



# Blue Cross Complete Prior Authorization Requirement Updates

Posting date: March 28, 2024

Summary: This document reflects the most recent updates to prior authorization requirements. To determine if a service requires an authorization or to submit a prior authorization request, visit the [mibluccrosscomplete.com](http://mibluccrosscomplete.com) under the [Prior Authorization Resources](#). Prior Authorization requirements are applicable to participating and non-participating providers. Noncontracted Laboratories must obtain authorization for all services rendered.

For medications covered under the medical benefit that require authorization, providers are encouraged to submit authorization requests using the *Blue Cross Complete Medication Prior Authorization Request form*, which is available at [mibluccrosscomplete.com](http://mibluccrosscomplete.com). The completed form must be faxed to PerformRx at **1-855-811-9326**.

Note: An authorization does not guarantee payment.

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PT Codes	Service Description	Summary
<b>11057</b>	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions	Effective 6/1/2024 - Prior Authorization removed
<b>11105</b>	Punch biopsy of skin (including simple closure, each separate/additional lesion	Effective 6/1/2024 - Prior Authorization removed
<b>11106</b>	Incisional biopsy of skin (including simple closure, when performed); single lesion	Effective 6/1/2024 - Prior Authorization removed
<b>11107</b>	Incisional biopsy of skin (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)	Effective 6/1/2024 - Prior Authorization removed
<b>11451</b>	Excision of skin and subcutaneous tissue for hidradenitis, axillary; with complex repair	Effective 6/1/2024 - Prior Authorization removed
<b>11462</b>	Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with simple or intermediate repair	Effective 6/1/2024 - Prior Authorization removed
<b>11463</b>	Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with complex repair	Effective 6/1/2024 - Prior Authorization removed
<b>11470</b>	Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with simple or intermediate repair	Effective 6/1/2024 - Prior Authorization removed

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PT Codes	Service Description	Summary
<b>11471</b>	Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with complex repair	Effective 6/1/2024 - Prior Authorization removed
<b>11621</b>	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm	Effective 6/1/2024 - Prior Authorization removed
<b>11622</b>	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm	Effective 6/1/2024 - Prior Authorization removed
<b>11624</b>	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm	Effective 6/1/2024 - Prior Authorization removed
<b>11626</b>	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm	Effective 6/1/2024 - Prior Authorization removed
<b>11640</b>	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less	Effective 6/1/2024 - Prior Authorization removed
<b>11643</b>	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm	Effective 6/1/2024 - Prior Authorization removed
<b>11644</b>	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm	Effective 6/1/2024 - Prior Authorization removed
<b>11646</b>	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm	Effective 6/1/2024 - Prior Authorization removed
<b>12001</b>	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	Effective 6/1/2024 - Prior Authorization removed
<b>12002</b>	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm	Effective 6/1/2024 - Prior Authorization removed
<b>12013</b>	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	Effective 6/1/2024 - Prior Authorization removed
<b>12014</b>	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm	Effective 6/1/2024 - Prior Authorization removed
<b>12020</b>	Treatment of superficial wound dehiscence; simple closure	Effective 6/1/2024 - Prior Authorization removed
<b>12021</b>	Treatment of superficial wound dehiscence; with packing	Effective 6/1/2024 - Prior Authorization removed

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PT Codes	Service Description	Summary
<b>12031</b>	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less	Effective 6/1/2024 - Prior Authorization removed
<b>12036</b>	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm	Effective 6/1/2024 - Prior Authorization removed
<b>12041</b>	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less	Effective 6/1/2024 - Prior Authorization removed
<b>12042</b>	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm	Effective 6/1/2024 - Prior Authorization removed
<b>12044</b>	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm	Effective 6/1/2024 - Prior Authorization removed
<b>12053</b>	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm	Effective 6/1/2024 - Prior Authorization removed
<b>12054</b>	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm	Effective 6/1/2024 - Prior Authorization removed
<b>13122</b>	Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)	Effective 6/1/2024 - Prior Authorization removed
<b>13133</b>	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less	Effective 6/1/2024 - Prior Authorization removed
<b>13153</b>	Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less	Effective 6/1/2024 - Prior Authorization removed
<b>13160</b>	Secondary closure of surgical wound or dehiscence, extensive or complicated	Effective 6/1/2024 - Prior Authorization removed
<b>14001</b>	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm	Effective 6/1/2024 - Prior Authorization removed
<b>14041</b>	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	Effective 6/1/2024 - Prior Authorization removed
<b>14350</b>	Filletted finger or toe flap, including preparation of recipient site	Effective 6/1/2024 - Prior Authorization removed
<b>15004</b>	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues)	Effective 6/1/2024 - Prior Authorization removed

