The creation of the list is inclusive of EH's Medical Policies, MedTech Data base, Provider Manual, Vendor Management and Place of Service policies.
Preauthorization is required for all Inpatient types of care including Medical, Surgical, Hospice, Skilled Nursing Care, Rehabilitation care, in addition to DME and Homecare services.
In addition to the defined services we have identified specific CPT/HCPCS codes that require Preauthorization.
Including:
All non-emergency inpatient hospital admissions (acute, rehabilitation, behavioral health and skilled nursing facility care)
Home health care (nursing, PT, OT, ST, home infusion therapy)

Note on City of New York: The EmblemHealth preauthorized service list will not apply to PPO CNY members who will migrate 1/1/20 except for any items on the P&A list related to: Home Health Care, Home Infusion, Nutritional Supplements & Enteral Therapy and High Tech radiology (Evicore). Preauth for CNY PPO members for all other services is managed for CNY by Empire BCBS.

****This list contains all PA codes, including codes that have diagnosis code rules.**

Medicare Line of Business: Pre-Authorization Rules Starting on 1/1/20

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less	No	Prior Authorization required for all Diagnosis Codes		Breast reconstruction (non-mastectomy)
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm	No	Prior Authorization required for all Diagnosis Codes		Breast reconstruction (non-mastectomy)
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)	No	Prior Authorization required for all Diagnosis Codes		Breast reconstruction (non-mastectomy)
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
11971	Removal of tissue expander(s) without insertion of prosthesis	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
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	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
15750	Flap; neurovascular pedicle	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
15757	Free skin flap with microvascular anastomosis	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
15758	Free fascial flap with microvascular anastomosis	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
15775	Punch graft for hair transplant; 1 to 15 punch grafts	No	Prior Authorization required for all Diagnosis Codes		Gender dysphoria treatment
15776	Punch graft for hair transplant; more than 15 punch grafts	No	Prior Authorization required for all Diagnosis Codes		Gender dysphoria treatment
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
15781	Dermabrasion; segmental, face	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
15782	Dermabrasion; regional, other than face	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
15783	Dermabrasion; superficial, any site (eg, tattoo removal)	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
15788	Chemical peel, facial; epidermal	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
15789	Chemical peel, facial; dermal	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
15792	Chemical peel, nonfacial; epidermal	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
15793	Chemical peel, nonfacial; dermal	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
15820	Blepharoplasty, lower eyelid	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
15822	Blepharoplasty, upper eyelid	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
19303	Mastectomy, simple, complete	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Gender dysphoria treatment

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19304	Mastectomy, subcutaneous	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Gender dysphoria treatment

