	PREPARATORY, ABOVE KNEE - KNEE DISARTICULATION ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYSTEM, PYLON NO COVER, SACH FOOT, LAMINATED SOCKET, MOLDED TO MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5595	PREPARATORY, HIP DISARTICULATION-HEMIPELVECTOMY, PYLON, NO COVER, SACH FOOT, THERMOPLASTIC OR EQUAL, MOLDED TO PATIENT MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5600	PREPARATORY, HIP DISARTICULATION-HEMIPELVECTOMY, PYLON, NO COVER, SACH FOOT, LAMINATED SOCKET, MOLDED TO PATIENT MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5610	ADDITION TO LOWER EXTREMITY, ENDOSKELETAL SYSTEM, ABOVE KNEE, HYDRACADENCE SYSTEM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5611	ADDITION TO LOWER EXTREMITY, ENDOSKELETAL SYSTEM, ABOVE KNEE - KNEE DISARTICULATION, 4 BAR LINKAGE, WITH FRICTION SWING PHASE CONTROL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5613	ADDITION TO LOWER EXTREMITY, ENDOSKELETAL SYSTEM, ABOVE KNEE-KNEE DISARTICULATION, 4 BAR LINKAGE, WITH HYDRAULIC SWING PHASE CONTROL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5614	ADDITION TO LOWER EXTREMITY, EXOSKELETAL SYSTEM, ABOVE KNEE-KNEE DISARTICULATION, 4 BAR LINKAGE, WITH PNEUMATIC SWING PHASE CONTROL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5615	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, 4 BAR LINKAGE OR MULTIAXIAL, FLUID SWING AND STANCE PHASE CONTROL	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
L5616	ADDITION TO LOWER EXTREMITY, ENDOSKELETAL SYSTEM, ABOVE KNEE, UNIVERSAL MULTIPLEX SYSTEM, FRICTION SWING PHASE CONTROL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5617	ADDITION TO LOWER EXTREMITY, QUICK CHANGE SELF-ALIGNING UNIT, ABOVE KNEE OR BELOW KNEE, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L5618	ADDITION TO LOWER EXTREMITY, TEST SOCKET, SYMES	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5620	ADDITION TO LOWER EXTREMITY, TEST SOCKET, BELOW KNEE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5622	ADDITION TO LOWER EXTREMITY, TEST SOCKET, KNEE DISARTICULATION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5624	ADDITION TO LOWER EXTREMITY, TEST SOCKET, ABOVE KNEE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5626	ADDITION TO LOWER EXTREMITY, TEST SOCKET, HIP DISARTICULATION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5628	ADDITION TO LOWER EXTREMITY, TEST SOCKET, HEMIPELVECTOMY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5629	ADDITION TO LOWER EXTREMITY, BELOW KNEE, ACRYLIC SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5630	ADDITION TO LOWER EXTREMITY, SYMES TYPE, EXPANDABLE WALL SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5631	ADDITION TO LOWER EXTREMITY, ABOVE KNEE OR KNEE DISARTICULATION, ACRYLIC SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5632	ADDITION TO LOWER EXTREMITY, SYMES TYPE, 'PTB' BRIM DESIGN SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5634	ADDITION TO LOWER EXTREMITY, SYMES TYPE, POSTERIOR OPENING (CANADIAN) SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5636	ADDITION TO LOWER EXTREMITY, SYMES TYPE, MEDIAL OPENING SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5637	ADDITION TO LOWER EXTREMITY, BELOW KNEE, TOTAL CONTACT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5638	ADDITION TO LOWER EXTREMITY, BELOW KNEE, LEATHER SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5639	ADDITION TO LOWER EXTREMITY, BELOW KNEE, WOOD SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L5640	ADDITION TO LOWER EXTREMITY, KNEE DISARTICULATION, LEATHER SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5642	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, LEATHER SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5643	ADDITION TO LOWER EXTREMITY, HIP DISARTICULATION, FLEXIBLE INNER SOCKET, EXTERNAL FRAME	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5644	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, WOOD SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5645	ADDITION TO LOWER EXTREMITY, BELOW KNEE, FLEXIBLE INNER SOCKET, EXTERNAL FRAME	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5646	ADDITION TO LOWER EXTREMITY, BELOW KNEE, AIR, FLUID, GEL OR EQUAL, CUSHION SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5647	ADDITION TO LOWER EXTREMITY, BELOW KNEE SUCTION SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5648	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, AIR, FLUID, GEL OR EQUAL, CUSHION SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5649	ADDITION TO LOWER EXTREMITY, ISCHIAL CONTAINMENT/NARROW M-L SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5650	ADDITIONS TO LOWER EXTREMITY, TOTAL CONTACT, ABOVE KNEE OR KNEE DISARTICULATION SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5651	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, FLEXIBLE INNER SOCKET, EXTERNAL FRAME	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5652	ADDITION TO LOWER EXTREMITY, SUCTION SUSPENSION, ABOVE KNEE OR KNEE DISARTICULATION SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5653	ADDITION TO LOWER EXTREMITY, KNEE DISARTICULATION, EXPANDABLE WALL SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5654	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, SYMES, (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5655	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, BELOW KNEE (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L5656	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, KNEE DISARTICULATION (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5658	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, ABOVE KNEE (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5661	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, MULTI-DUROMETER SYMES	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5665	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, MULTI-DUROMETER, BELOW KNEE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5666	ADDITION TO LOWER EXTREMITY, BELOW KNEE, CUFF SUSPENSION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5668	ADDITION TO LOWER EXTREMITY, BELOW KNEE, MOLDED DISTAL CUSHION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5670	ADDITION TO LOWER EXTREMITY, BELOW KNEE, MOLDED SUPRACONDYLAR SUSPENSION ('PTS' OR SIMILAR)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5671	ADDITION TO LOWER EXTREMITY, BELOW KNEE / ABOVE KNEE SUSPENSION LOCKING MECHANISM (SHUTTLE, LANYARD OR EQUAL), EXCLUDES SOCKET INSERT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5672	ADDITION TO LOWER EXTREMITY, BELOW KNEE, REMOVABLE MEDIAL BRIM SUSPENSION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5676	ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, KNEE JOINTS, SINGLE AXIS, PAIR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5677	ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, KNEE JOINTS, POLYCENTRIC, PAIR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5678	ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, JOINT COVERS, PAIR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5679	ADDITION TO LOWER EXTREMITY, BELOW KNEE/ABOVE KNEE, CUSTOM FABRICATED FROM EXISTING MOLD OR PREFABRICATED, SOCKET INSERT, SILICONE GEL, ELASTOMERIC OR EQUAL, NOT FOR USE WITH LOCKING MECHANISM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5680	ADDITION TO LOWER EXTREMITY, BELOW KNEE, THIGH LACER, NONMOLDED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L5681	ADDITION TO LOWER EXTREMITY, BELOW KNEE/ABOVE KNEE, CUSTOM FABRICATED SOCKET INSERT FOR CONGENITAL OR ATYPICAL TRAUMATIC AMPUTEE, SILICONE GEL, ELASTOMERIC OR EQUAL, FOR USE WITH OR WITHOUT LOCKING MECHANISM, INITIAL ONLY (FOR OTHER THAN INITIAL, USE CODE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5682	ADDITION TO LOWER EXTREMITY, BELOW KNEE, THIGH LACER, GLUTEAL/ISCHIAL, MOLDED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5683	ADDITION TO LOWER EXTREMITY, BELOW KNEE/ABOVE KNEE, CUSTOM FABRICATED SOCKET INSERT FOR OTHER THAN CONGENITAL OR ATYPICAL TRAUMATIC AMPUTEE, SILICONE GEL, ELASTOMERIC OR EQUAL, FOR USE WITH OR WITHOUT LOCKING MECHANISM, INITIAL ONLY (FOR OTHER THAN INITIA	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5684	ADDITION TO LOWER EXTREMITY, BELOW KNEE, FORK STRAP	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5685	ADDITION TO LOWER EXTREMITY PROSTHESIS, BELOW KNEE, SUSPENSION/SEALING SLEEVE, WITH OR WITHOUT VALVE, ANY MATERIAL, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5686	ADDITION TO LOWER EXTREMITY, BELOW KNEE, BACK CHECK (EXTENSION CONTROL)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5688	ADDITION TO LOWER EXTREMITY, BELOW KNEE, WAIST BELT, WEBBING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5690	ADDITION TO LOWER EXTREMITY, BELOW KNEE, WAIST BELT, PADDED AND LINED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5692	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, PELVIC CONTROL BELT, LIGHT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5694	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, PELVIC CONTROL BELT, PADDED AND LINED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5695	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, PELVIC CONTROL, SLEEVE SUSPENSION, NEOPRENE OR EQUAL, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5696	ADDITION TO LOWER EXTREMITY, ABOVE KNEE OR KNEE DISARTICULATION, PELVIC JOINT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5697	ADDITION TO LOWER EXTREMITY, ABOVE KNEE OR KNEE DISARTICULATION, PELVIC BAND	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5698	ADDITION TO LOWER EXTREMITY, ABOVE KNEE OR KNEE DISARTICULATION, SILESIAN BANDAGE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5699	ALL LOWER EXTREMITY PROSTHESES, SHOULDER HARNESS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L5700	REPLACEMENT, SOCKET, BELOW KNEE, MOLDED TO PATIENT MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5701	REPLACEMENT, SOCKET, ABOVE KNEE/KNEE DISARTICULATION, INCLUDING ATTACHMENT PLATE, MOLDED TO PATIENT MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5702	REPLACEMENT, SOCKET, HIP DISARTICULATION, INCLUDING HIP JOINT, MOLDED TO PATIENT MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5703	ANKLE, SYMES, MOLDED TO PATIENT MODEL, SOCKET WITHOUT SOLID ANKLE CUSHION HEEL (SACH) FOOT, REPLACEMENT ONLY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5704	CUSTOM SHAPED PROTECTIVE COVER, BELOW KNEE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5705	CUSTOM SHAPED PROTECTIVE COVER, ABOVE KNEE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5706	CUSTOM SHAPED PROTECTIVE COVER, KNEE DISARTICULATION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5707	CUSTOM SHAPED PROTECTIVE COVER, HIP DISARTICULATION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5710	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5711	ADDITIONS EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK, ULTRA-LIGHT MATERIAL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5712	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FRICTION SWING AND STANCE PHASE CONTROL (SAFETY KNEE)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5714	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, VARIABLE FRICTION SWING PHASE CONTROL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5716	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, MECHANICAL STANCE PHASE LOCK	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5718	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, FRICTION SWING AND STANCE PHASE CONTROL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5722	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC SWING, FRICTION STANCE PHASE CONTROL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L5724	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING PHASE CONTROL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5726	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, EXTERNAL JOINTS FLUID SWING PHASE CONTROL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5728	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING AND STANCE PHASE CONTROL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5780	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC/HYDRA PNEUMATIC SWING PHASE CONTROL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5781	ADDITION TO LOWER LIMB PROSTHESIS, VACUUM PUMP, RESIDUAL LIMB VOLUME MANAGEMENT AND MOISTURE EVACUATION SYSTEM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5782	ADDITION TO LOWER LIMB PROSTHESIS, VACUUM PUMP, RESIDUAL LIMB VOLUME MANAGEMENT AND MOISTURE EVACUATION SYSTEM, HEAVY DUTY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5783	ADDITION TO LOWER EXTREMITY, USER ADJUSTABLE, MECHANICAL, RESIDUAL LIMB VOLUME MANAGEMENT SYSTEM	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
L5785	ADDITION, EXOSKELETAL SYSTEM, BELOW KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5790	ADDITION, EXOSKELETAL SYSTEM, ABOVE KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5795	ADDITION, EXOSKELETAL SYSTEM, HIP DISARTICULATION, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5810	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5811	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK, ULTRA-LIGHT MATERIAL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5812	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FRICTION SWING AND STANCE PHASE CONTROL (SAFETY KNEE)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5814	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, HYDRAULIC SWING PHASE CONTROL, MECHANICAL STANCE PHASE LOCK	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5816	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, MECHANICAL STANCE PHASE LOCK	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L5818	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, FRICTION SWING, AND STANCE PHASE CONTROL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5822	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC SWING, FRICTION STANCE PHASE CONTROL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5824	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING PHASE CONTROL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5826	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, HYDRAULIC SWING PHASE CONTROL, WITH MINIATURE HIGH ACTIVITY FRAME	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5827	ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, ELECTROMECHANICAL SWING AND STANCE PHASE CONTROL, WITH OR WITHOUT SHOCK ABSORPTION AND STANCE EXTENSION DAMPING	Preauthorization required when purchase price exceeds $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
L5828	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING AND STANCE PHASE CONTROL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5830	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC/ SWING PHASE CONTROL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5840	ADDITION, ENDOSKELETAL KNEE/SHIN SYSTEM, 4-BAR LINKAGE OR MULTIAXIAL, PNEUMATIC SWING PHASE CONTROL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5841	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, PNEUMATIC SWING, AND STANCE PHASE CONTROL		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	InterQual® Evidence-Based Criteria & Guidelines