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PT Codes	Service Description	Summary
<b>15005</b>	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar	Effective 6/1/2024 - Prior Authorization removed
<b>15050</b>	Pinch graft, single or multiple, to cover small ulcer, tip of digit, or other minimal open area (except on face), up to defect size 2 cm diameter	Effective 6/1/2024 - Prior Authorization removed
<b>15100</b>	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)	Effective 6/1/2024 - Prior Authorization removed
<b>15101</b>	Split-thickness autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children,	Effective 6/1/2024 - Prior Authorization removed
<b>15120</b>	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)	Effective 6/1/2024 - Prior Authorization removed
<b>15121</b>	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof	Effective 6/1/2024 - Prior Authorization removed
<b>15130</b>	Dermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	Effective 6/1/2024 - Prior Authorization removed
<b>19301</b>	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	Effective 6/1/2024 - Prior Authorization removed
<b>20552</b>	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	Effective 6/1/2024 - Prior Authorization removed
<b>20553</b>	Injection(s); single or multiple trigger point(s), 3 or more muscles	Effective 6/1/2024 - Prior Authorization removed
<b>20702</b>	Manual preparation and insertion of drug-delivery device(s), intramedullary	Effective 6/1/2024 - Prior Authorization removed
<b>21011</b>	Excision, tumor, soft tissue of face or scalp, subcutaneous	Effective 6/1/2024 - Prior Authorization removed
<b>21012</b>	Excision, tumor, soft tissue of face or scalp, subcutaneous;	Effective 6/1/2024 - Prior Authorization removed
<b>21013</b>	Excision, tumor, soft tissue of face and scalp, subfascial	Effective 6/1/2024 - Prior Authorization removed

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PT Codes	Service Description	Summary
<b>21181</b>	Reconstruction by contouring of benign tumor of cranial bones, extracranial	Effective 6/1/2024 - Prior Authorization removed
<b>21199</b>	Osteotomy, mandible, segmental; with genioglossus advancement	Effective 6/1/2024 - Prior Authorization removed
<b>21275</b>	Secondary revision of orbitocraniofacial reconstruction	Effective 6/1/2024 - Prior Authorization removed
<b>22511</b>	Percutaneous Vertebroplasty Vertebral Body, Unilateral Or Bilateral Injection, Inclusive Of All Imaging Guidance; Lumbosacral	Effective 6/1/2024 - Prior Authorization removed
<b>22513</b>	Percutaneous Vertebral Augmentation, Including Cavity Creation	Effective 6/1/2024 - Prior Authorization removed
<b>22514</b>	Percutaneous Vertebral Augmentation, Including Cavity Creation (Fracture Reduction and Bone Biopsy Included When Performed) Using Mechanical Device (eg, Kyphoplasty), 1 Vertebral Body, Unilateral, Or Bilateral Cannulation, Inclusive of All Imaging Guidance	Effective 6/1/2024 - Prior Authorization removed
<b>22515</b>	Percutaneous Vertebral Augmentation, Including Cavity Creation (Fracture Reduction And Bone Biopsy Included When Performed) Using Mechanical Device (eg, Kyphoplasty), 1 Vertebral Body, Unilateral Or Bilateral Cannulation	Effective 6/1/2024 - Prior Authorization removed
<b>22551</b>	Arthrodesis, Anterior Interbody, Including Disc Space Preparation, Discectomy, Osteophytectomy and Decompression Of Spinal Cord and/or Nerve Roots; Cervical Below C2	Effective 6/1/2024 - Prior Authorization removed
<b>22552</b>	Arthrodesis, Anterior Interbody, Including Disc Space Preparation, Discectomy, Osteophytectomy and Decompression of Spinal Cord And/orNerve Roots; Cervical Below C2, Each Additional Interspace	Effective 6/1/2024 - Prior Authorization removed
<b>22554</b>	Arthrodesis, Anterior Interbody Technique, Including Minimal Discectomy to Prepare Interspace (Other Than for Decompression); Cervical Below C2	Effective 6/1/2024 - Prior Authorization removed
<b>22585</b>	Arthrodesis, Anterior Interbody Technique, Including Minimal Discectomy to Prepare Interspace (Other Than for Decompression); Each Additional Interspace	Effective 6/1/2024 - Prior Authorization removed
<b>22610</b>	Arthrodesis, posterior or posterolateral technique, single level; thoracic (with lateral transverse technique, when performed)	Effective 6/1/2024 - Prior Authorization removed