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19316	Mastopexy	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19318	Reduction mammaplasty	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19324	Mammaplasty, augmentation; without prosthetic implant	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19325	Mammaplasty, augmentation; with prosthetic implant	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19328	Removal of intact mammary implant	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19330	Removal of mammary implant material	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction(covered for postmastectomy reconstruction)	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19350	Nipple/areola reconstruction	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19364	Breast reconstruction with free flap	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19366	Breast reconstruction with other technique	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19370	Open periprosthetic capsulotomy, breast	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19371	Periprosthetic capsulectomy, breast	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19380	Revision of reconstructed breast (only after a mastectomy)	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
19396	Preparation of moulage for custom breast implant	Yes		Notification/prior authorization not required for the following diagnosis codes: C50.019, C50.011, C50.012, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.029, C50.021, C50.022, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929, C79.81, D05.90, D05.00, D05.01, D05.02, D05.10, D05.11, D05.12, D05.80, D05.81, D05.82, D05.91, D05.92, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13, Z42.1	Breast reconstruction (non-mastectomy)
20926	Tissue grafts, other (eg, paratenon, fat, dermis)	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
20974	Electrical stimulation to aid bone healing; noninvasive (nonoperative)	No	Prior Authorization required for all Diagnosis Codes		Bone growth stimulator
20975	Electrical stimulation to aid bone healing; invasive (operative)	No	Prior Authorization required for all Diagnosis Codes		Bone growth stimulator
20979	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)	No	Prior Authorization required for all Diagnosis Codes		Bone growth stimulator
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
21121	Genioplasty; sliding osteotomy, single piece	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21125	Augmentation, mandibular body or angle; prosthetic material	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
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)	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21150	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
21181	Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
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 than 40 sq cm	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
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 greater than 40 sq cm but less than 80 sq cm	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
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 greater than 80 sq cm	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21198	Osteotomy, mandible, segmental;	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21199	Osteotomy, mandible, segmental; with genioglossus advancement	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21215	Graft, bone; mandible (includes obtaining graft)	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21242	Arthroplasty, temporomandibular joint, with allograft	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
21261	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
21263	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
21268	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
21275	Secondary revision of orbitocraniofacial reconstruction	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
21299	Unlisted craniofacial and maxillofacial procedure	No	Prior Authorization required for all Diagnosis Codes		Orthognathic surgery
21685	Hyoid myotomy and suspension	No	Prior Authorization required for all Diagnosis Codes		Sleep apnea procedures and surgeries
21740	Reconstructive repair of pectus excavatum or carinatum; open	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
21899	Unlisted procedure, neck or thorax	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
22100	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; cervical	No	Prior Authorization required for all Diagnosis Codes		Spinal surgery
22101	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; thoracic	No	Prior Authorization required for all Diagnosis Codes		Spinal surgery
22102	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; lumbar	No	Prior Authorization required for all Diagnosis Codes		Spinal surgery
22110	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; cervical	No	Prior Authorization required for all Diagnosis Codes		Spinal surgery
22112	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; thoracic	No	Prior Authorization required for all Diagnosis Codes		Spinal surgery
22114	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; lumbar	No	Prior Authorization required for all Diagnosis Codes		Spinal surgery
22206	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); thoracic	No	Prior Authorization required for all Diagnosis Codes		Spinal surgery
22207	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); lumbar	No	Prior Authorization required for all Diagnosis Codes		Spinal surgery
22210	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical	No	Prior Authorization required for all Diagnosis Codes		Spinal surgery

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
22212	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic	No	Prior Authorization required for all Diagnosis Codes		Spinal surgery
22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar	No	Prior Authorization required for all Diagnosis Codes		Spinal surgery
22220	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical	No	Prior Authorization required for all Diagnosis Codes		Spinal surgery
22222	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic	No	Prior Authorization required for all Diagnosis Codes		Orthopedic surgeries Spine and joint surgeries
22224	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar	No	Prior Authorization required for all Diagnosis Codes		Spinal surgery
22899	Unlisted procedure, spine	No	Prior Authorization required for all Diagnosis Codes		Spinal surgery
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	No	Prior Authorization required for all Diagnosis Codes		Arthroplasty
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	No	Prior Authorization required for all Diagnosis Codes		Arthroplasty
24360	Arthroplasty, elbow; with membrane (eg, fascial)	No	Prior Authorization required for all Diagnosis Codes		Arthroplasty
24361	Arthroplasty, elbow; with distal humeral prosthetic replacement	No	Prior Authorization required for all Diagnosis Codes		Arthroplasty
24362	Arthroplasty, elbow; with implant and fascia lata ligament reconstruction	No	Prior Authorization required for all Diagnosis Codes		Arthroplasty
24363	Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)	No	Prior Authorization required for all Diagnosis Codes		Arthroplasty
27120	Acetabuloplasty; (eg, Whitman, Colonna, Haygroves, or cup type)	No	Prior Authorization required for all Diagnosis Codes		Arthroplasty
27122	Acetabuloplasty; resection, femoral head (eg, Girdlestone procedure)	No	Prior Authorization required for all Diagnosis Codes		Arthroplasty
27125	Hemiarthroplasty, hip partial	No	Prior Authorization required for all Diagnosis Codes		Arthroplasty
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), with or without autograft or allograft	No	Prior Authorization required for all Diagnosis Codes		Arthroplasty
27132	Conversation of previous hip surgery to total hip arthroplasty, both components with or without allograft or autograft	No	Prior Authorization required for all Diagnosis Codes		Arthroplasty