L5845	ADDITION, ENDOSKELETAL, KNEE-SHIN SYSTEM, STANCE FLEXION FEATURE, ADJUSTABLE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5848	ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM, FLUID STANCE EXTENSION, DAMPENING FEATURE, WITH OR WITHOUT ADJUSTABILITY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5850	ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE OR HIP DISARTICULATION, KNEE EXTENSION ASSIST	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5855	ADDITION, ENDOSKELETAL SYSTEM, HIP DISARTICULATION, MECHANICAL HIP EXTENSION ASSIST	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5856	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5857	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L5858	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, STANCE PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5859	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, POWERED AND PROGRAMMABLE FLEXION/EXTENSION ASSIST CONTROL, INCLUDES ANY TYPE MOTOR(S)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5910	ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, ALIGNABLE SYSTEM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5920	ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE OR HIP DISARTICULATION, ALIGNABLE SYSTEM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5925	ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE, KNEE DISARTICULATION OR HIP DISARTICULATION, MANUAL LOCK	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5926	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL, KNEE DISARTICULATION, ABOVE KNEE, HIP DISARTICULATION, POSITIONAL ROTATION UNIT, ANY TYPE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
L5930	ADDITION, ENDOSKELETAL SYSTEM, HIGH ACTIVITY KNEE CONTROL FRAME	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5940	ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5950	ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5960	ADDITION, ENDOSKELETAL SYSTEM, HIP DISARTICULATION, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5961	ADDITION, ENDOSKELETAL SYSTEM, POLYCENTRIC HIP JOINT, PNEUMATIC OR HYDRAULIC CONTROL, ROTATION CONTROL, WITH OR WITHOUT FLEXION AND/OR EXTENSION CONTROL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5962	ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, FLEXIBLE PROTECTIVE OUTER SURFACE COVERING SYSTEM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5964	ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE, FLEXIBLE PROTECTIVE OUTER SURFACE COVERING SYSTEM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5966	ADDITION, ENDOSKELETAL SYSTEM, HIP DISARTICULATION, FLEXIBLE PROTECTIVE OUTER SURFACE COVERING SYSTEM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5968	ADDITION TO LOWER LIMB PROSTHESIS, MULTIAXIAL ANKLE WITH SWING PHASE ACTIVE DORSIFLEXION FEATURE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L5969	ADDITION, ENDOSKELETAL ANKLE-FOOT OR ANKLE SYSTEM, POWER ASSIST, INCLUDES ANY TYPE MOTOR(S)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5970	ALL LOWER EXTREMITY PROSTHESES, FOOT, EXTERNAL KEEL, SACH FOOT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5971	ALL LOWER EXTREMITY PROSTHESIS, SOLID ANKLE CUSHION HEEL (SACH) FOOT, REPLACEMENT ONLY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5972	ALL LOWER EXTREMITY PROSTHESES, FOOT, FLEXIBLE KEEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5973	ENDOSKELETAL ANKLE FOOT SYSTEM, MICROPROCESSOR CONTROLLED FEATURE, DORSIFLEXION AND/OR PLANTAR FLEXION CONTROL, INCLUDES POWER SOURCE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
L5973	ENDOSKELETAL ANKLE FOOT SYSTEM, MICROPROCESSOR CONTROLLED FEATURE, DORSIFLEXION AND/OR PLANTAR FLEXION CONTROL, INCLUDES POWER SOURCE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
L5974	ALL LOWER EXTREMITY PROSTHESES, FOOT, SINGLE AXIS ANKLE/FOOT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5975	ALL LOWER EXTREMITY PROSTHESIS, COMBINATION SINGLE AXIS ANKLE AND FLEXIBLE KEEL FOOT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5976	ALL LOWER EXTREMITY PROSTHESES, ENERGY STORING FOOT (SEATTLE CARBON COPY II OR EQUAL)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5978	ALL LOWER EXTREMITY PROSTHESES, FOOT, MULTIAXIAL ANKLE/FOOT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5979	ALL LOWER EXTREMITY PROSTHESIS, MULTI-AXIAL ANKLE, DYNAMIC RESPONSE FOOT, ONE PIECE SYSTEM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5980	ALL LOWER EXTREMITY PROSTHESES, FLEX FOOT SYSTEM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5981	ALL LOWER EXTREMITY PROSTHESES, FLEX-WALK SYSTEM OR EQUAL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5982	ALL EXOSKELETAL LOWER EXTREMITY PROSTHESES, AXIAL ROTATION UNIT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5984	ALL ENDOSKELETAL LOWER EXTREMITY PROSTHESIS, AXIAL ROTATION UNIT, WITH OR WITHOUT ADJUSTABILITY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L5985	ALL ENDOSKELETAL LOWER EXTREMITY PROSTHESES, DYNAMIC PROSTHETIC PYLON	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5986	ALL LOWER EXTREMITY PROSTHESES, MULTI-AXIAL ROTATION UNIT ('MCP' OR EQUAL)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5987	ALL LOWER EXTREMITY PROSTHESIS, SHANK FOOT SYSTEM WITH VERTICAL LOADING PYLON	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5988	ADDITION TO LOWER LIMB PROSTHESIS, VERTICAL SHOCK REDUCING PYLON FEATURE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5990	ADDITION TO LOWER EXTREMITY PROSTHESIS, USER ADJUSTABLE HEEL HEIGHT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L5999	LOWER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6000	PARTIAL HAND, THUMB REMAINING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6010	PARTIAL HAND, LITTLE AND/OR RING FINGER REMAINING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6020	PARTIAL HAND, NO FINGER REMAINING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6028	PARTIAL HAND INCLUDING FINGERS, FLEXIBLE OR NON-FLEXIBLE INTERFACE, ENDOSKELETAL SYSTEM, MOLDED TO PATIENT MODEL, FOR USE WITHOUT EXTERNAL POWER, NOT INCLUDING INSERTS DESCRIBED BY L6692	Preauthorization required when purchase price exceeds $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
L6029	UPPER EXTREMITY ADDITION, TEST SOCKET/INTERFACE, PARTIAL HAND INCLUDING FINGERS	Preauthorization required when purchase price exceeds $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
L6030	UPPER EXTREMITY ADDITION, EXTERNAL FRAME, PARTIAL HAND INCLUDING FINGERS	Preauthorization required when purchase price exceeds $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
L6031	REPLACEMENT SOCKET/INTERFACE, PARTIAL HAND INCLUDING FINGERS, MOLDED TO PATIENT MODEL, FOR USE WITH OR WITHOUT EXTERNAL POWER	Preauthorization required when purchase price exceeds $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
L6032	ADDITION TO UPPER EXTREMITY PROSTHESIS, PARTIAL HAND INCLUDING FINGERS, ULTRALIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	Preauthorization required when purchase price exceeds $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
L6033	ADDITION TO UPPER EXTREMITY PROSTHESIS, PARTIAL HAND INCLUDING FINGERS, ACRYLIC MATERIAL	Preauthorization required when purchase price exceeds $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
L6037	IMMEDIATE POST-SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING ALIGNMENT AND SUSPENSION OF COMPONENTS, AND ONE CAST CHANGE, PARTIAL HAND INCLUDING FINGERS	Preauthorization required when purchase price exceeds $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L6050	WRIST DISARTICULATION, MOLDED SOCKET, FLEXIBLE ELBOW HINGES, TRICEPS PAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6055	WRIST DISARTICULATION, MOLDED SOCKET WITH EXPANDABLE INTERFACE, FLEXIBLE ELBOW HINGES, TRICEPS PAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6100	BELOW ELBOW, MOLDED SOCKET, FLEXIBLE ELBOW HINGE, TRICEPS PAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6110	BELOW ELBOW, MOLDED SOCKET, (MUENSTER OR NORTHWESTERN SUSPENSION TYPES)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6120	BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STEP-UP HINGES, HALF CUFF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6130	BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STUMP ACTIVATED LOCKING HINGE, HALF CUFF	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6200	ELBOW DISARTICULATION, MOLDED SOCKET, OUTSIDE LOCKING HINGE, FOREARM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6205	ELBOW DISARTICULATION, MOLDED SOCKET WITH EXPANDABLE INTERFACE, OUTSIDE LOCKING HINGES, FOREARM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6250	ABOVE ELBOW, MOLDED DOUBLE WALL SOCKET, INTERNAL LOCKING ELBOW, FOREARM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6300	SHOULDER DISARTICULATION, MOLDED SOCKET, SHOULDER BULKHEAD, HUMERAL SECTION, INTERNAL LOCKING ELBOW, FOREARM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6310	SHOULDER DISARTICULATION, PASSIVE RESTORATION (COMPLETE PROSTHESIS)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6320	SHOULDER DISARTICULATION, PASSIVE RESTORATION (SHOULDER CAP ONLY)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6350	INTERSCAPULAR THORACIC, MOLDED SOCKET, SHOULDER BULKHEAD, HUMERAL SECTION, INTERNAL LOCKING ELBOW, FOREARM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6360	INTERSCAPULAR THORACIC, PASSIVE RESTORATION (COMPLETE PROSTHESIS)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6370	INTERSCAPULAR THORACIC, PASSIVE RESTORATION (SHOULDER CAP ONLY)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L6380	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING ALIGNMENT AND SUSPENSION OF COMPONENTS, AND ONE CAST CHANGE, WRIST DISARTICULATION OR BELOW ELBOW	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6382	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING INCLUDING FITTING ALIGNMENT AND SUSPENSION OF COMPONENTS, AND ONE CAST CHANGE, ELBOW DISARTICULATION OR ABOVE ELBOW	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6384	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING INCLUDING FITTING ALIGNMENT AND SUSPENSION OF COMPONENTS, AND ONE CAST CHANGE, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6386	IMMEDIATE POST SURGICAL OR EARLY FITTING, EACH ADDITIONAL CAST CHANGE AND REALIGNMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6388	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF RIGID DRESSING ONLY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6400	BELOW ELBOW, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6450	ELBOW DISARTICULATION, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6500	ABOVE ELBOW, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6550	SHOULDER DISARTICULATION, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6570	INTERSCAPULAR THORACIC, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6580	PREPARATORY, WRIST DISARTICULATION OR BELOW ELBOW, SINGLE WALL PLASTIC SOCKET, FRICTION WRIST, FLEXIBLE ELBOW HINGES, FIGURE OF EIGHT HARNESS, HUMERAL CUFF, BOWDEN CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, MOLDED TO PATIENT MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6582	PREPARATORY, WRIST DISARTICULATION OR BELOW ELBOW, SINGLE WALL SOCKET, FRICTION WRIST, FLEXIBLE ELBOW HINGES, FIGURE OF EIGHT HARNESS, HUMERAL CUFF, BOWDEN CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, DIRECT FORMED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6584	PREPARATORY, ELBOW DISARTICULATION OR ABOVE ELBOW, SINGLE WALL PLASTIC SOCKET, FRICTION WRIST, LOCKING ELBOW, FIGURE OF EIGHT HARNESS, FAIR LEAD CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, MOLDED TO PATIENT MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6586	PREPARATORY, ELBOW DISARTICULATION OR ABOVE ELBOW, SINGLE WALL SOCKET, FRICTION WRIST, LOCKING ELBOW, FIGURE OF EIGHT HARNESS, FAIR LEAD CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, DIRECT FORMED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L6588	PREPARATORY, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC, SINGLE WALL PLASTIC SOCKET, SHOULDER JOINT, LOCKING ELBOW, FRICTION WRIST, CHEST STRAP, FAIR LEAD CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, MOLDED TO PATIENT MODEL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6590	PREPARATORY, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC, SINGLE WALL SOCKET, SHOULDER JOINT, LOCKING ELBOW, FRICTION WRIST, CHEST STRAP, FAIR LEAD CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, DIRECT FORMED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6600	UPPER EXTREMITY ADDITIONS, POLYCENTRIC HINGE, PAIR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6605	UPPER EXTREMITY ADDITIONS, SINGLE PIVOT HINGE, PAIR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6610	UPPER EXTREMITY ADDITIONS, FLEXIBLE METAL HINGE, PAIR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6611	ADDITION TO UPPER EXTREMITY PROSTHESIS, EXTERNAL POWERED, ADDITIONAL SWITCH, ANY TYPE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6615	UPPER EXTREMITY ADDITION, DISCONNECT LOCKING WRIST UNIT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6616	UPPER EXTREMITY ADDITION, ADDITIONAL DISCONNECT INSERT FOR LOCKING WRIST UNIT, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6620	UPPER EXTREMITY ADDITION, FLEXION/EXTENSION WRIST UNIT, WITH OR WITHOUT FRICTION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6621	UPPER EXTREMITY PROSTHESIS ADDITION, FLEXION/EXTENSION WRIST WITH OR WITHOUT FRICTION, FOR USE WITH EXTERNAL POWERED TERMINAL DEVICE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6623	UPPER EXTREMITY ADDITION, SPRING ASSISTED ROTATIONAL WRIST UNIT WITH LATCH RELEASE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6624	UPPER EXTREMITY ADDITION, FLEXION/EXTENSION AND ROTATION WRIST UNIT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6625	UPPER EXTREMITY ADDITION, ROTATION WRIST UNIT WITH CABLE LOCK	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6628	UPPER EXTREMITY ADDITION, QUICK DISCONNECT HOOK ADAPTER, OTTO BOCK OR EQUAL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6629	UPPER EXTREMITY ADDITION, QUICK DISCONNECT LAMINATION COLLAR WITH COUPLING PIECE, OTTO BOCK OR EQUAL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L6630	UPPER EXTREMITY ADDITION, STAINLESS STEEL, ANY WRIST	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6632	UPPER EXTREMITY ADDITION, LATEX SUSPENSION SLEEVE, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6635	UPPER EXTREMITY ADDITION, LIFT ASSIST FOR ELBOW	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6637	UPPER EXTREMITY ADDITION, NUDGE CONTROL ELBOW LOCK	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6638	UPPER EXTREMITY ADDITION TO PROSTHESIS, ELECTRIC LOCKING FEATURE, ONLY FOR USE WITH MANUALLY POWERED ELBOW	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6640	UPPER EXTREMITY ADDITIONS, SHOULDER ABDUCTION JOINT, PAIR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6641	UPPER EXTREMITY ADDITION, EXCURSION AMPLIFIER, PULLEY TYPE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6642	UPPER EXTREMITY ADDITION, EXCURSION AMPLIFIER, LEVER TYPE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6645	UPPER EXTREMITY ADDITION, SHOULDER FLEXION-ABDUCTION JOINT, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6646	UPPER EXTREMITY ADDITION, SHOULDER JOINT, MULTIPOSITIONAL LOCKING, FLEXION, ADJUSTABLE ABDUCTION FRICTION CONTROL, FOR USE WITH BODY POWERED OR EXTERNAL POWERED SYSTEM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6647	UPPER EXTREMITY ADDITION, SHOULDER LOCK MECHANISM, BODY POWERED ACTUATOR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6648	UPPER EXTREMITY ADDITION, SHOULDER LOCK