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PT Codes	Service Description	Summary
<b>22612</b>	Arthrodesis, Posterior or Posterolateral Technique, Single Interspace; Lumbar (With Lateral Transverse Technique)	Effective 6/1/2024 - Prior Authorization removed
<b>22614</b>	Arthrodesis, Posterior or Posterolateral Technique, Single Interspace; Each Additional Vertebral Segment	Effective 6/1/2024 - Prior Authorization removed
<b>22632</b>	Arthrodesis, Posterior Interbody Technique, Including Laminectomy And/or Discectomy to Prepare Interspace (other than for decompression), Single Interspace; Each Additional Interspace	Effective 6/1/2024 - Prior Authorization removed
<b>22634</b>	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace	Effective 6/1/2024 - Prior Authorization removed
<b>22830</b>	Exploration of spinal fusion	Effective 6/1/2024 - Prior Authorization removed
<b>22853</b>	Insertion Of Interbody Biomechanical Device(s)	Effective 6/1/2024 - Prior Authorization removed
<b>22854</b>	Insertion Of Intervertebral Biomechanical Device(s) (eg, Synthetic Cage, Mesh) With Integral Anterior Instrumentation For Device Anchoring (eg, Screws, Flanges), When Performed, To Vertebral Corpectomy(ies) (Vertebral Body Resection, Partial Or Complete)	Effective 6/1/2024 - Prior Authorization removed
<b>22858</b>	Total Disc Arthroplasty (Artificial Disc), Anterior Approach, Including Discectomy with End Plate Preparation (Includes Osteophyctomy for Nerve Root Or Spinal Cord Decompression And Microdissection); Second Level, Cervical	Effective 6/1/2024 - Prior Authorization removed
<b>22859</b>	Insertion Of Intervertebral Biomechanical Device(s) (eg, Synthetic Cage, Mesh, Methylmethacrylate) To Intervertebral Disc Space Or Vertebral Body Defect Without Interbody Arthrodesis, Each Contiguous Effect (List Separately In Addition To Code For Primary	Effective 6/1/2024 - Prior Authorization removed
<b>22867</b>	Insertion Of Interlaminar/Interspinous Process Stabilization/Distracton Device, Without Fusion, Including Image Guidance When Performed, With Open Decompression, Lumbar; Single Level	Effective 6/1/2024 - Prior Authorization removed
<b>22868</b>	Insertion Of Interlaminar/Interspinous Process Stabilization/Distracton Device, Without Fusion, Including Image Guidance When Performed, With Open Decompression, Lumbar; Second Level	Effective 6/1/2024 - Prior Authorization removed



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PT Codes	Service Description	Summary
<b>22869</b>	Insertion Of Interlaminar/Interspinous Process Stabilization/Distracton Device, Without Open Decompression Or Fusion, Including Image Guidance When Performed, Lumbar	Effective 6/1/2024 - Prior Authorization removed
<b>22870</b>	Insertion Of Interlaminar/Interspinous Process Stabilization/Distracton Device, Without Open Decompression or Fusion, Including Image Guidance When Performed, Lumbar; Second Level	Effective 6/1/2024 - Prior Authorization removed
<b>27132</b>	Conversion Of Previous Hip Surgery to Total Hip Arthroplasty, With or Without Autograft or Allograft	Effective 6/1/2024 - Prior Authorization removed
<b>27134</b>	Revision Of Total Hip Arthroplasty; Both Components, With or Without Autograft or Allograft	Effective 6/1/2024 - Prior Authorization removed
<b>27137</b>	Revision Of Total Hip Arthroplasty; Acetabular Component Only, With or Without Autograft or Allograft	Effective 6/1/2024 - Prior Authorization removed
<b>27138</b>	Revision Of Total Hip Arthroplasty; Femoral Component Only, With or Without Autograft or Allograft	Effective 6/1/2024 - Prior Authorization removed
<b>27438</b>	Arthroplasty, Patella; With Prosthesis	Effective 6/1/2024 - Prior Authorization removed
<b>28291</b>	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant	Effective 6/1/2024 - Prior Authorization removed
<b>30130</b>	Excision inferior turbinate, partial or complete, any method	Effective 6/1/2024 - Prior Authorization removed
<b>37220</b>	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	Effective 6/1/2024 - Prior Authorization removed
<b>37222</b>	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty	Effective 6/1/2024 - Prior Authorization removed
<b>37223</b>	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel	Effective 6/1/2024 - Prior Authorization removed
<b>37224</b>	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	Effective 6/1/2024 - Prior Authorization removed
<b>42145</b>	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty)	Effective 6/1/2024 - Prior Authorization removed