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	No	Prior Authorization required for all Diagnosis Codes		Arthroplasty
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft	No	Prior Authorization required for all Diagnosis Codes		Arthroplasty
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft	No	Prior Authorization required for all Diagnosis Codes		Arthroplasty
27412	Autologous chondrocyte implantation, knee	No	Prior Authorization required for all Diagnosis Codes		Cartilage implants
27445	Arthroplasty, knee, hinge prosthesis (eg, Walldius type)	No	Prior Authorization required for all Diagnosis Codes		Arthroplasty
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	No	Prior Authorization required for all Diagnosis Codes		Arthroplasty
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	No	Prior Authorization required for all Diagnosis Codes		Arthroplasty
27486	Revision of total knee arthroplasty, with or without allograft; 1 component	No	Prior Authorization required for all Diagnosis Codes		Arthroplasty
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	No	Prior Authorization required for all Diagnosis Codes		Arthroplasty
28344	Reconstruction, toe(s); polydactyly	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
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	No	Prior Authorization required for all Diagnosis Codes		Potentially unproven services (including experimental/ investigational)
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])	No	Prior Authorization required for all Diagnosis Codes		Cartilage implants
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	No	Prior Authorization required for all Diagnosis Codes		Cartilage implants
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral	No	Prior Authorization required for all Diagnosis Codes		Cartilage implants
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	No	Prior Authorization required for all Diagnosis Codes		Arthroscopy
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	No	Prior Authorization required for all Diagnosis Codes		Arthroscopy
29916	Arthroscopy, hip, surgical; with labral repair	No	Prior Authorization required for all Diagnosis Codes		Arthroscopy

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	No	Prior Authorization required for all Diagnosis Codes		Rhinoplasty
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	No	Prior Authorization required for all Diagnosis Codes		Rhinoplasty
30420	Rhinoplasty, primary; including major septal repair	No	Prior Authorization required for all Diagnosis Codes		Rhinoplasty
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	No	Prior Authorization required for all Diagnosis Codes		Rhinoplasty
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	No	Prior Authorization required for all Diagnosis Codes		Rhinoplasty
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)	No	Prior Authorization required for all Diagnosis Codes		Rhinoplasty
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	No	Prior Authorization required for all Diagnosis Codes		Rhinoplasty
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies	No	Prior Authorization required for all Diagnosis Codes		Rhinoplasty
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)	No	Prior Authorization required for all Diagnosis Codes		Rhinoplasty
30540	Repair choanal atresia; intranasal	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
30545	Repair choanal atresia; transpalatine	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
30560	Lysis intranasal synechia	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa	No	Prior Authorization required for all Diagnosis Codes		Sinuplasty
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)	No	Prior Authorization required for all Diagnosis Codes		Sinuplasty
31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)	No	Prior Authorization required for all Diagnosis Codes		Sinuplasty
31298	Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia (eg, balloon dilation)	No	Prior Authorization required for all Diagnosis Codes		Sinuplasty