MECHANISM, EXTERNAL POWERED ACTUATOR	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6650	UPPER EXTREMITY ADDITION, SHOULDER UNIVERSAL JOINT, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6655	UPPER EXTREMITY ADDITION, STANDARD CONTROL CABLE, EXTRA	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6660	UPPER EXTREMITY ADDITION, HEAVY DUTY CONTROL CABLE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L6665	UPPER EXTREMITY ADDITION, TEFLON, OR EQUAL, CABLE LINING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6670	UPPER EXTREMITY ADDITION, HOOK TO HAND, CABLE ADAPTER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6672	UPPER EXTREMITY ADDITION, HARNESS, CHEST OR SHOULDER, SADDLE TYPE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6675	UPPER EXTREMITY ADDITION, HARNESS, (E.G., FIGURE OF EIGHT TYPE), SINGLE CABLE DESIGN	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6676	UPPER EXTREMITY ADDITION, HARNESS, (E.G., FIGURE OF EIGHT TYPE), DUAL CABLE DESIGN	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6677	UPPER EXTREMITY ADDITION, HARNESS, TRIPLE CONTROL, SIMULTANEOUS OPERATION OF TERMINAL DEVICE AND ELBOW	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6680	UPPER EXTREMITY ADDITION, TEST SOCKET, WRIST DISARTICULATION OR BELOW ELBOW	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6682	UPPER EXTREMITY ADDITION, TEST SOCKET, ELBOW DISARTICULATION OR ABOVE ELBOW	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6684	UPPER EXTREMITY ADDITION, TEST SOCKET, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6686	UPPER EXTREMITY ADDITION, SUCTION SOCKET	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6687	UPPER EXTREMITY ADDITION, FRAME TYPE SOCKET, BELOW ELBOW OR WRIST DISARTICULATION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6688	UPPER EXTREMITY ADDITION, FRAME TYPE SOCKET, ABOVE ELBOW OR ELBOW DISARTICULATION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6689	UPPER EXTREMITY ADDITION, FRAME TYPE SOCKET, SHOULDER DISARTICULATION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6690	UPPER EXTREMITY ADDITION, FRAME TYPE SOCKET, INTERSCAPULAR-THORACIC	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6691	UPPER EXTREMITY ADDITION, REMOVABLE INSERT, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L6692	UPPER EXTREMITY ADDITION, SILICONE GEL INSERT OR EQUAL, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6693	UPPER EXTREMITY ADDITION, LOCKING ELBOW, FOREARM COUNTERBALANCE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6694	ADDITION TO UPPER EXTREMITY PROSTHESIS, BELOW ELBOW/ABOVE ELBOW, CUSTOM FABRICATED FROM EXISTING MOLD OR PREFABRICATED, SOCKET INSERT, SILICONE GEL, ELASTOMERIC OR EQUAL, FOR USE WITH LOCKING MECHANISM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6695	ADDITION TO UPPER EXTREMITY PROSTHESIS, BELOW ELBOW/ABOVE ELBOW, CUSTOM FABRICATED FROM EXISTING MOLD OR PREFABRICATED, SOCKET INSERT, SILICONE GEL, ELASTOMERIC OR EQUAL, NOT FOR USE WITH LOCKING MECHANISM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6696	ADDITION TO UPPER EXTREMITY PROSTHESIS, BELOW ELBOW/ABOVE ELBOW, CUSTOM FABRICATED SOCKET INSERT FOR CONGENITAL OR ATYPICAL TRAUMATIC AMPUTEE, SILICONE GEL, ELASTOMERIC OR EQUAL, FOR USE WITH OR WITHOUT LOCKING MECHANISM, INITIAL ONLY (FOR OTHER THAN INIT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6697	ADDITION TO UPPER EXTREMITY PROSTHESIS, BELOW ELBOW/ABOVE ELBOW, CUSTOM FABRICATED SOCKET INSERT FOR OTHER THAN CONGENITAL OR ATYPICAL TRAUMATIC AMPUTEE, SILICONE GEL, ELASTOMERIC OR EQUAL, FOR USE WITH OR WITHOUT LOCKING MECHANISM, INITIAL ONLY (FOR OTHE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6698	ADDITION TO UPPER EXTREMITY PROSTHESIS, BELOW ELBOW/ABOVE ELBOW, LOCK MECHANISM, EXCLUDES SOCKET INSERT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6700	UPPER EXTREMITY ADDITION, EXTERNAL POWERED FEATURE, MYOELECTRONIC CONTROL MODULE, ADDITIONAL EMG INPUTS, PATTERN-RECOGNITION DECODING INTENT MOVEMENT	Preauthorization required when purchase price exceeds $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
L6703	TERMINAL DEVICE, PASSIVE HAND/MITT, ANY MATERIAL, ANY SIZE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6704	TERMINAL DEVICE, SPORT/RECREATIONAL/WORK ATTACHMENT, ANY MATERIAL, ANY SIZE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6706	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6707	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6708	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6709	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6711	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED, PEDIATRIC	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L6712	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED, PEDIATRIC	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6713	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, PEDIATRIC	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6714	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, PEDIATRIC	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6715	TERMINAL DEVICE, MULTIPLE ARTICULATING DIGIT, INCLUDES MOTOR(S), INITIAL ISSUE OR REPLACEMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6721	TERMINAL DEVICE, HOOK OR HAND, HEAVY DUTY, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6722	TERMINAL DEVICE, HOOK OR HAND, HEAVY DUTY, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6805	ADDITION TO TERMINAL DEVICE, MODIFIER WRIST UNIT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6810	ADDITION TO TERMINAL DEVICE, PRECISION PINCH DEVICE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6880	ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, INDEPENDENTLY ARTICULATING DIGITS, ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS, INCLUDES MOTOR(S)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6881	AUTOMATIC GRASP FEATURE, ADDITION TO UPPER LIMB ELECTRIC PROSTHETIC TERMINAL DEVICE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6882	MICROPROCESSOR CONTROL FEATURE, ADDITION TO UPPER LIMB PROSTHETIC TERMINAL DEVICE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6883	REPLACEMENT SOCKET, BELOW ELBOW/WRIST DISARTICULATION, MOLDED TO PATIENT MODEL, FOR USE WITH OR WITHOUT EXTERNAL POWER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6884	REPLACEMENT SOCKET, ABOVE ELBOW/ELBOW DISARTICULATION, MOLDED TO PATIENT MODEL, FOR USE WITH OR WITHOUT EXTERNAL POWER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6885	REPLACEMENT SOCKET, SHOULDER DISARTICULATION/INTERSCAPULAR THORACIC, MOLDED TO PATIENT MODEL, FOR USE WITH OR WITHOUT EXTERNAL POWER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6890	ADDITION TO UPPER EXTREMITY PROSTHESIS, GLOVE FOR TERMINAL DEVICE, ANY MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L6895	ADDITION TO UPPER EXTREMITY PROSTHESIS, GLOVE FOR TERMINAL DEVICE, ANY MATERIAL, CUSTOM FABRICATED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6900	HAND RESTORATION (CASTS, SHADING AND MEASUREMENTS INCLUDED), PARTIAL HAND, WITH GLOVE, THUMB OR ONE FINGER REMAINING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6905	HAND RESTORATION (CASTS, SHADING AND MEASUREMENTS INCLUDED), PARTIAL HAND, WITH GLOVE, MULTIPLE FINGERS REMAINING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6910	HAND RESTORATION (CASTS, SHADING AND MEASUREMENTS INCLUDED), PARTIAL HAND, WITH GLOVE, NO FINGERS REMAINING	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L6915	HAND RESTORATION (SHADING, AND MEASUREMENTS INCLUDED), REPLACEMENT GLOVE FOR ABOVE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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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	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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 D	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7007	ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7008	ELECTRIC HAND, SWITCH OR MYOELECTRIC, CONTROLLED, PEDIATRIC	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7009	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7040	PREHENSILE ACTUATOR, SWITCH CONTROLLED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7045	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, PEDIATRIC	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7170	ELECTRONIC ELBOW, HOSMER OR EQUAL, SWITCH CONTROLLED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7180	ELECTRONIC ELBOW, MICROPROCESSOR SEQUENTIAL CONTROL OF ELBOW AND TERMINAL DEVICE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7181	ELECTRONIC ELBOW, MICROPROCESSOR SIMULTANEOUS CONTROL OF ELBOW AND TERMINAL DEVICE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7185	ELECTRONIC ELBOW, ADOLESCENT, VARIETY VILLAGE OR EQUAL, SWITCH CONTROLLED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7186	ELECTRONIC ELBOW, CHILD, VARIETY VILLAGE OR EQUAL, SWITCH CONTROLLED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7190	ELECTRONIC ELBOW, ADOLESCENT, VARIETY VILLAGE OR EQUAL, MYOELECTRONICALLY CONTROLLED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L7191	ELECTRONIC ELBOW, CHILD, VARIETY VILLAGE OR EQUAL, MYOELECTRONICALLY CONTROLLED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7360	SIX VOLT BATTERY, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7362	BATTERY CHARGER, SIX VOLT, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7364	TWELVE VOLT BATTERY, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7366	BATTERY CHARGER, TWELVE VOLT, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7367	LITHIUM ION BATTERY, RECHARGEABLE, REPLACEMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7368	LITHIUM ION BATTERY CHARGER, REPLACEMENT ONLY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7400	ADDITION TO UPPER EXTREMITY PROSTHESIS, BELOW ELBOW/WRIST DISARTICULATION, ULTRALIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7401	ADDITION TO UPPER EXTREMITY PROSTHESIS, ABOVE ELBOW DISARTICULATION, ULTRALIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7402	ADDITION TO UPPER EXTREMITY PROSTHESIS, SHOULDER DISARTICULATION/INTERSCAPULAR THORACIC, ULTRALIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7403	ADDITION TO UPPER EXTREMITY PROSTHESIS, BELOW ELBOW/WRIST DISARTICULATION, ACRYLIC MATERIAL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7404	ADDITION TO UPPER EXTREMITY PROSTHESIS, ABOVE ELBOW DISARTICULATION, ACRYLIC MATERIAL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7405	ADDITION TO UPPER EXTREMITY PROSTHESIS, SHOULDER DISARTICULATION/INTERSCAPULAR THORACIC, ACRYLIC MATERIAL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7406	ADDITION TO UPPER EXTREMITY, USER ADJUSTABLE, MECHANICAL, RESIDUAL LIMB VOLUME MANAGEMENT SYSTEM	Preauthorization required when purchase price exceeds $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
L7499	UPPER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L7510	REPAIR OF PROSTHETIC DEVICE, REPAIR OR REPLACE MINOR PARTS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7520	REPAIR PROSTHETIC DEVICE, LABOR COMPONENT, PER 15 MINUTES	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7600	PROSTHETIC DONNING SLEEVE, ANY MATERIAL, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7900	MALE VACUUM ERECTION SYSTEM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L7902	TENSION RING, FOR VACUUM ERECTION DEVICE, ANY TYPE, REPLACEMENT ONLY, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8000	BREAST PROSTHESIS, MASTECTOMY BRA, WITHOUT INTEGRATED BREAST PROSTHESIS FORM, ANY SIZE, ANY TYPE	Pays without authorization for breast-cancer related diagnoses: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621. C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C79.81, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.90, D05.91, D05.92, D48.61, D48.62, I97.2, N65.0, N65.1, Q79.8, T85.43XA,T85.43XD, T85.43XS, Z42.1, Z45.811, Z45.812, Z45.811, Z45.819, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13. Authorization required for all other diagnoses	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L8001	BREAST PROSTHESIS, MASTECTOMY BRA, WITH INTEGRATED BREAST PROSTHESIS FORM, UNILATERAL, ANY SIZE, ANY TYPE	Pays without authorization for breast-cancer related diagnoses: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621. C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C79.81, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.90, D05.91, D05.92, D48.61, D48.62, I97.2, N65.0, N65.1, Q79.8, T85.43XA,T85.43XD, T85.43XS, Z42.1, Z45.811, Z45.812, Z45.811, Z45.819, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13. Authorization required for all other diagnoses	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8002	BREAST PROSTHESIS, MASTECTOMY BRA, WITH INTEGRATED BREAST PROSTHESIS FORM, BILATERAL, ANY SIZE, ANY TYPE	Pays without authorization for breast-cancer related diagnoses: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621. C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C79.81, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.90, D05.91, D05.92, D48.61, D48.62, I97.2, N65.0, N65.1, Q79.8, T85.43XA,T85.43XD, T85.43XS, Z42.1, Z45.811, Z45.812, Z45.811, Z45.819, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13. Authorization required for all other diagnoses	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L8020	BREAST PROSTHESIS, MASTECTOMY FORM	Pays without authorization for breast-cancer related diagnoses: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621. C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C79.81, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.90, D05.91, D05.92, D48.61, D48.62, I97.2, N65.0, N65.1, Q79.8, T85.43XA,T85.43XD, T85.43XS, Z42.1, Z45.811, Z45.812, Z45.811, Z45.819, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13. Authorization required for all other diagnoses	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8030	BREAST PROSTHESIS, SILICONE OR EQUAL, WITHOUT INTEGRAL ADHESIVE	Pays without authorization for breast-cancer related diagnoses: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621. C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C79.81, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.90, D05.91, D05.92, D48.61, D48.62, I97.2, N65.0, N65.1, Q79.8, T85.43XA,T85.43XD, T85.43XS, Z42.1, Z45.811, Z45.812, Z45.811, Z45.819, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13. Authorization required for all other diagnoses	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L8031	BREAST PROSTHESIS, SILICONE OR EQUAL, WITH INTEGRAL ADHESIVE	Pays without authorization for breast-cancer related diagnoses: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621. C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C79.81, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.90, D05.91, D05.92, D48.61, D48.62, I97.2, N65.0, N65.1, Q79.8, T85.43XA,T85.43XD, T85.43XS, Z42.1, Z45.811, Z45.812, Z45.811, Z45.819, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13. Authorization required for all other diagnoses	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8032	NIPPLE PROSTHESIS, PREFABRICATED, REUSABLE, ANY TYPE, EACH	Pays without authorization for breast-cancer related diagnoses: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621. C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C79.81, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.90, D05.91, D05.92, D48.61, D48.62, I97.2, N65.0, N65.1, Q79.8, T85.43XA,T85.43XD, T85.43XS, Z42.1, Z45.811, Z45.812, Z45.811, Z45.819, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13. Authorization