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PT Codes	Service Description	Summary
54304	Plastic operation on penis for correction of chordee or for first stage hypospadias repair with or without transplantation of prepuce and/or skin flaps	Effective 6/1/2024 - Prior Authorization removed
54690	Laparoscopy, surgical; orchiectomy	Effective 6/1/2024 - Prior Authorization removed
55180	Scrotoplasty; complicated	Effective 6/1/2024 - Prior Authorization removed
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance	Effective 6/1/2024 - Prior Authorization removed
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach	Effective 6/1/2024 - Prior Authorization removed
62380	Endoscopic Decompression of Spinal Cord, Nerve Root(S), Including Laminotomy, Partial Facetectomy, Foraminotomy, Discectomy and/or Excision of Herniated Intervertebral Disc, 1 Interspace, Lumbar	Effective 6/1/2024 - Prior Authorization removed
63012	Laminectomy With Removal of Abnormal Facets and/or Pars Inter-Articularis with Decompression of Cauda Equina and Nerve Roots For Spondylolisthesis, Lumbar (Gill Type Procedure)	Effective 6/1/2024 - Prior Authorization removed
63020	Laminotomy (Hemilaminectomy), With Decompression of Nerve Root(s), Including Partial Facetectomy, Foraminotomy And/or Excision of Herniated Intervertebral Disc; 1 Interspace, Cervical	Effective 6/1/2024 - Prior Authorization removed
63030	Laminotomy (Hemilaminectomy), With Decompression of Nerve Root(s), Including Partial Facetectomy, Foraminotomy And/or Excision of Herniated Intervertebral Disc; 1 Interspace, Lumbar	Effective 6/1/2024 - Prior Authorization removed
63035	Laminotomy (Hemilaminectomy), With Decompression of Nerve Root(s)	Effective 6/1/2024 - Prior Authorization removed
63042	Laminotomy (Hemilaminectomy), With Decompression of Nerve Root(s),	Effective 6/1/2024 - Prior Authorization removed
63044	Laminotomy (Hemilaminectomy), With Decompression of Nerve Root(S),	Effective 6/1/2024 - Prior Authorization removed
63047	Laminectomy, Facetectomy and Foraminotomy (Unilateral or Bilateral with Decompression Of Spinal Cord, Cauda Equina And/or Nerve Root(S),	Effective 6/1/2024 - Prior Authorization removed



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PT Codes	Service Description	Summary
<b>63048</b>	Laminectomy, Facetectomy and Foraminotomy (Unilateral or Bilateral With Decompression Of Spinal Cord, Cauda Equina And/or Nerve Root(S), Single Vertebral Segment; Each Additional Vertebral Segment, Cervical, Thora	Effective 6/1/2024 - Prior Authorization removed
<b>63051</b>	Laminoplasty, Cervical, With Decompression Of The Spinal Cord, 2 Or More Vertebral Segments; With Reconstruction Of The Posterior Bony Elements (Including The Application Of Bridging Bone Graft And Non-Segmental Fixation Devices	Effective 6/1/2024 - Prior Authorization removed
<b>63056</b>	Transpedicular Approach with Decompression Of Spinal Cord, Equina And/or Nerve Root(S), Single Segment; Lumbar (Including Transfacet, Or Lateral Extraforaminal Approach	Effective 6/1/2024 - Prior Authorization removed
<b>63057</b>	Transpedicular Approach with Decompression Of Spinal Cord, Equina And/or Nerve Root(s) (eg, Herniated Intervertebral Disc), Single Segment; Each Additional Segment, Thoracic Or Lumbar	Effective 6/1/2024 - Prior Authorization removed
<b>63081</b>	Vertebral Corpectomy (Vertebral Body Resection), Partial or Complete, Anterior Approach with Decompression Of Spinal Cord And/or Nerve Root(s); Cervical, Single Segment	Effective 6/1/2024 - Prior Authorization removed
<b>63650</b>	Percutaneous Implantation of Neurostimulator Electrode Array, Epidural	Effective 6/1/2024 - Prior Authorization removed
<b>63655</b>	Laminectomy For Implantation of Neurostimulator Electrodes, Plate/Paddle, Epidural	Effective 6/1/2024 - Prior Authorization removed
<b>64451</b>	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed	Effective 6/1/2024 - Prior Authorization removed
<b>64454</b>	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance	Effective 6/1/2024 - Prior Authorization removed
<b>64490</b>	Injection(s), Diagnostic or Therapeutic Agent, Paravertebral Facet (Zygapophyseal) Joint (or Nerves Innervating That Joint) With Image Guidance (Fluoroscopy or Ct), Cervical or Thoracic	Effective 6/1/2024 - Prior Authorization removed
<b>64491</b>	Injection(s), Diagnostic or Therapeutic Agent, Paravertebral Facet (Zygapophyseal) Joint (or Nerves Innervating That Joint) With Image Guidance (Fluoroscopy or Ct), Cervical or Thoracic;	Effective 6/1/2024 - Prior Authorization removed
<b>64492</b>	Injection(s), Diagnostic or Therapeutic Agent, Paravertebral Facet (Zygapophyseal) Joint (or Nerves Innervating That Joint) With Image Guidance (Fluoroscopy or Ct), Cervical Or Thoracic;	Effective 6/1/2024 - Prior Authorization removed