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
32850	Donor pneumonectomy(s) (including cold preservation), from cadaver donor	No	Prior Authorization required for all Diagnosis Codes		Lung Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
32851	Lung transplant, single; without cardiopulmonary bypass	No	Prior Authorization required for all Diagnosis Codes		Lung Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
32852	Lung transplant, single; with cardiopulmonary bypass	No	Prior Authorization required for all Diagnosis Codes		Lung Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
32853	Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass	No	Prior Authorization required for all Diagnosis Codes		Lung Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
32854	Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass	No	Prior Authorization required for all Diagnosis Codes		Lung Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
32855	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; unilateral	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
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	No	Prior Authorization required for all Diagnosis Codes		Lung Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
33927	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy	No	Prior Authorization required for all Diagnosis Codes		Ventricular assist devices (VAD) A mechanical pump that takes over the function of the damaged ventricle of the heart and restores normal blood flow
33928	Removal and replacement of total replacement heart system (artificial heart)	No	Prior Authorization required for all Diagnosis Codes		Ventricular assist devices (VAD) A mechanical pump that takes over the function of the damaged ventricle of the heart and restores normal blood flow
33929	Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure)	No	Prior Authorization required for all Diagnosis Codes		Ventricular assist devices (VAD) A mechanical pump that takes over the function of the damaged ventricle of the heart and restores normal blood flow
33930	Donor cardiectomy-pneumonectomy (including cold preservation)	No	Prior Authorization required for all Diagnosis Codes		Heart/lung Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
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	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
33935	Heart-lung transplant with recipient cardiectomy-pneumonectomy	No	Prior Authorization required for all Diagnosis Codes		Heart/lung Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
33940	Donor cardiectomy (including cold preservation)	No	Prior Authorization required for all Diagnosis Codes		Heart Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
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 implantation	No	Prior Authorization required for all Diagnosis Codes		Heart Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
33945	Heart transplant, with or without recipient cardiectomy	No	Prior Authorization required for all Diagnosis Codes		Heart Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
33975	Insertion of ventricular assist device; extracorporeal, single ventricle	No	Prior Authorization required for all Diagnosis Codes		Ventricular assist devices (VAD)
33976	Insertion of ventricular assist device; extracorporeal, biventricular	No	Prior Authorization required for all Diagnosis Codes		Ventricular assist devices (VAD)
33979	Insertion of ventricular assist device, implantable intracorporeal, single ventricle	No	Prior Authorization required for all Diagnosis Codes		Ventricular assist devices (VAD)
33981	Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump	No	Prior Authorization required for all Diagnosis Codes		Ventricular assist devices (VAD)
33982	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass	No	Prior Authorization required for all Diagnosis Codes		Ventricular assist devices (VAD)
33983	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass	No	Prior Authorization required for all Diagnosis Codes		Ventricular assist devices (VAD)
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated (New Code 01/01/2017)	No	Prior Authorization required for all Diagnosis Codes		Vein procedures
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 (Lisa separately in addition to code for primary procedure) (New Code 01/01/2017)	No	Prior Authorization required for all Diagnosis Codes		Varicose Vein Treatment
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	No	Prior Authorization required for all Diagnosis Codes		Vein procedures

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
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 to code for primary procedure) (Revised Code 01/01/2017)	No	Prior Authorization required for all Diagnosis Codes		Varicose Vein Treatment
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	No	Prior Authorization required for all Diagnosis Codes		Vein procedures
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 for primary procedure) (Revised Code 01/01/2017)	No	Prior Authorization required for all Diagnosis Codes		Varicose Vein Treatment
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated	No	Prior Authorization required for all Diagnosis Codes		Varicose Vein Treatment
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	No	Prior Authorization required for all Diagnosis Codes		Varicose Vein Treatment
36514	Therapeutic apheresis; for plasma pheresis	No	Prior Authorization required for all Diagnosis Codes		Potentially unproven services (including experimental/ investigational)
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions	No	Prior Authorization required for all Diagnosis Codes		Vein procedures
37718	Ligation, division, and stripping, short saphenous vein	No	Prior Authorization required for all Diagnosis Codes		Vein procedures
37722	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	No	Prior Authorization required for all Diagnosis Codes		Vein procedures
37780	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)	No	Prior Authorization required for all Diagnosis Codes		Vein procedures