required for all other diagnoses	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L8033	NIPPLE PROSTHESIS, CUSTOM FABRICATED, REUSABLE, ANY MATERIAL, ANY TYPE, EACH	Pays without authorization for breast-cancer related diagnoses: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621. C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C79.81, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.90, D05.91, D05.92, D48.61, D48.62, I97.2, N65.0, N65.1, Q79.8, T85.43XA,T85.43XD, T85.43XS, Z42.1, Z45.811, Z45.812, Z45.811, Z45.819, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13. Authorization required for all other diagnoses	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8035	CUSTOM BREAST PROSTHESIS, POST MASTECTOMY, MOLDED TO PATIENT MODEL	Pays without authorization for breast-cancer related diagnoses: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621. C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C79.81, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.90, D05.91, D05.92, D48.61, D48.62, I97.2, N65.0, N65.1, Q79.8, T85.43XA,T85.43XD, T85.43XS, Z42.1, Z45.811, Z45.812, Z45.811, Z45.819, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13. Authorization required for all other diagnoses	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L8039	BREAST PROSTHESIS, NOT OTHERWISE SPECIFIED	Pays without authorization for breast-cancer related diagnoses: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621. C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C79.81, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.90, D05.91, D05.92, D48.61, D48.62, I97.2, N65.0, N65.1, Q79.8, T85.43XA,T85.43XD, T85.43XS, Z42.1, Z45.811, Z45.812, Z45.811, Z45.819, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13. Authorization required for all other diagnoses	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8040	NASAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8040	NASAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8041	MIDFACIAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8041	MIDFACIAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8042	ORBITAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8042	ORBITAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8043	UPPER FACIAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8043	UPPER FACIAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8044	HEMI-FACIAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8044	HEMI-FACIAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8045	AURICULAR PROSTHESIS, PROVIDED BY A NON-PHYSICIAN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8045	AURICULAR PROSTHESIS, PROVIDED BY A NON-PHYSICIAN	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L8046	PARTIAL FACIAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8046	PARTIAL FACIAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8047	NASAL SEPTAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8047	NASAL SEPTAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8048	UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT, PROVIDED BY A NON-PHYSICIAN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8048	UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT, PROVIDED BY A NON-PHYSICIAN	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8049	REPAIR OR MODIFICATION OF MAXILLOFACIAL PROSTHESIS, LABOR COMPONENT, 15 MINUTE INCREMENTS, PROVIDED BY A NON-PHYSICIAN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8049	REPAIR OR MODIFICATION OF MAXILLOFACIAL PROSTHESIS, LABOR COMPONENT, 15 MINUTE INCREMENTS, PROVIDED BY A NON-PHYSICIAN	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8300	TRUSS, SINGLE WITH STANDARD PAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8310	TRUSS, DOUBLE WITH STANDARD PADS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8320	TRUSS, ADDITION TO STANDARD PAD, WATER PAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8330	TRUSS, ADDITION TO STANDARD PAD, SCROTAL PAD	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8400	PROSTHETIC SHEATH, BELOW KNEE, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8410	PROSTHETIC SHEATH, ABOVE KNEE, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8415	PROSTHETIC SHEATH, UPPER LIMB, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8417	PROSTHETIC SHEATH/SOCK, INCLUDING A GEL CUSHION LAYER, BELOW KNEE OR ABOVE KNEE, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L8420	PROSTHETIC SOCK, MULTIPLE PLY, BELOW KNEE, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8430	PROSTHETIC SOCK, MULTIPLE PLY, ABOVE KNEE, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8435	PROSTHETIC SOCK, MULTIPLE PLY, UPPER LIMB, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8440	PROSTHETIC SHRINKER, BELOW KNEE, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8460	PROSTHETIC SHRINKER, ABOVE KNEE, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8465	PROSTHETIC SHRINKER, UPPER LIMB, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8470	PROSTHETIC SOCK, SINGLE PLY, FITTING, BELOW KNEE, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8480	PROSTHETIC SOCK, SINGLE PLY, FITTING, ABOVE KNEE, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8485	PROSTHETIC SOCK, SINGLE PLY, FITTING, UPPER LIMB, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8499	UNLISTED PROCEDURE FOR MISCELLANEOUS PROSTHETIC SERVICES	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8500	ARTIFICIAL LARYNX, ANY TYPE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8501	TRACHEOSTOMY SPEAKING VALVE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8505	ARTIFICIAL LARYNX REPLACEMENT BATTERY / ACCESSORY, ANY TYPE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8507	TRACHEO-ESOPHAGEAL VOICE PROSTHESIS, PATIENT INSERTED, ANY TYPE, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8509	TRACHEO-ESOPHAGEAL VOICE PROSTHESIS, INSERTED BY A LICENSED HEALTH CARE PROVIDER, ANY TYPE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L8510	VOICE AMPLIFIER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8511	INSERT FOR INDWELLING TRACHEOESOPHAGEAL PROSTHESIS, WITH OR WITHOUT VALVE, REPLACEMENT ONLY, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8512	GELATIN CAPSULES OR EQUIVALENT, FOR USE WITH TRACHEOESOPHAGEAL VOICE PROSTHESIS, REPLACEMENT ONLY, PER 10	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8513	CLEANING DEVICE USED WITH TRACHEOESOPHAGEAL VOICE PROSTHESIS, PIPET, BRUSH, OR EQUAL, REPLACEMENT ONLY, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8514	TRACHEOESOPHAGEAL PUNCTURE DILATOR, REPLACEMENT ONLY, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8515	GELATIN CAPSULE, APPLICATION DEVICE FOR USE WITH TRACHEOESOPHAGEAL VOICE PROSTHESIS, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8600	IMPLANTABLE BREAST PROSTHESIS, SILICONE OR EQUAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8603	INJECTABLE BULKING AGENT, COLLAGEN IMPLANT, URINARY TRACT, 2.5 ML SYRINGE, INCLUDES SHIPPING AND NECESSARY SUPPLIES	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8604	INJECTABLE BULKING AGENT, DEXTRANOMER/HYALURONIC ACID COPOLYMER IMPLANT, URINARY TRACT, 1 ML, INCLUDES SHIPPING AND NECESSARY SUPPLIES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8605	INJECTABLE BULKING AGENT, DEXTRANOMER/HYALURONIC ACID COPOLYMER IMPLANT, ANAL CANAL, 1 ML, INCLUDES SHIPPING AND NECESSARY SUPPLIES		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
L8605	INJECTABLE BULKING AGENT, DEXTRANOMER/HYALURONIC ACID COPOLYMER IMPLANT, ANAL CANAL, 1 ML, INCLUDES SHIPPING AND NECESSARY SUPPLIES	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
L8606	INJECTABLE BULKING AGENT, SYNTHETIC IMPLANT, URINARY TRACT, 1 ML SYRINGE, INCLUDES SHIPPING AND NECESSARY SUPPLIES	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8607	INJECTABLE BULKING AGENT FOR VOCAL CORD MEDIALIZATION, 0.1 ML, INCLUDES SHIPPING AND NECESSARY SUPPLIES	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8608	MISCELLANEOUS EXTERNAL COMPONENT, SUPPLY OR ACCESSORY FOR USE WITH THE ARGUS II RETINAL PROSTHESIS SYSTEM		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
L8609	ARTIFICIAL CORNEA	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8610	OCULAR IMPLANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L8612	AQUEOUS SHUNT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8613	OSSICULA IMPLANT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8614	COCHLEAR DEVICE, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8614	COCHLEAR DEVICE, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8615	HEADSET/HEADPIECE FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8616	MICROPHONE FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8617	TRANSMITTING COIL FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8618	TRANSMITTER CABLE FOR USE WITH COCHLEAR IMPLANT DEVICE OR AUDITORY OSSEOINTEGRATED DEVICE, REPLACEMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8619	COCHLEAR IMPLANT, EXTERNAL SPEECH PROCESSOR AND CONTROLLER, INTEGRATED SYSTEM, REPLACEMENT	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8619	COCHLEAR IMPLANT, EXTERNAL SPEECH PROCESSOR AND CONTROLLER, INTEGRATED SYSTEM, REPLACEMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8621	ZINC AIR BATTERY FOR USE WITH COCHLEAR IMPLANT DEVICE AND AUDITORY OSSEOINTEGRATED SOUND PROCESSORS, REPLACEMENT, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8622	ALKALINE BATTERY FOR USE WITH COCHLEAR IMPLANT DEVICE, ANY SIZE, REPLACEMENT, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8623	LITHIUM ION BATTERY FOR USE WITH COCHLEAR IMPLANT DEVICE SPEECH PROCESSOR, OTHER THAN EAR LEVEL, REPLACEMENT, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8624	LITHIUM ION BATTERY FOR USE WITH COCHLEAR IMPLANT OR AUDITORY OSSEOINTEGRATED DEVICE SPEECH PROCESSOR, EAR LEVEL, REPLACEMENT, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8625	EXTERNAL RECHARGING SYSTEM FOR BATTERY FOR USE WITH COCHLEAR IMPLANT OR AUDITORY OSSEOINTEGRATED DEVICE, REPLACEMENT ONLY, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8627	COCHLEAR IMPLANT, EXTERNAL SPEECH PROCESSOR, COMPONENT, REPLACEMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L8628	COCHLEAR IMPLANT, EXTERNAL CONTROLLER COMPONENT, REPLACEMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8629	TRANSMITTING COIL AND CABLE, INTEGRATED, FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8630	METACARPOPHALANGEAL JOINT IMPLANT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8631	METACARPAL PHALANGEAL JOINT REPLACEMENT, TWO OR MORE PIECES, METAL (E.G., STAINLESS STEEL OR COBALT CHROME), CERAMIC-LIKE MATERIAL (E.G., PYROCARBON), FOR SURGICAL IMPLANTATION (ALL SIZES, INCLUDES ENTIRE SYSTEM)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8641	METATARSAL JOINT IMPLANT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8642	HALLUX IMPLANT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8658	INTERPHALANGEAL JOINT SPACER, SILICONE OR EQUAL, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8659	INTERPHALANGEAL FINGER JOINT REPLACEMENT, 2 OR MORE PIECES, METAL (E.G., STAINLESS STEEL OR COBALT CHROME), CERAMIC-LIKE MATERIAL (E.G., PYROCARBON) FOR SURGICAL IMPLANTATION, ANY SIZE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8670	VASCULAR GRAFT MATERIAL, SYNTHETIC, IMPLANT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8678	ELECTRICAL STIMULATOR SUPPLIES (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR, PER MONTH	Preauthorization required when billed charges exceed $500 per line item	8/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
L8679	IMPLANTABLE NEUROSTIMULATOR, PULSE GENERATOR, ANY TYPE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8679	IMPLANTABLE NEUROSTIMULATOR, PULSE GENERATOR, ANY TYPE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8679	IMPLANTABLE NEUROSTIMULATOR, PULSE GENERATOR, ANY TYPE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8680	IMPLANTABLE NEUROSTIMULATOR ELECTRODE, EACH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8680	IMPLANTABLE NEUROSTIMULATOR ELECTRODE, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8680	IMPLANTABLE NEUROSTIMULATOR ELECTRODE, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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L8681	PATIENT PROGRAMMER (EXTERNAL) FOR USE WITH IMPLANTABLE PROGRAMMABLE NEUROSTIMULATOR PULSE GENERATOR, REPLACEMENT ONLY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8681	PATIENT PROGRAMMER (EXTERNAL) FOR USE WITH IMPLANTABLE PROGRAMMABLE NEUROSTIMULATOR PULSE GENERATOR, REPLACEMENT ONLY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8682	IMPLANTABLE NEUROSTIMULATOR RADIOFREQUENCY RECEIVER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8682	IMPLANTABLE NEUROSTIMULATOR RADIOFREQUENCY RECEIVER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8682	IMPLANTABLE NEUROSTIMULATOR RADIOFREQUENCY RECEIVER	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8683	RADIOFREQUENCY TRANSMITTER (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR RADIOFREQUENCY RECEIVER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8683	RADIOFREQUENCY TRANSMITTER (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR RADIOFREQUENCY RECEIVER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8683	RADIOFREQUENCY TRANSMITTER (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR RADIOFREQUENCY RECEIVER	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8684	RADIOFREQUENCY TRANSMITTER (EXTERNAL) FOR USE WITH IMPLANTABLE SACRAL ROOT NEUROSTIMULATOR RECEIVER FOR BOWEL AND BLADDER MANAGEMENT, REPLACEMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8685	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, SINGLE ARRAY, RECHARGEABLE, INCLUDES EXTENSION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8685	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, SINGLE ARRAY, RECHARGEABLE, INCLUDES EXTENSION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8686	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, SINGLE ARRAY, NON-RECHARGEABLE, INCLUDES EXTENSION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8686	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, SINGLE ARRAY, NON-RECHARGEABLE, INCLUDES EXTENSION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8686	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, SINGLE ARRAY, NON-RECHARGEABLE, INCLUDES EXTENSION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8687	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, DUAL ARRAY, RECHARGEABLE, INCLUDES EXTENSION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8687	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, DUAL ARRAY, RECHARGEABLE, INCLUDES EXTENSION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8687	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, DUAL ARRAY, RECHARGEABLE, INCLUDES EXTENSION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