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<b>64493</b>	Injection(s), Diagnostic or Therapeutic Agent, Paravertebral Facet (Zygapophyseal) Joint (or Nerves Innervating That Joint) With Image Guidance (Fluoroscopy or Ct), Lumbar or Sacral; Single Level	Effective 6/1/2024 - Prior Authorization removed
<b>64494</b>	Injection(s), Diagnostic or Therapeutic Agent, Paravertebral Facet (Zygapophyseal) Joint (or Nerves Innervating That Joint) With Image Guidance (Fluoroscopy or Ct), Lumbar or Sacral;	Effective 6/1/2024 - Prior Authorization removed
<b>64495</b>	Injection(s), Diagnostic or Therapeutic Agent, Paravertebral Facet (Zygapophyseal) Joint (or Nerves Innervating That Joint) With Image Guidance (Fluoroscopy or Ct), Lumbar or Sacral; Third and Any Additional Level(s)	Effective 6/1/2024 - Prior Authorization removed
<b>64581</b>	Incision for implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)	Effective 6/1/2024 - Prior Authorization removed
<b>65730</b>	Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia)	Effective 6/1/2024 - Prior Authorization removed
<b>65750</b>	Keratoplasty (corneal transplant); penetrating (in aphakia)	Effective 6/1/2024 - Prior Authorization removed
<b>65755</b>	Keratoplasty (corneal transplant); penetrating (in pseudophakia)	Effective 6/1/2024 - Prior Authorization removed
<b>67911</b>	Correction of lid retraction	Effective 6/1/2024 - Prior Authorization removed
<b>77014</b>	Computed tomography guidance for placement of radiation therapy fields	Effective 6/1/2024 - Prior Authorization removed
<b>81185</b>	CACNA1A GENE FULL GENE SEQ	Effective 6/1/2024 - Prior Authorization removed
<b>81222</b>	CFTR GENE DUP/DELET VARIANTS	Effective 6/1/2024 - Prior Authorization removed
<b>81224</b>	CFTR GENE INTRON POLY T	Effective 6/1/2024 - Prior Authorization removed
<b>81233</b>	BTK GENE COMMON VARIANTS	Effective 6/1/2024 - Prior Authorization removed
<b>81234</b>	DMPK GENE DETC ABNOR ALLELE	Effective 6/1/2024 - Prior Authorization removed

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81240	F2 GENE	Effective 6/1/2024 - Prior Authorization removed
81247	G6PD GENE ALYS CMN VARIANT	Effective 6/1/2024 - Prior Authorization removed
81261	IGH GENE REARRANGE AMP METH	Effective 6/1/2024 - Prior Authorization removed
81264	IGK REARRANGEABN CLONAL POP	Effective 6/1/2024 - Prior Authorization removed
81267	CHIMERISM ANAL NO CELL SELEC	Effective 6/1/2024 - Prior Authorization removed
81302	MECP2 GENE FULL SEQ	Effective 6/1/2024 - Prior Authorization removed
81328	SLCO1B1 GENE COM VARIANTS	Effective 6/1/2024 - Prior Authorization removed
81383	HLA II TYPING 1 ALLELE HR	Effective 6/1/2024 - Prior Authorization removed
81430	HEARING LOSS SEQUENCE ANALYS	Effective 6/1/2024 - Prior Authorization removed
81431	HEARING LOSS DUP/DEL ANALYS	Effective 6/1/2024 - Prior Authorization removed
81434	HEREDITARY RETINAL DISORDERS	Effective 6/1/2024 - Prior Authorization removed
81435	HEREDITARY COLON CA DSORDRS	Effective 6/1/2024 - Prior Authorization removed
82507	CITRATE	Effective 6/1/2024 - Prior Authorization removed
87516	HEPATITIS B DNA AMP PROBE	Effective 6/1/2024 - Prior Authorization removed
87521	HEPATITIS C PROBE&RVRS TRNSC	Effective 6/1/2024 - Prior Authorization removed
87535	HIV-1 PROBE&REVERSE TRNSCRPJ	Effective 6/1/2024 - Prior Authorization removed

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PT Codes	Service Description	Summary
87624	HPV HIGH-RISK TYPES	Effective 6/1/2024 - Prior Authorization removed
88120	CYTP URNE 3-5 PROBES EA SPEC	Effective 6/1/2024 - Prior Authorization removed
88262	CHROMOSOME ANALYSIS 15-20	Effective 6/1/2024 - Prior Authorization removed
88273	CYTOGENETICS 10-30	Effective 6/1/2024 - Prior Authorization removed
88275	CYTOGENETICS 100-300	Effective 6/1/2024 - Prior Authorization removed
91111	Gastrointestinal tract imaging, intraluminal, esophagus with interpretation and report	Effective 6/1/2024 - Prior Authorization removed
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report	Effective 6/1/2024 - Prior Authorization removed
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens	Effective 6/1/2024 - Prior Authorization removed
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, 1 eye	Effective 6/1/2024 - Prior Authorization removed
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	Effective 6/1/2024 - Ages 21 and under: 72 visits without Prior Authorization; Ages 21 and over: 36 visits per year without Prior Authorization
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	Effective 6/1/2024 - Ages 21 and under: 72 visits without Prior Authorization; Ages 21 and over: 36 visits per year without Prior Authorization
92526	Treatment of swallowing dysfunction and/or oral function for feeding	Effective 6/1/2024 - Prior Authorization removed
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	Effective 6/1/2024 - Prior Authorization removed