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous	No	Prior Authorization required for all Diagnosis Codes		Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
38208	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
38209	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
38210	Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
38212	Transplant preparation of hematopoietic progenitor cells; red blood cell removal	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
38213	Transplant preparation of hematopoietic progenitor cells; platelet depletion	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
38214	Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
38215	Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
38232	Bone marrow harvesting for transplantation; autologous	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	No	Prior Authorization required for all Diagnosis Codes		Bone marrow harvest Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
38241	Hematopoietic progenitor cell (HPC); autologous transplantation	No	Prior Authorization required for all Diagnosis Codes		Bone marrow harvest Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
38242	Allogeneic lymphocyte infusions	No	Prior Authorization required for all Diagnosis Codes		Bone marrow harvest Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
38999	Unlisted procedure, hemic or lymphatic system	No	Prior Authorization required for all Diagnosis Codes		Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
41512	Tongue base suspension, permanent suture technique	No	Prior Authorization required for all Diagnosis Codes		Sleep apnea procedures and surgeries Maxillomandibular advancement or oral pharyngeal tissue reduction for treatment of obstructive sleep apnea

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session	No	Prior Authorization required for all Diagnosis Codes		Sleep apnea procedures and surgeries Maxillomandibular advancement or oral pharyngeal tissue reduction for treatment of obstructive sleep apnea
41599	Unlisted procedure, tongue, floor of mouth	No	Prior Authorization required for all Diagnosis Codes		Sleep apnea procedures and surgeries
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)	No	Prior Authorization required for all Diagnosis Codes		Sleep apnea procedures and surgeries
44132	Donor enterectomy (including cold preservation), open; from cadaver donor	No	Prior Authorization required for all Diagnosis Codes		Intestine Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
44133	Donor enterectomy (including cold preservation), open; partial, from living donor	No	Prior Authorization required for all Diagnosis Codes		Intestine Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
44135	Intestinal allotransplantation; from cadaver donor	No	Prior Authorization required for all Diagnosis Codes		Intestine Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
44136	Intestinal allotransplantation; from living donor	No	Prior Authorization required for all Diagnosis Codes		Transplant Services related to transplants Organ or tissue transplant or transplant related services before pre-treatment or evaluation
44137	Removal of transplanted intestinal allograft, complete	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
44715	Backbench standard preparation of cadaver or living donor intestine allograft prior to transplantation, including mobilization and fashioning of the superior mesenteric artery and vein	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
44720	Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; venous anastomosis, each	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
44721	Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; arterial anastomosis, each	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
47133	Donor hepatectomy (including cold preservation), from cadaver donor	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
47135	Liver allotransplantation, orthotopic, partial or whole, from cadaver or living donor, any age	No	Prior Authorization required for all Diagnosis Codes		Liver Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
47140	Donor hepatectomy (including cold preservation), from living donor; left lateral segment only (segments II and III)	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
47141	Donor hepatectomy (including cold preservation), from living donor; total left lobectomy (segments II, III and IV)	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
47142	Donor hepatectomy (including cold preservation), from living donor; total right lobectomy (segments V, VI, VII and VIII)	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
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 common bile duct for implantation; without trisegment or lobe split	No	Prior Authorization required for all Diagnosis Codes		Liver Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
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 common bile duct for implantation; with trisegment split of whole liver graft into 2 partial liver grafts (ie, left lateral segment [segments II and III] and right trisegment [segments I and IV through VIII])	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
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 common bile duct for implantation; with lobe split of whole liver graft into 2 partial liver grafts (ie, left lobe [segments II, III, and IV] and right lobe [segments I and V through VIII])	No	Prior Authorization required for all Diagnosis Codes		Services related to transplants Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
47146	Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; venous anastomosis, each	No	Prior Authorization required for all Diagnosis Codes		Transplant of tissue or organs Organ or tissue transplant or transplant-related services prior to pre-treatment or evaluation Request for transplant or transplant-related services prior to pre-treatment or evaluation