L8688	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, DUAL ARRAY, NON-RECHARGEABLE, INCLUDES EXTENSION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8688	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, DUAL ARRAY, NON-RECHARGEABLE, INCLUDES EXTENSION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8688	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, DUAL ARRAY, NON-RECHARGEABLE, INCLUDES EXTENSION	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8689	EXTERNAL RECHARGING SYSTEM FOR BATTERY (INTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT ONLY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8689	EXTERNAL RECHARGING SYSTEM FOR BATTERY (INTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT ONLY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8690	AUDITORY OSSEOINTEGRATED DEVICE, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8691	AUDITORY OSSEOINTEGRATED DEVICE, EXTERNAL SOUND PROCESSOR, EXCLUDES TRANSDUCER/ACTUATOR, REPLACEMENT ONLY, EACH	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8692	AUDITORY OSSEOINTEGRATED DEVICE, EXTERNAL SOUND PROCESSOR, USED WITHOUT OSSEOINTEGRATION, BODY WORN, INCLUDES HEADBAND OR OTHER MEANS OF EXTERNAL ATTACHMENT	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8693	AUDITORY OSSEOINTEGRATED DEVICE ABUTMENT, ANY LENGTH, REPLACEMENT ONLY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8695	EXTERNAL RECHARGING SYSTEM FOR BATTERY (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT ONLY	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8696	ANTENNA (EXTERNAL) FOR USE WITH IMPLANTABLE DIAPHRAGMATIC/PHRENIC NERVE STIMULATION DEVICE, REPLACEMENT, EACH	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8699	PROSTHETIC IMPLANT, NOT OTHERWISE SPECIFIED	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
L8720	EXTERNAL LOWER EXTREMITY SENSORY PROSTHETIC DEVICE, CUTANEOUS STIMULATION OF MECHANORECEPTORS PROXIMAL TO THE ANKLE, PER LEG	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
L8721	RECEPTOR SOLE FOR USE WITH L8720, REPLACEMENT, EACH	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
L9900	ORTHOTIC AND PROSTHETIC SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS "L" CODE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
M0076	PROLOTHERAPY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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M0224	INTRAVENOUS INFUSION, PEMIVIBART, FOR THE PRE-EXPOSURE PROPHYLAXIS ONLY, FOR CERTAIN ADULTS AND ADOLESCENTS (12 YEARS OF AGE AND OLDER WEIGHING AT LEAST 40 KG) WITH NO KNOWN SARS-COV-2 EXPOSURE, WHO EITHER HAVE MODERATE-TO-SEVERE IMMUNE COMPROMISE DUE TO	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
P9020	PLATELET RICH PLASMA, EACH UNIT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q0138	INJECTION, FERUMOXYTOL, FOR TREATMENT OF IRON DEFICIENCY ANEMIA, 1 MG (NON-ESRD USE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q0139	INJECTION, FERUMOXYTOL, FOR TREATMENT OF IRON DEFICIENCY ANEMIA, 1 MG (FOR ESRD ON DIALYSIS)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q0155	DRONABINOL (SYNDROS), 0.1 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN	Preauthorization required when purchase price exceeds $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q0224	INJECTION, PEMIVIBART, FOR THE PRE-EXPOSURE PROPHYLAXIS ONLY, FOR CERTAIN ADULTS AND ADOLESCENTS (12 YEARS OF AGE AND OLDER WEIGHING AT LEAST 40 KG) WITH NO KNOWN SARS-COV-2 EXPOSURE, AND WHO EITHER HAVE MODERATE-TO-SEVERE IMMUNE COMPROMISE DUE TO A MEDIC		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
Q0249	INJECTION, TOCILIZUMAB, FOR HOSPITALIZED ADULTS AND PEDIATRIC PATIENTS (2 YEARS OF AGE AND OLDER) WITH COVID-19 WHO ARE RECEIVING SYSTEMIC CORTICOSTEROIDS AND REQUIRE SUPPLEMENTAL OXYGEN, NON-INVASIVE OR INVASIVE MECHANICAL VENTILATION, OR EXTRACORPOREAL	Preauthorization required when billed charges exceed $500 per line item	1/1/2025	Sendero internal medical policy RX.001 "Biologic and Special ty Treatments for Autoimmune Diseases"	InterQual® Evidence-Based Criteria & Guidelines
Q0507	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH AN EXTERNAL VENTRICULAR ASSIST DEVICE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q0508	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH AN IMPLANTED VENTRICULAR ASSIST DEVICE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q0509	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH ANY IMPLANTED VENTRICULAR ASSIST DEVICE FOR WHICH PAYMENT WAS NOT MADE UNDER MEDICARE PART A	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q0516	PHARMACY SUPPLYING FEE FOR HIV PRE-EXPOSURE PROPHYLAXIS FDA APPROVED PRESCRIPTION ORAL DRUG, PER 30-DAYS	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
Q0517	PHARMACY SUPPLYING FEE FOR HIV PRE-EXPOSURE PROPHYLAXIS FDA APPROVED PRESCRIPTION ORAL DRUG, PER 60-DAYS	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
Q0518	PHARMACY SUPPLYING FEE FOR HIV PRE-EXPOSURE PROPHYLAXIS FDA APPROVED PRESCRIPTION ORAL DRUG, PER 90-DAYS	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	InterQual® Evidence-Based Criteria & Guidelines	
Q2041	AXICABTAGENE CILOLEUCEL, UP TO 200 MILLION AUTOLOGOUS ANTI-CD19 CAR POSITIVE VIABLE T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q2042	TISAGENLECLEUCEL, UP TO 600 MILLION CAR-POSITIVE VIABLE T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q2043	SIPULEUCEL-T, MINIMUM OF 50 MILLION AUTOLOGOUS CD54+ CELLS ACTIVATED WITH PAP-GM-CSF, INCLUDING LEUKAPHERESIS AND ALL OTHER PREPARATORY PROCEDURES, PER INFUSION	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q2052	SERVICES, SUPPLIES AND ACCESSORIES USED IN THE HOME FOR THE ADMINISTRATION OF INTRAVENOUS IMMUNE GLOBULIN (IVIG)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Q2053	BREXUCABTAGENE AUTOLEUCEL, UP TO 200 MILLION AUTOLOGOUS ANTI-CD19 CAR POSITIVE VIABLE T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q2054	LISOCABTAGENE MARALEUCEL, UP TO 110 MILLION AUTOLOGOUS ANTI-CD19 CAR-POSITIVE VIABLE T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
Q2055	IDECABTAGENE VICLEUCEL, UP TO 510 MILLION AUTOLOGOUS B-CELL MATURATION ANTIGEN (BCMA) DIRECTED CAR-POSITIVE T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
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		5/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
Q2057	AFAMITRESGENE AUTOLEUCEL, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE		6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q3027	INJECTION, INTERFERON BETA-1A, 1 MCG FOR INTRAMUSCULAR USE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q3028	INJECTION, INTERFERON BETA-1A, 1 MCG FOR SUBCUTANEOUS USE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q3031	COLLAGEN SKIN TEST		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q4074	ILOPROST, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 20 MICROGRAMS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q4101	APLIGRAF, PER SQUARE CENTIMETER	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4101	APLIGRAF, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4102	OASIS WOUND MATRIX, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4103	OASIS BURN MATRIX, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4104	INTEGRA BILAYER MATRIX WOUND DRESSING (BMWD), PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4105	INTEGRA DERMAL REGENERATION TEMPLATE (DRT) OR INTEGRA OMNIGRAFT DERMAL REGENERATION MATRIX, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4106	DERMAGRAFT, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4107	GRAFTJACKET, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4108	INTEGRA MATRIX, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4110	PRIMATRIX, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4111	GAMMAGRAFT, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4112	CYMETRA, INJECTABLE, 1 CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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Q4113	GRAFTJACKET XPRESS, INJECTABLE, 1 CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4115	ALLOSKIN, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4117	HYALOMATRIX, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4118	MATRISTEM MICROMATRIX, 1 MG		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4121	THERASKIN, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4123	ALLOSKIN RT, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4125	ARTHROFLEX, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4126	MEMODERM, DERMASPAN, TRANZGRAFT OR INTEGUPLY, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4127	TALYMED, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4130	STRATTICE TM, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4134	HMATRIX, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4135	MEDISKIN, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4136	EZ-DERM, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4137	AMNIOEXCEL, AMNIOEXCEL PLUS OR BIODEXCEL, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4138	BIODFENCE DRYFLEX, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4139	AMNIOMATRIX OR BIODMATRIX, INJECTABLE, 1 CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4140	BIODFENCE, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4141	ALLOSKIN AC, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4142	XCM BIOLOGIC TISSUE MATRIX, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4143	REPRIZA, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4145	EPIFIX, INJECTABLE, 1 MG		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4146	TENSIX, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4147	ARCHITECT, ARCHITECT PX, OR ARCHITECT FX, EXTRACELLULAR MATRIX, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4148	NEOX CORD 1K, NEOX CORD RT, OR CLARIX CORD 1K, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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Q4149	EXCELLAGEN, 0.1 CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4150	ALLOWRAP DS OR DRY, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4151	AMNIOBAND OR GUARDIAN, PER SQUARE CENTIMETER		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4152	DERMAPURE, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4153	DERMAVEST AND PLURIVEST, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4154	BIOVANCE, PER SQUARE CENTIMETER		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4155	NEOXFLO OR CLARIXFLO, 1 MG		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4156	NEOX 100 OR CLARIX 100, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4157	REVITALON, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4158	KERECIS OMEGA3, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4159	AFFINITY, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4160	NUSHIELD, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4161	BIO-CONNEKT WOUND MATRIX, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4162	WOUNDEX FLOW, BIOSKIN FLOW, 0.5 CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4163	WOUNDEX, BIOSKIN, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4164	HELICOLL, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4165	KERAMATRIX OR KERASORB, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4166	CYTAL, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4167	TRUSKIN, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4169	ARTACENT WOUND, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4170	CYGNUS, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4171	INTERFYL, 1 MG		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4173	PALINGEN OR PALINGEN XPLUS, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4174	PALINGEN OR PROMATRX, 0.36 MG PER 0.25 CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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Q4175	MIRODERM, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4176	NEOPATCH OR THERION, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4177	FLOWERAMNIOFLO, 0.1 CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4178	FLOWERAMNIOPATCH, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4179	FLOWERDERM, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4180	REVITA, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4181	AMNIO WOUND, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4182	TRANSCYTE, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4183	SURGIGRAFT, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4184	CELLESTA OR CELLESTA DUO, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4185	CELLESTA FLOWABLE AMNION (25 MG PER CC); PER 0.5 CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4187	EPICORD, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4188	AMNIOARMOR, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4189	ARTACENT AC, 1 MG		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4190	ARTACENT AC, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4191	RESTORIGIN, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4192	RESTORIGIN, 1 CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4193	COLL-E-DERM, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4194	NOVACHOR, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4195	PURAPLY, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4196	PURAPLY AM, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4197	PURAPLY XT, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4198	GENESIS AMNIOTIC MEMBRANE, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4200	SKIN TE, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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Q4201	MATRION, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4202	KEROXX (2.5G/CC), 1CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4203	DERMA-GIDE, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4204	XWRAP, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4205	MEMBRANE GRAFT OR MEMBRANE WRAP, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4206	FLUID FLOW OR FLUID GF, 1 CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4208	NOVAFIX, PER SQUARE CENITMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4209	SURGRAFT, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4210	AXOLOTL GRAFT OR AXOLOTL DUALGRAFT, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4211	AMNION BIO OR AXOBIOMEMBRANE, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4212	ALLOGEN, PER CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4213	ASCENT, 0.5 MG		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4214	CELLESTA CORD, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4215	AXOLOTL AMBIENT OR AXOLOTL CRYO, 0.1 MG		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4216	ARTACENT CORD, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4217	WOUNDFIX, BIOWOUND, WOUNDFIX PLUS, BIOWOUND PLUS, WOUNDFIX XPLUS OR BIOWOUND XPLUS, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4218	SURGICORD, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4219	SURGIGRAFT-DUAL, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4221	AMNIOWRAP2, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4227	AMNIOCORE, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4228	BIONEXTPATCH, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4229	COGENEX AMNIOTIC MEMBRANE, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4230	COGENEX FLOWABLE AMNION, PER 0.5 CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4231	CORPLEX P, PER CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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Q4232	CORPLEX, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4233	SURFACTOR OR NUDYN, PER 0.5 CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4234	XCELLERATE, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4235	AMNIOREPAIR OR ALTIPLY, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4236	CAREPATCH, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4237	CRYO-CORD, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4239	AMNIO-MAXX OR AMNIO-MAXX LITE, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4240	CORECYTE, FOR TOPICAL USE ONLY, PER 0.5 CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4241	POLYCYTE, FOR TOPICAL USE ONLY, PER 0.5 CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4242	AMNIOCYTE PLUS, PER 0.5 CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4244	PROCENTA, PER 200 MG		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4245	AMNIOTEXT, PER CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4246	CORETEXT OR PROTEXT, PER CC		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4247	AMNIOTEXT PATCH, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4248	DERMACYTE AMNIOTIC MEMBRANE ALLOGRAFT, PER SQUARE CENTIMETER		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4262	DUAL LAYER IMPAX MEMBRANE, PER SQUARE CENTIMETER		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4263	SURGRAFT TL, PER SQUARE CENTIMETER		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4264	COCOON MEMBRANE, PER SQUARE CENTIMETER		5/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4265	NEOSTIM TL, PER SQUARE CENTIMETER		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4266	NEOSTIM MEMBRANE, PER SQUARE CENTIMETER		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4267	NEOSTIM DL, PER SQUARE CENTIMETER		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4268	SURGRAFT FT, PER SQUARE CENTIMETER		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4269	SURGRAFT XT, PER SQUARE CENTIMETER		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4270	COMPLETE SL, PER SQUARE CENTIMETER		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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Q4271	COMPLETE FT, PER SQUARE CENTIMETER		8/15/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4272	ESANO A, PER SQUARE CENTIMETER		7/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4273	ESANO AAA, PER SQUARE CENTIMETER		7/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4274	ESANO AC, PER SQUARE CENTIMETER		7/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4275	ESANO ACA, PER SQUARE CENTIMETER		7/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4276	ORION, PER SQUARE CENTIMETER		7/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4277	WOUNDPLUS MEMBRANE OR E-GRAFT, PER SQUARE CENTIMETER		7/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4278	EPIEFFECT, PER SQUARE CENTIMETER		7/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4279	VENDAJE AC, PER SQUARE CENTIMETER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4280	XCELL AMNIO MATRIX, PER SQUARE CENTIMETER		7/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4281	BARRERA SL OR BARRERA DL, PER SQUARE CENTIMETER		7/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4282	CYGNUS DUAL, PER SQUARE CENTIMETER		7/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4283	BIOVANCE TRI-LAYER OR BIOVANCE 3L, PER SQUARE CENTIMETER		7/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4284	DERMABIND SL, PER SQUARE CENTIMETER		7/1/2023	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4287	DERMABIND DL, PER SQUARE CENTIMETER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4288	DERMABIND CH, PER SQUARE CENTIMETER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4289	REVOSHIELD + AMNIOTIC BARRIER, PER SQUARE CENTIMETER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4290	MEMBRANE WRAP-HYDRO, PER SQUARE CENTIMETER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4291	LAMELLAS XT, PER SQUARE CENTIMETER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4292	LAMELLAS, PER SQUARE CENTIMETER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4293	ACESSO DL, PER SQUARE CENTIMETER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4294	AMNIO QUAD-CORE, PER SQUARE CENTIMETER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4295	AMNIO TRI-CORE AMNIOTIC, PER SQUARE CENTIMETER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4296	REBOUND MATRIX, PER SQUARE CENTIMETER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
Q4297	EMERGE MATRIX, PER SQUARE CENTIMETER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4298	AMNICORE PRO, PER SQUARE CENTIMETER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4299	AMNICORE PRO+, PER SQUARE CENTIMETER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4300	ACESSO TL, PER SQUARE CENTIMETER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4301	ACTIVATE MATRIX, PER SQUARE CENTIMETER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4302	COMPLETE ACA, PER SQUARE CENTIMETER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4303	COMPLETE AA, PER SQUARE CENTIMETER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4304	GRAFIX PLUS, PER SQUARE CENTIMETER		4/1/2024	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4305	AMERICAN AMNION AC TRI-LAYER, PER SQUARE CENTIMETER		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	InterQual® Evidence-Based Criteria & Guidelines
Q4306	AMERICAN AMNION AC, PER SQUARE CENTIMETER		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	InterQual® Evidence-Based Criteria & Guidelines
Q4307	AMERICAN AMNION, PER SQUARE CENTIMETER		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	InterQual® Evidence-Based Criteria & Guidelines
Q4308	SANOPELLIS, PER SQUARE CENTIMETER		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	InterQual® Evidence-Based Criteria & Guidelines
Q4309	VIA MATRIX, PER SQUARE CENTIMETER		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	InterQual® Evidence-Based Criteria & Guidelines
Q4310	PROCENTA, PER 100 MG		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	InterQual® Evidence-Based Criteria & Guidelines
Q4334	AMNIOPLAST 1, PER SQUARE CENTIMETER		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4335	AMNIOPLAST 2, PER SQUARE CENTIMETER		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4336	ARTACENT C, PER SQUARE CENTIMETER		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4337	ARTACENT TRIDENT, PER SQUARE CENTIMETER		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4338	ARTACENT VELOS, PER SQUARE CENTIMETER		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4339	ARTACENT VERICLEN, PER SQUARE CENTIMETER		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4340	SIMPLIGRAFT, PER SQUARE CENTIMETER		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4341	SIMPLIMAX, PER SQUARE CENTIMETER		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4342	THERAMEND, PER SQUARE CENTIMETER		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4343	DERMACYTE AC MATRIX AMNIOTIC MEMBRANE ALLOGRAFT, PER SQUARE CENTIMETER		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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Q4344	TRI-MEMBRANE WRAP, PER SQUARE CENTIMETER		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4345	MATRIX HD ALLOGRAFT DERMIS, PER SQUARE CENTIMETER		3/1/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4346	SHELTER DM MATRIX, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4347	RAMPART DL MATRIX, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4348	SENTRY SL MATRIX, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4349	MANTLE DL MATRIX, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4350	PALISADE DM MATRIX, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4351	ENCLOSE TL MATRIX, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4352	OVERLAY SL MATRIX, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4353	XCEED TL MATRIX, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4354	PALINGEN DUAL-LAYER MEMBRANE, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4355	ABIOMEND XPLUS MEMBRANE AND ABIOMEND XPLUS HYDROMEMBRANE, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4356	ABIOMEND MEMBRANE AND ABIOMEND HYDROMEMBRANE, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4357	XWRAP PLUS, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4358	XWRAP DUAL, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4359	CHORIPLY, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4360	AMCHOPLAST FD, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4361	EPIXPRESS, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4362	CYGNUS DISK, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4363	AMNIO BURGEON MEMBRANE AND HYDROMEMBRANE, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4364	AMNIO BURGEON XPLUS MEMBRANE AND XPLUS HYDROMEMBRANE, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4365	AMNIO BURGEON DUAL-LAYER MEMBRANE, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4366	DUAL LAYER AMNIO BURGEON X-MEMBRANE, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
Q4367	AMNIOCORE SL, PER SQUARE CENTIMETER		6/15/2025	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
Q5001	HOSPICE OR HOME HEALTH CARE PROVIDED IN PATIENT'S HOME/RESIDENCE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q5002	HOSPICE OR HOME HEALTH CARE PROVIDED IN ASSISTED LIVING FACILITY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q5003	HOSPICE CARE PROVIDED IN NURSING LONG TERM CARE FACILITY (LTC) OR NON-SKILLED NURSING FACILITY (NF)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q5004	HOSPICE CARE PROVIDED IN SKILLED NURSING FACILITY (SNF)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q5005	HOSPICE CARE PROVIDED IN INPATIENT HOSPITAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q5006	HOSPICE CARE PROVIDED IN INPATIENT HOSPICE FACILITY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q5007	HOSPICE CARE PROVIDED IN LONG TERM CARE FACILITY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q5008	HOSPICE CARE PROVIDED IN INPATIENT PSYCHIATRIC FACILITY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q5009	HOSPICE OR HOME HEALTH CARE PROVIDED IN PLACE NOT OTHERWISE SPECIFIED (NOS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q5010	HOSPICE HOME CARE PROVIDED IN A HOSPICE FACILITY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q5101	INJECTION, FILGRASTIM-SNDZ, BIOSIMILAR, (ZARXIO), 1 MICROGRAM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q5103	INJECTION, INFLIXIMAB-DYYB, BIOSIMILAR, (INFLECTRA), 10 MG	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	Sendero internal medical policy RX.001 "Biologic and Special	InterQual® Evidence-Based Criteria & Guidelines
Q5104	INJECTION, INFLIXIMAB-ABDA, BIOSIMILAR, (RENFLEXIS), 10 MG	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	Sendero internal medical policy RX.001 "Biologic and Special	InterQual® Evidence-Based Criteria & Guidelines
Q5106	INJECTION, EPOETIN ALFA-EPBX, BIOSIMILAR, (RETACRIT) (FOR NON-ESRD USE), 1000 UNITS	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q5107	INJECTION, BEVACIZUMAB-AWWB, BIOSIMILAR, (MVASI), 10 MG	Includes step therapy requirements through either biosimilars or therapeutically similar medications for the below medications only when used for cancer/chemotherapy indications. Preauthorization required when billed charges exceed $500 per line item	1/1/2022	OncolHealth medical policy, "Bevacizumab: Alymsys, Avastin	InterQual® Evidence-Based Criteria & Guidelines
Q5108	INJECTION, PEGFILGRASTIM-JMDB (FULPHILA), BIOSIMILAR, 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q5109	INJECTION, INFLIXIMAB-QBTX, BIOSIMILAR, (IXIFI), 10 MG	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	Sendero internal medical policy RX.001 "Biologic and Special	InterQual® Evidence-Based Criteria & Guidelines
Q5110	INJECTION, FILGRASTIM-AAFI, BIOSIMILAR, (NIVESTYM), 1 MICROGRAM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q5111	INJECTION, PEGFILGRASTIM-CBQV (UDENYCA), BIOSIMILAR, 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
Q5112	INJECTION, TRASTUZUMAB-DTTB, BIOSIMILAR, (ONTRUZANT), 10 MG	Includes step therapy requirements through either biosimilars or therapeutically similar medications for the below medications only when used for cancer/chemotherapy indications. Preauthorization required for all uses.	1/1/2022	OncoHealth Medical Policy, "Trastuzumab: Herceptin, Herce	InterQual® Evidence-Based Criteria & Guidelines
Q5113	INJECTION, TRASTUZUMAB-PKRB, BIOSIMILAR, (HERZUMA), 10 MG	Includes step therapy requirements through either biosimilars or therapeutically similar medications for the below medications only when used for cancer/chemotherapy indications. Preauthorization required for all uses.	1/1/2022	OncoHealth Medical Policy, "Trastuzumab: Herceptin, Herce	InterQual® Evidence-Based Criteria & Guidelines
Q5114	INJECTION, TRASTUZUMAB-DKST, BIOSIMILAR, (OGIVRI), 10 MG	Includes step therapy requirements through either biosimilars or therapeutically similar medications for the below medications only when used for cancer/chemotherapy indications. Preauthorization required for all uses.	1/1/2022	OncoHealth Medical Policy, "Trastuzumab: Herceptin, Herce	InterQual® Evidence-Based Criteria & Guidelines
Q5115	INJECTION, RITUXIMAB-ABBS, BIOSIMILAR, (TRUXIMA), 10 MG	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	OncoHealth Medical Policy, "Rituximab: Riabni, Rituxan, Ritu	InterQual® Evidence-Based Criteria & Guidelines
Q5116	INJECTION, TRASTUZUMAB-QYYP, BIOSIMILAR, (TRAZIMERA), 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	OncoHealth Medical Policy, "Trastuzumab: Herceptin, Herce	InterQual® Evidence-Based Criteria & Guidelines
Q5117	INJECTION, TRASTUZUMAB-ANNS, BIOSIMILAR, (KANJINTI), 10 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	OncoHealth Medical Policy, "Trastuzumab: Herceptin, Herce	InterQual® Evidence-Based Criteria & Guidelines
Q5118	INJECTION, BEVACIZUMAB-BVZR, BIOSIMILAR, (ZIRABEV), 10 MG	Includes step therapy requirements through either biosimilars or therapeutically similar medications for the below medications only when used for cancer/chemotherapy indications. Preauthorization required when billed charges exceed $500 per line item	1/1/2025	OncoHealth medical policy, "Bevacizumab: Alymsys, Avastin,	InterQual® Evidence-Based Criteria & Guidelines
Q5119	INJECTION, RITUXIMAB-PVVR, BIOSIMILAR, (RUXIENCE), 10 MG	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	OncoHealth Medical Policy, "Rituximab: Riabni, Rituxan, Ritu	InterQual® Evidence-Based Criteria & Guidelines
Q5120	INJECTION, PEGFILGRASTIM-BMEZ (ZIEXTENZO), BIOSIMILAR, 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q5121	INJECTION, INFLIXIMAB-AXXQ, BIOSIMILAR, (AVSOLA), 10 MG	Preauthorization required when billed charges exceed $500 per line item	2/28/2021	Sendero internal medical policy RX.001 "Biologic and Special	InterQual® Evidence-Based Criteria & Guidelines
Q5122	INJECTION, PEGFILGRASTIM-APGF (NYVEPRIA), BIOSIMILAR, 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Sendero internal medical policy RX.001 "Biologic and Special	InterQual® Evidence-Based Criteria & Guidelines
Q5123	INJECTION, RITUXIMAB-ARRX, BIOSIMILAR, (RIABNI), 10 MG	Includes step therapy requirements through either biosimilars or therapeutically similar medications for the below medications only when used for cancer/chemotherapy indications. Preauthorization required for all uses.	1/1/2022	OncoHealth Medical Policy, "Rituximab: Riabni, Rituxan, Ritu	InterQual® Evidence-Based Criteria & Guidelines
Q5124	INJECTION, RANIBIZUMAB-NUNA, BIOSIMILAR, (BYOOVIZ), 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Q5126	INJECTION, BEVACIZUMAB-MALY, BIOSIMILAR, (ALYMSYS), 10 MG	Includes step therapy requirements through either biosimilars or therapeutically similar medications for the below medications only when used for cancer/chemotherapy indications. Preauthorization required when billed charges exceed $500 per line item	5/15/2023	OncolHealth medical policy, "Bevacizumab: Alymsys, Avastin [illegible]"	InterQual® Evidence-Based Criteria & Guidelines [illegible]