# Blue Cross Complete Prior Authorization Requirement Updates

PT Codes	Service Description	Summary
93793	Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio test result, patient instructions,	Effective 6/1/2024 - Prior Authorization removed
93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)	Effective 6/1/2024 - Prior Authorization removed
95700	Electroencephalogram continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG technologist	Effective 6/1/2024 - Prior Authorization removed
95705	Electroencephalogram, without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored	Effective 6/1/2024 - Prior Authorization removed
95706	Electroencephalogram, without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	Effective 6/1/2024 - Prior Authorization removed
95707	Electroencephalogram, without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	Effective 6/1/2024 - Prior Authorization removed
95708	Electroencephalogram, without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	Effective 6/1/2024 - Prior Authorization removed
95709	Electroencephalogram, without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	Effective 6/1/2024 - Prior Authorization removed
95710	Electroencephalogram, without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	Effective 6/1/2024 - Prior Authorization removed
95711	Electroencephalogram with video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored	Effective 6/1/2024 - Prior Authorization removed
95712	Electroencephalogram with video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	Effective 6/1/2024 - Prior Authorization removed
95713	Electroencephalogram with video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	Effective 6/1/2024 - Prior Authorization removed

# Blue Cross Complete Prior Authorization Requirement Updates

PT Codes	Service Description	Summary
95714	Electroencephalogram with video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	Effective 6/1/2024 - Prior Authorization removed
95715	Electroencephalogram with video, review of data, technical description by EEG technologist, each increment of 12-26 hours;	Effective 6/1/2024 - Prior Authorization removed
95716	Electroencephalogram with video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	Effective 6/1/2024 - Prior Authorization removed
95717	Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report,	Effective 6/1/2024 - Prior Authorization removed
95718	Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report	Effective 6/1/2024 - Prior Authorization removed
95719	Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpret	Effective 6/1/2024 - Prior Authorization removed
95720	Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpret	Effective 6/1/2024 - Prior Authorization removed
95721	Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60	Effective 6/1/2024 - Prior Authorization removed
95724	Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84	Effective 6/1/2024 - Prior Authorization removed
95725	Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG re	Effective 6/1/2024 - Prior Authorization removed
95726	Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events,	Effective 6/1/2024 - Prior Authorization removed



# Blue Cross Complete Prior Authorization Requirement Updates

PT Codes	Service Description	Summary
	analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG re	
<b>97016</b>	Application Of a Modality To 1 Or More Areas; Vasopneumatic Devices	Effective 6/1/2024 - Prior Authorization removed
<b>97018</b>	Application Of a Modality To 1 Or More Areas; Paraffin Bath	Effective 6/1/2024 - Prior Authorization removed
<b>97022</b>	Application Of a Modality To 1 Or More Areas; Whirlpool	Effective 6/1/2024 - Prior Authorization removed
<b>97026</b>	Application Of a Modality To 1 Or More Areas; Infrared	Effective 6/1/2024 - Prior Authorization removed
<b>97032</b>	Application Of a Modality To 1 Or More Areas; Electrical Stimulation (Manual), Each 15 Minutes	Effective 6/1/2024 - Prior Authorization removed
<b>97033</b>	Application Of a Modality To 1 Or More Areas; Iontophoresis	Effective 6/1/2024 - Prior Authorization removed
<b>97110</b>	Therapeutic Procedure, 1 Or More Areas, each 15 Minutes; Therapeutic Exercises To Develop Strength And Endurance, Range Of Motion And Flexibility	Effective 6/1/2024 - Ages 21 and under: 72 visits without Prior Authorization; Ages 21 and over: 36 visits per year without Prior Authorization
<b>97112</b>	Therapeutic Procedure, 1 Or More Areas, each 15 Minutes; Neuromuscular Reeducation Of Movement, Balance, Coordination, Kinesthetic Sense, Posture, And/or Proprioception For Sitting And/or Standing Activities	Effective 6/1/2024 - Ages 21 and under: 72 visits without Prior Authorization; Ages 21 and over: 36 visits per year without Prior Authorization
<b>97116</b>	Therapeutic Procedure, 1 Or More Areas, each 15 Minutes; Gait Training (Includes Stair Climbing)	Effective 6/1/2024 - Ages 21 and under: 72 visits without Prior Authorization; Ages 21 and over: 36 visits per year without Prior Authorization
<b>97124</b>	Therapeutic Procedure, 1 Or More Areas, each 15 Minutes; Massage, Including Effleurage, Petrissage And/or Tapotement	Effective 6/1/2024 - Ages 21 and under: 72 visits without Prior Authorization; Ages 21 and over: 36 visits per year without Prior Authorization