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
47147	Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; arterial anastomosis, each	No	Prior Authorization required for all Diagnosis Codes		Liver Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
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 arterial anastomoses from iliac artery to superior mesenteric artery and to splenic artery	No	Prior Authorization required for all Diagnosis Codes		Pancreas Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
48552	Backbench reconstruction of cadaver donor pancreas allograft prior to transplantation, venous anastomosis, each	No	Prior Authorization required for all Diagnosis Codes		Pancreas Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
48554	Transplantation of pancreatic allograft	No	Prior Authorization required for all Diagnosis Codes		Pancreas Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
50300	Donor nephrectomy (including cold preservation); from cadaver donor, unilateral or bilateral	No	Prior Authorization required for all Diagnosis Codes		Kidney Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
50320	Donor nephrectomy (including cold preservation); open, from living donor	No	Prior Authorization required for all Diagnosis Codes		Kidney Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
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 vein(s), and renal artery(s), ligating branches, as necessary	No	Prior Authorization required for all Diagnosis Codes		Kidney Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
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 necessary	No	Prior Authorization required for all Diagnosis Codes		Transplant of tissue or organs Organ or tissue transplant or transplant-related services prior to pre-treatment or evaluation Request for transplant or transplant-related services prior to pre-treatment or evaluation
50340	Recipient nephrectomy (separate procedure	No	Prior Authorization required for all Diagnosis Codes		Kidney Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy	No	Prior Authorization required for all Diagnosis Codes		Kidney Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
50365	Renal allotransplantation, implantation of graft; with recipient nephrectomy	No	Prior Authorization required for all Diagnosis Codes		Kidney Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
50370	Removal of transplanted renal allograft	No	Prior Authorization required for all Diagnosis Codes		Kidney Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
50380	Renal autotransplantation, reimplantation of kidney	No	Prior Authorization required for all Diagnosis Codes		Kidney Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
50547	Laparoscopy, surgical; donor nephrectomy (including cold preservation), from living donor	No	Prior Authorization required for all Diagnosis Codes		Kidney Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
53430	Urethroplasty, reconstruction of female urethra	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
54125	Amputation of penis; complete	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
54401	Insertion of penile prosthesis; inflatable (self-contained)	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
54660	Insertion of testicular prosthesis (separate procedure)	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
54690	Laparoscopy, surgical; orchiectomy	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
55175	Scrotoplasty; simple	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
55180	Scrotoplasty; complicated	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
55970	Intersex surgery; male to female	No	Prior Authorization required for all Diagnosis Codes		Gender dysphoria treatment
55980	Intersex surgery; female to male	No	Prior Authorization required for all Diagnosis Codes		Gender dysphoria treatment

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
56625	Vulvectomy simple; complete	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
56800	Plastic repair of introitus	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
56805	Clitoroplasty for intersex state	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
57106	Vaginectomy, partial removal of vaginal wall	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
57110	Vaginectomy, complete removal of vaginal wall	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
57291	Construction of artificial vagina; without graft	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
57292	Construction of artificial vagina; with graft	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
57335	Vaginoplasty for intersex state	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient and outpatient procedures
58152	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocystopexy (eg, Marshall-Marchetti-Krantz, Burch	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient and outpatient procedures

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient and outpatient procedures
58260	Vaginal hysterectomy, for uterus 250 g or less;	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient only Vaginal hysterectomies
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy (vaginal) – inpatient only
58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy (vaginal) – inpatient only
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient only Vaginal hysterectomies
58275	Vaginal hysterectomy, with total or partial vaginectomy;	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient only Vaginal hysterectomies
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy (vaginal) – inpatient only
58290	Vaginal hysterectomy, for uterus greater than 250 g;	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
58293	Vaginal hysterectomy, for uterus greater than 250 g; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient only Vaginal hysterectomies
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient only Vaginal hysterectomies
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient and outpatient procedures
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient and outpatient procedures
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient and outpatient procedures
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient and outpatient procedures
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient and outpatient procedures
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient and outpatient procedures
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient and outpatient procedures
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient and outpatient procedures
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient and outpatient procedures
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient and outpatient procedures
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient and outpatient procedures
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	No	Prior Authorization required for all Diagnosis Codes		Hysterectomy – inpatient and outpatient procedures