Q5127	INJECTION, PEGFILGRASTIM-FPGK (STIMUFEND), BIOSIMILAR, 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	8/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
Q5128	INJECTION, RANIBIZUMAB-EQRN (CIMERLI), BIOSIMILAR, 0.1 MG	Preauthorization required when billed charges exceed $500 per line item	8/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
Q5129	INJECTION, BEVACIZUMAB-ADCD (VEGZELMA), BIOSIMILAR, 10 MG	Includes step therapy requirements through either biosimilars or therapeutically similar medications for the below medications only when used for cancer/chemotherapy indications. Preauthorization required when billed charges exceed $500 per line item	8/15/2023	OncolHealth medical policy, "Bevacizumab: Alymsys, Avastin [illegible]"	InterQual® Evidence-Based Criteria & Guidelines [illegible]
Q5130	INJECTION, PEGFILGRASTIM-PBBK (FYLNETRA), BIOSIMILAR, 0.5 MG	Preauthorization required when billed charges exceed $500 per line item	8/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
Q5131	INJECTION, ADALIMUMAB-AACF (IDACIO), BIOSIMILAR, 20 MG	Preauthorization required when billed charges exceed $500 per line item	7/1/2023	Sendero internal medical policy RX.001 "Biologic and Specialty Treatments for Autoimmune Diseases"	InterQual® Evidence-Based Criteria & Guidelines
Q5132	INJECTION, ADALIMUMAB-AFZB (ABRILADA), BIOSIMILAR, 10 MG	Preauthorization required when billed charges exceed $500 per line item	4/1/2024	Sendero internal medical policy RX.001 "Biologic and Specialty Treatments for Autoimmune Diseases"	InterQual® Evidence-Based Criteria & Guidelines
Q5133	INJECTION, TOCILIZUMAB-BAVI (TOFIDENCE), BIOSIMILAR, 1 MG	Preauthorization required when billed charges exceed $500 per line item	11/26/2024	Sendero internal medical policy RX.001 "Biologic and Specialty Treatments for Autoimmune Diseases"	InterQual® Evidence-Based Criteria & Guidelines
Q5134	INJECTION, NATALIZUMAB-SZTN (TYRUKO), BIOSIMILAR, 1 MG	Preauthorization required when billed charges exceed $500 per line item	9/1/2024	Sendero internal medical policy RX.001 "Biologic and Specialty Treatments for Autoimmune Diseases"	InterQual® Evidence-Based Criteria & Guidelines
Q5135	INJECTION, TOCILIZUMAB-AAZG (TYENNE), BIOSIMILAR, 1 MG	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q5136	INJECTION, DENOSUMAB-BBDZ (JUBBONTI/WYOST), BIOSIMILAR, 1 MG	Preauthorization required when billed charges exceed $500 per line item	3/1/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q5139	INJECTION, ECULIZUMAB-AEEB (BKEMV), BIOSIMILAR, 10 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q5140	INJECTION, ADALIMUMAB-FKJP, BIOSIMILAR, 1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q5141	INJECTION, ADALIMUMAB-AATY, BIOSIMILAR, 1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q5142	INJECTION, ADALIMUMAB-RYVK BIOSIMILAR, 1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q5143	INJECTION, ADALIMUMAB-ADBM, BIOSIMILAR, 1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q5144	INJECTION, ADALIMUMAB-AACF (IDACIO), BIOSIMILAR, 1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q5145	INJECTION, ADALIMUMAB-AFZB (ABRILADA), BIOSIMILAR, 1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	

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Q5146	INJECTION, TRASTUZUMAB-STRF (HERCESSI), BIOSIMILAR, 10 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q5147	INJECTION, AFLIBERCEPT-AYYH (PAVBLU), BIOSIMILAR, 1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q5148	INJECTION, FILGRASTIM-TXID (NYPOZI), BIOSIMILAR, 1 MICROGRAM	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q5149	INJECTION, AFLIBERCEPT-ABZV (ENZEEVU), BIOSIMILAR, 1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q5150	INJECTION, AFLIBERCEPT-MRBB (AHZANTIVE), BIOSIMILAR, 1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q5151	INJECTION, ECULIZUMAB-AAGH (EPYSQLI), BIOSIMILAR, 2 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q5152	INJECTION, ECULIZUMAB-AEEB (BKEMV), BIOSIMILAR, 2 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q9980	HYALURONAN OR DERIVATIVE, GENVISC 850, FOR INTRA-ARTICULAR INJECTION, 1 MG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
Q9996	INJECTION, USTEKINUMAB-TTWE (PYZCHIVA), SUBCUTANEOUS, 1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q9997	INJECTION, USTEKINUMAB-TTWE (PYZCHIVA), INTRAVENOUS, 1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q9998	INJECTION, USTEKINUMAB-AEKN (SELARSDI), 1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
Q9999	INJECTION, USTEKINUMAB-AAUZ (OTULFI), BIOSIMILAR, 1 MG	Preauthorization required when billed charges exceed $500 per line item	6/15/2025	InterQual® Evidence-Based Criteria & Guidelines	
S0145	INJECTION, PEGYLATED INTERFERON ALFA-2A, 180 MCG PER ML	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S0148	INJECTION, PEGYLATED INTERFERON ALFA-2B, 10 MCG	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S0270	PHYSICIAN MANAGEMENT OF PATIENT HOME CARE, STANDARD MONTHLY CASE RATE (PER 30 DAYS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S0270	PHYSICIAN MANAGEMENT OF PATIENT HOME CARE, STANDARD MONTHLY CASE RATE (PER 30 DAYS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S0271	PHYSICIAN MANAGEMENT OF PATIENT HOME CARE, HOSPICE MONTHLY CASE RATE (PER 30 DAYS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S0272	PHYSICIAN MANAGEMENT OF PATIENT HOME CARE, EPISODIC CARE MONTHLY CASE RATE (PER 30 DAYS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S0273	PHYSICIAN VISIT AT MEMBER'S HOME, OUTSIDE OF A CAPITATION ARRANGEMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S0274	NURSE PRACTITIONER VISIT AT MEMBER'S HOME, OUTSIDE OF A CAPITATION ARRANGEMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S0280	MEDICAL HOME PROGRAM, COMPREHENSIVE CARE COORDINATION AND PLANNING, INITIAL PLAN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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S0281	MEDICAL HOME PROGRAM, COMPREHENSIVE CARE COORDINATION AND PLANNING, MAINTENANCE OF PLAN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S1030	CONTINUOUS NONINVASIVE GLUCOSE MONITORING DEVICE, PURCHASE (FOR PHYSICIAN INTERPRETATION OF DATA, USE CPT CODE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S1031	CONTINUOUS NONINVASIVE GLUCOSE MONITORING DEVICE, RENTAL, INCLUDING SENSOR, SENSOR REPLACEMENT, AND DOWNLOAD TO MONITOR (FOR PHYSICIAN INTERPRETATION OF DATA, USE CPT CODE)	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S1034	ARTIFICIAL PANCREAS DEVICE SYSTEM (E.G., LOW GLUCOSE SUSPEND (LGS) FEATURE) INCLUDING CONTINUOUS GLUCOSE MONITOR, BLOOD GLUCOSE DEVICE, INSULIN PUMP AND COMPUTER ALGORITHM THAT COMMUNICATES WITH ALL OF THE DEVICES	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S1035	SENSOR; INVASIVE (E.G., SUBCUTANEOUS), DISPOSABLE, FOR USE WITH ARTIFICIAL PANCREAS DEVICE SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S1036	TRANSMITTER; EXTERNAL, FOR USE WITH ARTIFICIAL PANCREAS DEVICE SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S1037	RECEIVER (MONITOR); EXTERNAL, FOR USE WITH ARTIFICIAL PANCREAS DEVICE SYSTEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S1040	CRANIAL REMOLDING ORTHOSIS, PEDIATRIC, RIGID, WITH SOFT INTERFACE MATERIAL, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT(S)	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S1090	MOMETASONE FUROATE SINUS IMPLANT, 370 MICROGRAMS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S2065	SIMULTANEOUS PANCREAS KIDNEY TRANSPLANTATION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S2066	BREAST RECONSTRUCTION WITH GLUTEAL ARTERY PERFORATOR (GAP) FLAP, INCLUDING HARVESTING OF THE FLAP, MICROVASCULAR TRANSFER, CLOSURE OF DONOR SITE AND SHAPING THE FLAP INTO A BREAST, UNILATERAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S2067	BREAST RECONSTRUCTION OF A SINGLE BREAST WITH "STACKED" DEEP INFERIOR EPIGASTRIC PERFORATOR (DIEP) FLAP(S) AND/OR GLUTEAL ARTERY PERFORATOR (GAP) FLAP(S), INCLUDING HARVESTING OF THE FLAP(S), MICROVASCULAR TRANSFER, CLOSURE OF DONOR SITE(S) AND SHAPING TH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S2075	LAPAROSCOPY, SURGICAL; REPAIR INCISIONAL OR VENTRAL HERNIA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S2077	LAPAROSCOPY, SURGICAL; IMPLANTATION OF MESH OR OTHER PROSTHESIS FOR INCISIONAL OR VENTRAL HERNIA REPAIR (LIST SEPARATELY IN ADDITION TO CODE FOR INCISIONAL OR VENTRAL HERNIA REPAIR)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S2112	ARTHROSCOPY, KNEE, SURGICAL FOR HARVESTING OF CARTILAGE (CHONDROCYTE CELLS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S2117	ARTHROEREISIS, SUBTALAR		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S2118	METAL-ON-METAL TOTAL HIP RESURFACING, INCLUDING ACETABULAR AND FEMORAL COMPONENTS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S2202	ECHOSCLEROTHERAPY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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S2202	ECHOSCLEROTHERAPY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S2235	IMPLANTATION OF AUDITORY BRAIN STEM IMPLANT	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S2300	ARTHROSCOPY, SHOULDER, SURGICAL; WITH THERMALLY-INDUCED CAPSULORRHAPHY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S2348	DECOMPRESSION PROCEDURE, PERCUTANEOUS, OF NUCLEUS PULPOSUS OF INTERVERTEBRAL DISC, USING RADIOFREQUENCY ENERGY, SINGLE OR MULTIPLE LEVELS, LUMBAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S3650	SALIVA TEST, HORMONE LEVEL; DURING MENOPAUSE		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S3652	SALIVA TEST, HORMONE LEVEL; TO ASSESS PRETERM LABOR RISK		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S3722	DOSE OPTIMIZATION BY AREA UNDER THE CURVE (AUC) ANALYSIS, FOR INFUSIONAL 5-FLUOROURACIL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S3800	GENETIC TESTING FOR AMYOTROPHIC LATERAL SCLEROSIS (ALS)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S3840	DNA ANALYSIS FOR GERMLINE MUTATIONS OF THE RET PROTO-ONCOGENE FOR SUSCEPTIBILITY TO MULTIPLE ENDOCRINE NEOPLASIA TYPE 2		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S3841	GENETIC TESTING FOR RETINOBLASTOMA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S3842	GENETIC TESTING FOR VON HIPPEL-LINDAU DISEASE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S3844	DNA ANALYSIS OF THE CONNEXIN 26 GENE (GJB2) FOR SUSCEPTIBILITY TO CONGENITAL, PROFOUND DEAFNESS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S3845	GENETIC TESTING FOR ALPHA-THALASSEMIA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S3846	GENETIC TESTING FOR HEMOGLOBIN E BETA-THALASSEMIA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S3849	GENETIC TESTING FOR NIEMANN-PICK DISEASE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S3850	GENETIC TESTING FOR SICKLE CELL ANEMIA		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S3853	GENETIC TESTING FOR MYOTONIC MUSCULAR DYSTROPHY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S3854	GENE EXPRESSION PROFILING PANEL FOR USE IN THE MANAGEMENT OF BREAST CANCER TREATMENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S3861	GENETIC TESTING, SODIUM CHANNEL, VOLTAGE-GATED, TYPE V, ALPHA SUBUNIT (SCN5A) AND VARIANTS FOR SUSPECTED BRUGADA SYNDROME		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S3861	GENETIC TESTING, SODIUM CHANNEL, VOLTAGE-GATED, TYPE V, ALPHA SUBUNIT (SCN5A) AND VARIANTS FOR SUSPECTED BRUGADA SYNDROME		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S3865	COMPREHENSIVE GENE SEQUENCE ANALYSIS FOR HYPERTROPHIC CARDIOMYOPATHY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S3865	COMPREHENSIVE GENE SEQUENCE ANALYSIS FOR HYPERTROPHIC CARDIOMYOPATHY		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines

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S3866	GENETIC ANALYSIS FOR A SPECIFIC GENE MUTATION FOR HYPERTROPHIC CARDIOMYOPATHY (HCM) IN AN INDIVIDUAL WITH A KNOWN HCM MUTATION IN THE FAMILY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S3870	COMPARATIVE GENOMIC HYBRIDIZATION (CGH) MICROARRAY TESTING FOR DEVELOPMENTAL DELAY, AUTISM SPECTRUM DISORDER AND/OR INTELLECTUAL DISABILITY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S3900	SURFACE ELECTROMYOGRAPHY (EMG)		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S5035	HOME INFUSION THERAPY, ROUTINE SERVICE OF INFUSION DEVICE (E.G., PUMP MAINTENANCE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S5036	HOME INFUSION THERAPY, REPAIR OF INFUSION DEVICE (E.G., PUMP REPAIR)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S5108	HOME CARE TRAINING TO HOME CARE CLIENT, PER 15 MINUTES		4/14/2020	InterQual® Evidence-Based Criteria & Guidelines	
S5108	HOME CARE TRAINING TO HOME CARE CLIENT, PER 15 MINUTES		4/14/2020	InterQual® Evidence-Based Criteria & Guidelines	
S5109	HOME CARE TRAINING TO HOME CARE CLIENT, PER SESSION		4/14/2020	InterQual® Evidence-Based Criteria & Guidelines	
S5109	HOME CARE TRAINING TO HOME CARE CLIENT, PER SESSION		4/14/2020	InterQual® Evidence-Based Criteria & Guidelines	
S5110	HOME CARE TRAINING, FAMILY; PER 15 MINUTES		4/14/2020	InterQual® Evidence-Based Criteria & Guidelines	
S5110	HOME CARE TRAINING, FAMILY; PER 15 MINUTES		4/14/2020	InterQual® Evidence-Based Criteria & Guidelines	
S5111	HOME CARE TRAINING, FAMILY; PER SESSION		4/14/2020	InterQual® Evidence-Based Criteria & Guidelines	
S5111	HOME CARE TRAINING, FAMILY; PER SESSION		4/14/2020	InterQual® Evidence-Based Criteria & Guidelines	
S5115	HOME CARE TRAINING, NON-FAMILY; PER 15 MINUTES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S5116	HOME CARE TRAINING, NON-FAMILY; PER SESSION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S5181	HOME HEALTH RESPIRATORY THERAPY, NOS, PER DIEM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S8035	MAGNETIC SOURCE IMAGING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S8037	MAGNETIC RESONANCE CHOLANGIOPANCREATOGRAPHY (MRCP)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S8040	TOPOGRAPHIC BRAIN MAPPING		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S8042	MAGNETIC RESONANCE IMAGING (MRI), LOW-FIELD		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S8085	FLUORINE-18 FLUORODEOXYGLUCOSE (F-18 FDG) IMAGING USING DUAL-HEAD COINCIDENCE DETECTION SYSTEM (NON-DEDICATED PET SCAN)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S8092	ELECTRON BEAM COMPUTED TOMOGRAPHY (ALSO KNOWN AS ULTRAFAST CT, CINE CT)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S8120	OXYGEN CONTENTS, GASEOUS, 1 UNIT EQUALS 1 CUBIC FOOT	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
S8121	OXYGEN CONTENTS, LIQUID, 1 UNIT EQUALS 1 POUND	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S8130	INTERFERENTIAL CURRENT STIMULATOR, 2 CHANNEL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S8130	INTERFERENTIAL CURRENT STIMULATOR, 2 CHANNEL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S8131	INTERFERENTIAL CURRENT STIMULATOR, 4 CHANNEL		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S8131	INTERFERENTIAL CURRENT STIMULATOR, 4 CHANNEL	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S8270	ENURESIS ALARM, USING AUDITORY BUZZER AND/OR VIBRATION DEVICE	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S8301	INFECTION CONTROL SUPPLIES, NOT OTHERWISE SPECIFIED	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S8930	ELECTRICAL STIMULATION OF AURICULAR ACUPUNCTURE POINTS; EACH 15 MINUTES OF PERSONAL ONE-ON-ONE CONTACT WITH THE PATIENT		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S8940	EQUESTRIAN/HIPPOTHERAPY, PER SESSION		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S8990	PHYSICAL OR MANIPULATIVE THERAPY PERFORMED FOR MAINTENANCE RATHER THAN RESTORATION	Effective 1/27/2025 For Physical or Occupational Therapy only, authorization required when visits exceed 12 per calendar year (initial evaluation excluded).	7/7/2020	InterQual® Evidence-Based Criteria & Guidelines	