# Blue Cross Complete Prior Authorization Requirement Updates

PT Codes	Service Description	Summary
97129	Therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity	Effective 6/1/2024 - Prior Authorization removed
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity	Effective 6/1/2024 - Prior Authorization removed
97140	Manual Therapy Techniques (Eg, Mobilization/ Manipulation, Manual Lymphatic Drainage, Manual Traction), 1 Or More Regions, Each 15 Minutes	Effective 6/1/2024 - Ages 21 and under: 72 visits without Prior Authorization; Ages 21 and over: 36 visits per year without Prior Authorization
97530	Therapeutic Activities, Direct (One-On-One) Patient Contact (Use of Dynamic Activities to Improve Functional Performance), Each 15 Minutes	Effective 6/1/2024 - Ages 21 and under: 72 visits without Prior Authorization; Ages 21 and over: 36 visits per year without Prior Authorization
97533	Sensory Integrative Techniques to Enhance Sensory Processing and Promote Adaptive Responses to Environmental Demands, Direct (One-On-One) Patient Contact, Each 15 Minutes	Effective 6/1/2024 - Prior Authorization removed
97597	Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound	Effective 6/1/2024 - Prior Authorization removed
97598	Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/dermis, exudate, debris, biofilm), including topical application(s), wound	Effective 6/1/2024 - Prior Authorization removed
97605	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment, including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s)	Effective 6/1/2024 - Prior Authorization removed
97606	Negative pressure wound therapy, utilizing durable medical equipment, including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s)	Effective 6/1/2024 - Prior Authorization removed
97607	Negative pressure wound therapy	Effective 6/1/2024 - Prior Authorization removed

# Blue Cross Complete Prior Authorization Requirement Updates

PT Codes	Service Description	Summary
<b>97608</b>	Negative pressure wound therapy, utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions	Effective 6/1/2024 - Prior Authorization removed
<b>99183</b>	Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session	Effective 6/1/2024 - Prior Authorization removed
<b>99341</b>	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care	Effective 6/1/2024 - Prior Authorization removed
<b>99401</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes	Effective 6/1/2024 - Prior Authorization removed
<b>99404</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes	Effective 6/1/2024 - Prior Authorization removed
<b>99441</b>	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service pro	Effective 6/1/2024 - Prior Authorization removed
<b>99443</b>	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service pro	Effective 6/1/2024 - Prior Authorization removed
<b>A0425</b>	Ground mileage, per statute mile	Effective 6/1/2024 - Prior Authorization removed
<b>A0426</b>	Ambulance service, advanced life support, nonemergency transport, level 1	Effective 6/1/2024 - Prior Authorization removed
<b>A0428</b>	Ambulance service, basic life support, nonemergency transport,	Effective 6/1/2024 - Prior Authorization removed
<b>A0431</b>	Ambulance service, conventional air services, transport, one way	Effective 6/1/2024 - Prior Authorization removed
<b>B4034</b>	Specialty care transport	Effective 6/1/2024 - Prior Authorization removed

# Blue Cross Complete Prior Authorization Requirement Updates

PT Codes	Service Description	Summary
<b>B4035</b>	Enteral feeding supply kit; pump fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing,	Effective 6/1/2024 - Prior Authorization removed
<b>B4036</b>	Enteral feeding supply kit; gravity fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape	Effective 6/1/2024 - Prior Authorization removed
<b>B4087</b>	Gastrostomy/jejunostomy tube, standard, any material/type	Effective 6/1/2024 - Prior Authorization removed
<b>B4088</b>	Gastrostomy/jejunostomy tube, low-profile, any material/ type,	Effective 6/1/2024 - Prior Authorization removed
<b>B4149</b>	Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber	Effective 6/1/2024 - Prior Authorization removed
<b>B4153</b>	Enteral formula, nutritionally complete, hydrolyzed proteins, includes fats, carbohydrates, vitamins and minerals	Effective 6/1/2024 - Prior Authorization removed
<b>B4154</b>	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral fee	Effective 6/1/2024 - Prior Authorization removed
<b>B4155</b>	Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arginine), fat	Effective 6/1/2024 - Prior Authorization removed
<b>B4158</b>	Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit	Effective 6/1/2024 - Prior Authorization removed
<b>B4161</b>	Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Effective 6/1/2024 - Prior Authorization removed
<b>B4162</b>	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube	Effective 6/1/2024 - Prior Authorization removed
<b>B4220</b>	Parenteral nutrition supply kit; premix, per day	Effective 6/1/2024 - Prior Authorization removed