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
58940	Oophorectomy, partial or total, unilateral or bilateral;	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
61850	Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical	No	Prior Authorization required for all Diagnosis Codes		Potentially unproven services (including experimental/ investigational)
61863	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array	No	Prior Authorization required for all Diagnosis Codes		Potentially unproven services (including experimental/ investigational)
61864	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)	No	Prior Authorization required for all Diagnosis Codes		Potentially unproven services (including experimental/ investigational)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
61867	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array	No	Prior Authorization required for all Diagnosis Codes		Potentially unproven services (including experimental/ investigational)
61868	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)	No	Prior Authorization required for all Diagnosis Codes		Potentially unproven services (including experimental/ investigational)
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	No	Prior Authorization required for all Diagnosis Codes		Vagus nerve stimulation
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	No	Prior Authorization required for all Diagnosis Codes		Potentially unproven services (including experimental/ investigational)
64405	Injection, anesthetic agent; greater occipital nerve	No	Prior Authorization required for all Diagnosis Codes		Potentially unproven services (including experimental/ investigational)
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	No	Prior Authorization required for all Diagnosis Codes		Potentially unproven services (including experimental/ investigational)
64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	No	Prior Authorization required for all Diagnosis Codes		Vagus nerve stimulation
64722	Decompression; unspecified nerve(s) (specify)	No	Prior Authorization required for all Diagnosis Codes		Potentially unproven services (including experimental/ investigational)
64744	Transection or avulsion of; greater occipital nerve	No	Prior Authorization required for all Diagnosis Codes		Potentially unproven services (including experimental/ investigational)

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
64856	Suture of major peripheral nerve, arm or leg, except sciatic; including transposition	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
64892	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
64896	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length	Yes	Requires a PA when submitted with these diagnosis codes ONLY: F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890. If submitted with other diagnosis codes, then does not require a PA.	If submitted with other diagnosis codes, then does not require a PA.	Gender dysphoria treatment
66180	Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft	No	Prior Authorization required for all Diagnosis Codes		Potentially unproven services (including experimental/ investigational)
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
67908	Repair of blepharoptosis; conjunctive-tarso-Müller's muscle-levator resection (eg, Fasanella-Servet type)	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
67909	Reduction of overcorrection of ptosis	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
67950	Canthoplasty (reconstruction of canthus)	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
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	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
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	No	Prior Authorization required for all Diagnosis Codes		Cosmetic and reconstructive surgery
69714	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	No	Prior Authorization required for all Diagnosis Codes		Cochlear and other auditory implants
69715	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy	No	Prior Authorization required for all Diagnosis Codes		Cochlear and other auditory implants
69718	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy	No	Prior Authorization required for all Diagnosis Codes		Cochlear and other auditory implants
69930	Cochlear device implantation, with or without mastoidectomy	No	Prior Authorization required for all Diagnosis Codes		Cochlear and other auditory implants
76981	Ultrasound, elastography; parenchyma (eg, organ)	No	Prior Authorization required for all Diagnosis Codes		
76983	Ultrasound, elastography; each additional target lesion (List separately in addition to code for primary procedure)	No	Prior Authorization required for all Diagnosis Codes		
81163	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	No	Prior Authorization required for all Diagnosis Codes		