S9001	HOME UTERINE MONITOR WITH OR WITHOUT ASSOCIATED NURSING SERVICES		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S9002	INTRA-VAGINAL MOTION SENSOR SYSTEM, PROVIDES BIOFEEDBACK FOR PELVIC FLOOR MUSCLE REHABILITATION DEVICE		9/1/2024	InterQual® Evidence-Based Criteria & Guidelines	InterQual® Evidence-Based Criteria & Guidelines
S9055	PROCUREN OR OTHER GROWTH FACTOR PREPARATION TO PROMOTE WOUND HEALING		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S9056	COMA STIMULATION PER DIEM		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S9061	HOME ADMINISTRATION OF AEROSOLIZED DRUG THERAPY (E.G., PENTAMIDINE); ADMINISTRATIVE SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE COORDINATION, ALL NECESSARY SUPPLIES AND EQUIPMENT (DRUGS AND NURSING VISITS CODED SEPARATELY), PER DIEM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9090	VERTEBRAL AXIAL DECOMPRESSION, PER SESSION		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
S9097	HOME VISIT FOR WOUND CARE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9098	HOME VISIT, PHOTOTHERAPY SERVICES (E.G., BILI-LITE), INCLUDING EQUIPMENT RENTAL, NURSING SERVICES, BLOOD DRAW, SUPPLIES, AND OTHER SERVICES, PER DIEM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9110	TELEMONITORING OF PATIENT IN THEIR HOME, INCLUDING ALL NECESSARY EQUIPMENT; COMPUTER SYSTEM, CONNECTIONS, AND SOFTWARE; MAINTENANCE; PATIENT EDUCATION AND SUPPORT; PER MONTH		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9123	NURSING CARE, IN THE HOME; BY REGISTERED NURSE, PER HOUR (USE FOR GENERAL NURSING CARE ONLY, NOT TO BE USED WHEN CPT CODES 99500-99602 CAN BE USED)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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S9124	NURSING CARE, IN THE HOME; BY LICENSED PRACTICAL NURSE, PER HOUR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9126	HOSPICE CARE, IN THE HOME, PER DIEM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9127	SOCIAL WORK VISIT, IN THE HOME, PER DIEM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9128	SPEECH THERAPY, IN THE HOME, PER DIEM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9129	OCCUPATIONAL THERAPY, IN THE HOME, PER DIEM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9131	PHYSICAL THERAPY; IN THE HOME, PER DIEM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9208	HOME MANAGEMENT OF PRETERM LABOR, INCLUDING ADMINISTRATIVE SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE COORDINATION, AND ALL NECESSARY SUPPLIES OR EQUIPMENT (DRUGS AND NURSING VISITS CODED SEPARATELY), PER DIEM (DO NOT USE THIS CODE WITH ANY HOME INFUS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9209	HOME MANAGEMENT OF PRETERM PREMATURE RUPTURE OF MEMBRANES (PPROM), INCLUDING ADMINISTRATIVE SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE COORDINATION, AND ALL NECESSARY SUPPLIES OR EQUIPMENT (DRUGS AND NURSING VISITS CODED SEPARATELY), PER DIEM (DO NOT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9211	HOME MANAGEMENT OF GESTATIONAL HYPERTENSION, INCLUDES ADMINISTRATIVE SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE COORDINATION AND ALL NECESSARY SUPPLIES AND EQUIPMENT (DRUGS AND NURSING VISITS CODED SEPARATELY); PER DIEM (DO NOT USE THIS CODE WITH ANY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9212	HOME MANAGEMENT OF POSTPARTUM HYPERTENSION, INCLUDES ADMINISTRATIVE SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE COORDINATION, AND ALL NECESSARY SUPPLIES AND EQUIPMENT (DRUGS AND NURSING VISITS CODED SEPARATELY), PER DIEM (DO NOT USE THIS CODE WITH ANY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9213	HOME MANAGEMENT OF PREECLAMPSIA, INCLUDES ADMINISTRATIVE SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE COORDINATION, AND ALL NECESSARY SUPPLIES AND EQUIPMENT (DRUGS AND NURSING SERVICES CODED SEPARATELY); PER DIEM (DO NOT USE THIS CODE WITH ANY HOME INFU		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9214	HOME MANAGEMENT OF GESTATIONAL DIABETES, INCLUDES ADMINISTRATIVE SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE COORDINATION, AND ALL NECESSARY SUPPLIES AND EQUIPMENT (DRUGS AND NURSING VISITS CODED SEPARATELY); PER DIEM (DO NOT USE THIS CODE WITH ANY HOM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9370	HOME THERAPY, INTERMITTENT ANTI-EMETIC INJECTION THERAPY; ADMINISTRATIVE SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE COORDINATION, AND ALL NECESSARY SUPPLIES AND EQUIPMENT (DRUGS AND NURSING VISITS CODED SEPARATELY), PER DIEM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9372	HOME THERAPY; INTERMITTENT ANTICOAGULANT INJECTION THERAPY (E.G., HEPARIN); ADMINISTRATIVE SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE COORDINATION, AND ALL NECESSARY SUPPLIES AND EQUIPMENT (DRUGS AND NURSING VISITS CODED SEPARATELY), PER DIEM (DO NOT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9445	PATIENT EDUCATION, NOT OTHERWISE CLASSIFIED, NON-PHYSICIAN PROVIDER, INDIVIDUAL, PER SESSION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9480	INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES, PER DIEM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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S9485	CRISIS INTERVENTION MENTAL HEALTH SERVICES, PER DIEM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9529	ROUTINE VENIPUNCTURE FOR COLLECTION OF SPECIMEN(S), SINGLE HOME BOUND, NURSING HOME, OR SKILLED NURSING FACILITY PATIENT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9537	HOME THERAPY; HEMATOPOIETIC HORMONE INJECTION THERAPY (E.G., ERYTHROPOIETIN, G-CSF, GM-CSF); ADMINISTRATIVE SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE COORDINATION, AND ALL NECESSARY SUPPLIES AND EQUIPMENT (DRUGS AND NURSING VISITS CODED SEPARATELY),		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9560	HOME INJECTABLE THERAPY; HORMONAL THERAPY (E.G.; LEUPROLIDE, GOSERELIN), INCLUDING ADMINISTRATIVE SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE COORDINATION, AND ALL NECESSARY SUPPLIES AND EQUIPMENT (DRUGS AND NURSING VISITS CODED SEPARATELY), PER DIEM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9562	HOME INJECTABLE THERAPY, PALIVIZUMAB OR OTHER MONOCLONAL ANTIBODY FOR RSV, INCLUDING ADMINISTRATIVE SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE COORDINATION, AND ALL NECESSARY SUPPLIES AND EQUIPMENT (DRUGS AND NURSING VISITS CODED SEPARATELY), PER DIEM	Preauthorization required when billed charges exceed $500 per line item	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9562	HOME INJECTABLE THERAPY, PALIVIZUMAB OR OTHER MONOCLONAL ANTIBODY FOR RSV, INCLUDING ADMINISTRATIVE SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE COORDINATION, AND ALL NECESSARY SUPPLIES AND EQUIPMENT (DRUGS AND NURSING VISITS CODED SEPARATELY), PER DIEM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9590	HOME THERAPY, IRRIGATION THERAPY (E.G., STERILE IRRIGATION OF AN ORGAN OR ANATOMICAL CAVITY); INCLUDING ADMINISTRATIVE SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE COORDINATION, AND ALL NECESSARY SUPPLIES AND EQUIPMENT (DRUGS AND NURSING VISITS CODED SE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
S9810	HOME THERAPY; PROFESSIONAL PHARMACY SERVICES FOR PROVISION OF INFUSION, SPECIALTY DRUG ADMINISTRATION, AND/OR DISEASE STATE MANAGEMENT, NOT OTHERWISE CLASSIFIED, PER HOUR (DO NOT USE THIS CODE WITH ANY PER DIEM CODE)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
T1000	PRIVATE DUTY / INDEPENDENT NURSING SERVICE(S) - LICENSED, UP TO 15 MINUTES		8/15/2023	InterQual® Evidence-Based Criteria & Guidelines	
T2004	NON-EMERGENCY TRANSPORT; COMMERCIAL CARRIER, MULTI-PASS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V2623	PROSTHETIC EYE, PLASTIC, CUSTOM	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V2623	PROSTHETIC EYE, PLASTIC, CUSTOM		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V2624	POLISHING/RESURFACING OF OCULAR PROSTHESIS	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V2625	ENLARGEMENT OF OCULAR PROSTHESIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V2626	REDUCTION OF OCULAR PROSTHESIS		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V2627	SCLERAL COVER SHELL	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V2628	FABRICATION AND FITTING OF OCULAR CONFORMER	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
V2629	PROSTHETIC EYE, OTHER TYPE	Effective 6/15/2025 Preauthorization required when billed charges exceed $500 per line item (Previously was $250)	1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5030	HEARING AID, MONAURAL, BODY WORN, AIR CONDUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5040	HEARING AID, MONAURAL, BODY WORN, BONE CONDUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5050	HEARING AID, MONAURAL, IN THE EAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5060	HEARING AID, MONAURAL, BEHIND THE EAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5070	GLASSES, AIR CONDUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5080	GLASSES, BONE CONDUCTION		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5095	SEMI-IMPLANTABLE MIDDLE EAR HEARING PROSTHESIS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
V5095	SEMI-IMPLANTABLE MIDDLE EAR HEARING PROSTHESIS		1/1/2022	Evidence of Coverage (EOC, Plan coverage document)	InterQual® Evidence-Based Criteria & Guidelines
V5100	HEARING AID, BILATERAL, BODY WORN		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5120	BINAURAL, BODY		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5130	BINAURAL, IN THE EAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5140	BINAURAL, BEHIND THE EAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5150	BINAURAL, GLASSES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5170	HEARING AID, CROS, IN THE EAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5180	HEARING AID, CROS, BEHIND THE EAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5190	HEARING AID, CONTRALATERAL ROUTING, MONAURAL, GLASSES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5210	HEARING AID, BICROS, IN THE EAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5220	HEARING AID, BICROS, BEHIND THE EAR		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5230	HEARING AID, CONTRALATERAL ROUTING SYSTEM, BINAURAL, GLASSES		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5242	HEARING AID, ANALOG, MONAURAL, CIC (COMPLETELY IN THE EAR CANAL)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5243	HEARING AID, ANALOG, MONAURAL, ITC (IN THE CANAL)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5244	HEARING AID, DIGITALLY PROGRAMMABLE ANALOG, MONAURAL, CIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5245	HEARING AID, DIGITALLY PROGRAMMABLE, ANALOG, MONAURAL, ITC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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Code	Description	Comment	Effective Date	Policy/Guideline 1	Policy/Guideline 2
V5246	HEARING AID, DIGITALLY PROGRAMMABLE ANALOG, MONAURAL, ITE (IN THE EAR)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5247	HEARING AID, DIGITALLY PROGRAMMABLE ANALOG, MONAURAL, BTE (BEHIND THE EAR)		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5248	HEARING AID, ANALOG, BINAURAL, CIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5249	HEARING AID, ANALOG, BINAURAL, ITC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5250	HEARING AID, DIGITALLY PROGRAMMABLE ANALOG, BINAURAL, CIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5251	HEARING AID, DIGITALLY PROGRAMMABLE ANALOG, BINAURAL, ITC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5252	HEARING AID, DIGITALLY PROGRAMMABLE, BINAURAL, ITE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5253	HEARING AID, DIGITALLY PROGRAMMABLE, BINAURAL, BTE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5254	HEARING AID, DIGITAL, MONAURAL, CIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5255	HEARING AID, DIGITAL, MONAURAL, ITC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5256	HEARING AID, DIGITAL, MONAURAL, ITE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5257	HEARING AID, DIGITAL, MONAURAL, BTE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5258	HEARING AID, DIGITAL, BINAURAL, CIC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5259	HEARING AID, DIGITAL, BINAURAL, ITC		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5260	HEARING AID, DIGITAL, BINAURAL, ITE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5261	HEARING AID, DIGITAL, BINAURAL, BTE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5262	HEARING AID, DISPOSABLE, ANY TYPE, MONAURAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5263	HEARING AID, DISPOSABLE, ANY TYPE, BINAURAL		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5267	HEARING AID OR ASSISTIVE LISTENING DEVICE/SUPPLIES/ACCESSORIES, NOT OTHERWISE SPECIFIED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5268	ASSISTIVE LISTENING DEVICE, TELEPHONE AMPLIFIER, ANY TYPE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5269	ASSISTIVE LISTENING DEVICE, ALERTING, ANY TYPE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5270	ASSISTIVE LISTENING DEVICE, TELEVISION AMPLIFIER, ANY TYPE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5271	ASSISTIVE LISTENING DEVICE, TELEVISION CAPTION DECODER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5272	ASSISTIVE LISTENING DEVICE, TDD		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	

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V5273	ASSISTIVE LISTENING DEVICE, FOR USE WITH COCHLEAR IMPLANT		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5274	ASSISTIVE LISTENING DEVICE, NOT OTHERWISE SPECIFIED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5281	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM SYSTEM, MONAURAL, (1 RECEIVER, TRANSMITTER, MICROPHONE), ANY TYPE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5282	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM SYSTEM, BINAURAL, (2 RECEIVERS, TRANSMITTER, MICROPHONE), ANY TYPE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5283	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM NECK, LOOP INDUCTION RECEIVER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5284	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM, EAR LEVEL RECEIVER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5285	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM, DIRECT AUDIO INPUT RECEIVER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5286	ASSISTIVE LISTENING DEVICE, PERSONAL BLUE TOOTH FM/DM RECEIVER		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5287	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM RECEIVER, NOT OTHERWISE SPECIFIED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5288	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM TRANSMITTER ASSISTIVE LISTENING DEVICE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5289	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM ADAPTER/BOOT COUPLING DEVICE FOR RECEIVER, ANY TYPE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5290	ASSISTIVE LISTENING DEVICE, TRANSMITTER MICROPHONE, ANY TYPE		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	
V5298	HEARING AID, NOT OTHERWISE CLASSIFIED		1/1/2022	InterQual® Evidence-Based Criteria & Guidelines	