# Blue Cross Complete Prior Authorization Requirement Updates

PT Codes	Service Description	Summary
<b>B9002</b>	Enteral nutrition infusion pump, any type	Effective 6/1/2024 - Prior Authorization removed
<b>G0151</b>	Services Of Physical Therapist In Home Health Setting, Each 15 Minutes	Effective 6/1/2024 - Prior Authorization required after 18 visits
<b>G0152</b>	Services Of Occupational Therapist In Home Health Setting, Each 15 Minutes	Effective 6/1/2024 - Prior Authorization required after 18 visits
<b>G0299</b>	Direct skilled nursing services of a registered nurse in the home health or hospice setting, each 15 minutes	Effective 6/1/2024 - Prior Authorization required after 18 visits
<b>G0300</b>	Direct skilled nursing services of a licensed practical nurse in the home health or hospice setting, each 15 minutes	Effective 6/1/2024 - Prior Authorization required after 18 visits
<b>G0422</b>	Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session	Effective 6/1/2024 - Prior Authorization removed
<b>G0423</b>	Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session	Effective 6/1/2024 - Prior Authorization removed
<b>Q4008</b>	Cast supplies, long arm cast, pediatric (0-10 years), fiberglass	Effective 6/1/2024 - Prior Authorization removed
<b>Q4101</b>	Apligraf, per sq cm	Effective 6/1/2024 - Prior Authorization removed
<b>Q4196</b>	PuraPly AM, per sq cm	Effective 6/1/2024 - Prior Authorization removed
<b>S5498</b>	Home infusion therapy, catheter care/maintenance, simple (single lumen), includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment,	Effective 6/1/2024 - Prior Authorization removed
<b>S5501</b>	Home infusion therapy, catheter care/maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment	Effective 6/1/2024 - Prior Authorization removed
<b>S5502</b>	Home infusion therapy, catheter care/maintenance, implanted access device, includes administrative services, professional	Effective 6/1/2024 - Prior Authorization removed

## Blue Cross Complete Prior Authorization Requirement Updates

PT Codes	Service Description	Summary
	pharmacy services, care coordination and all necessary supplies and equipment	
<b>S9330</b>	Home infusion therapy, continuous (24 hours or more) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment	Effective 6/1/2024 - Prior Authorization removed
<b>S9331</b>	Home infusion therapy, intermittent (less than 24 hours) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment	Effective 6/1/2024 - Prior Authorization removed
<b>S9348</b>	Home infusion therapy, sympathomimetic/inotropic agent infusion therapy (e.g., Dobutamine); administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment	Effective 6/1/2024 - Prior Authorization removed
<b>S9351</b>	Home infusion therapy, continuous or intermittent antiemetic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and visits coded separately)	Effective 6/1/2024 - Prior Authorization removed
<b>S9355</b>	Home infusion therapy, chelation therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment	Effective 6/1/2024 - Prior Authorization removed
<b>S9375</b>	Home infusion therapy, hydration therapy; more than 1 liter but no more than 2 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies	Effective 6/1/2024 - Prior Authorization removed
<b>S9376</b>	Home infusion therapy, hydration therapy; more than 2 liters but no more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies	Effective 6/1/2024 - Prior Authorization removed
<b>S9490</b>	Home infusion therapy, corticosteroid infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment	Effective 6/1/2024 - Prior Authorization removed
<b>S9501</b>	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment	Effective 6/1/2024 - Prior Authorization removed



# Blue Cross Complete Prior Authorization Requirement Updates

PT Codes	Service Description	Summary
<b>S9502</b>	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 8 hours, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment	Effective 6/1/2024 - Prior Authorization removed
<b>S9503</b>	Home infusion therapy, antibiotic, antiviral, or antifungal; once every 6 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment	Effective 6/1/2024 - Prior Authorization removed
<b>V2510</b>	Contact lens, gas permeable, spherical, per lens	Effective 6/1/2024 - Prior Authorization removed
<b>V2520</b>	Contact lens, hydrophilic, spherical, per lens	Effective 6/1/2024 - Prior Authorization removed
<b>V2521</b>	Contact lens, hydrophilic, toric, or prism ballast, per lens	Effective 6/1/2024 - Prior Authorization removed
<b>V2531</b>	Contact lens, scleral, gas permeable, per lens (for contact lens modification, see 92325)	Effective 6/1/2024 - Prior Authorization removed
<b>V5130</b>	Binaural, in the ear	Effective 6/1/2024 - Prior Authorization removed
<b>V5221</b>	Hearing aid, contralateral routing system, binaural, BTE/BTE	Effective 6/1/2024 - Prior Authorization removed
<b>V5259</b>	Hearing aid, digital, binaural, ITC	Effective 6/1/2024 - Prior Authorization removed

## Contact Us

Types of service - outpatient/non-patient	Vendors
Laboratory	<ul style="list-style-type: none"> <li>• Drugscan: <b>1-800-235-4890</b></li> <li>• JVHL: <b>1-800-445-4979</b></li> <li>• Quest Diagnostics: <b>1-866-697-8378</b></li> </ul>
Nondiabetic DME, P&O and medical supplies	<ul style="list-style-type: none"> <li>• Northwood, Inc.: Call <b>1-800-393-6432</b> to identify a contracted supplier</li> </ul>
Non-emergency diagnostic imaging services	<ul style="list-style-type: none"> <li>• Evolent: <b>1-800-424-5351</b>, Evolent website: <a href="http://radmd.com">radmd.com</a>*</li> </ul>