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
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)	No	Prior Authorization required for all Diagnosis Codes		
81165	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	No	Prior Authorization required for all Diagnosis Codes		
81166	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangement)	No	Prior Authorization required for all Diagnosis Codes		
81167	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)	No	Prior Authorization required for all Diagnosis Codes		
81185	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; full gene sequence	No	Prior Authorization required for all Diagnosis Codes		
81186	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; known familial variant	No	Prior Authorization required for all Diagnosis Codes		
81189	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; full gene sequence	No	Prior Authorization required for all Diagnosis Codes		
81190	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; known familial variant(s)	No	Prior Authorization required for all Diagnosis Codes		
81306	NUDT15 (nudix hydrolase 15) (eg, drug metabolism) gene analysis, common variant(s) (eg, *2, *3, *4, *5, *6)	No	Prior Authorization required for all Diagnosis Codes		
81518	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 11 genes (7 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithms reported as percentage risk for metastatic recurrence and likelihood of benefit from extended endocrine therapy	No	Prior Authorization required for all Diagnosis Codes		
81596	Infectious disease, chronic hepatitis C virus (HCV) infection, six biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, and haptoglobin) utilizing serum, prognostic algorithm reported as scores for fibrosis and necroinflammatory activity in liver	No	Prior Authorization required for all Diagnosis Codes		

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
95782	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	No	Prior Authorization required for all Diagnosis Codes		Sleep studies
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	No	Prior Authorization required for all Diagnosis Codes		Sleep studies
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)	No	Prior Authorization required for all Diagnosis Codes		Potentially unproven services (including experimental/ investigational)
95966	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)	No	Prior Authorization required for all Diagnosis Codes		Potentially unproven services (including experimental/ investigational)
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	No	Prior Authorization required for all Diagnosis Codes		Neuropsychological Testing
96121	Neurobehavioral status examination (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)	No	Prior Authorization required for all Diagnosis Codes		Neuropsychological Testing
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 report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	No	Prior Authorization required for all Diagnosis Codes		Neuropsychological Testing

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
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 report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)	No	Prior Authorization required for all Diagnosis Codes		Neuropsychological Testing
96132	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 report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	No	Prior Authorization required for all Diagnosis Codes		Neuropsychological Testing
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 report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)	No	Prior Authorization required for all Diagnosis Codes		Neuropsychological Testing
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	No	Prior Authorization required for all Diagnosis Codes		Neuropsychological Testing
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)	No	Prior Authorization required for all Diagnosis Codes		Neuropsychological Testing
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	No	Prior Authorization required for all Diagnosis Codes		Neuropsychological Testing

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
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)	No	Prior Authorization required for all Diagnosis Codes		Neuropsychological Testing
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	No	Prior Authorization required for all Diagnosis Codes		Neuropsychological Testing
0081U	Oncology (uveal melanoma), mRNA, geneexpression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping genes), utilizing fine needle aspirate or formalin-fixed paraffinembedded tissue, algorithm reported as risk of metastasis	No	Prior Authorization required for all Diagnosis Codes		
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])	No	Prior Authorization required for all Diagnosis Codes		
0516T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; electrode only	No	Prior Authorization required for all Diagnosis Codes		
0517T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; pulse generator component(s) (battery and/or transmitter) only	No	Prior Authorization required for all Diagnosis Codes		
0518T	Removal of only pulse generator component(s) (battery and/or transmitter) of wireless cardiac stimulator for left ventricular pacing	No	Prior Authorization required for all Diagnosis Codes		
0519T	Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator component(s) (battery and/or transmitter)	No	Prior Authorization required for all Diagnosis Codes		

Pre-Authorization Codes		Diagnosis Codes			
CPT Codes	**Description**	**Medicare - Does Diagnosis Code Rule Apply?**	**Medicare - Diagnosis Code Rule REQUIRES PA for the following diagnosis codes:**	**Medicare - Diagnosis Code Rule Does NOT require a PA for the following diagnosis codes:**	**Category / Procedures and Services**
0520T	Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator component(s) (battery and/or transmitter), including placement of a new electrode	No	Prior Authorization required for all Diagnosis Codes		
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	No	Prior Authorization required for all Diagnosis Codes		
0522T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, wireless cardiac stimulator for left ventricular pacing	No	Prior Authorization required for all Diagnosis Codes		