MASSACHUSETTS

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Medical Policy

Outpatient Prior Authorization Code List for Commercial Plans Managed Care (HMO and POS), PPO, EPO and Indemnity

Policy Number: 072

Related Medical Policies:

Medicare Advantage Management, #132
Medical Technology Assessment Non-Covered Services List, #400
InterQual Musculoskeletal Services Management, #220
InterQual Musculoskeletal Services Management CPT and HCPCS Codes, #221

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Overview

The table below represents medical policies with corresponding specific procedure codes. These procedure codes **require prior authorization** when they are performed in the **outpatient setting**.

If the procedure codes that are listed in this document are performed in the **inpatient setting**, precertification/prior authorization is **required** for all products.

How to use the table

- If a policy-specific prior authorization request form **is included** under the policy title column, please complete the prior authorization request form using authorization manager.
- If there is no policy-specific prior authorization request form, providers should complete **either** of the following using authorization manager.
    - Massachusetts Collaborative Prior Authorization Form **OR**
    - Blue Cross Blue Shield of Massachusetts Pre-certification Request Form

Click on the title for complete list of drugs that require prior authorization:
- Medical Benefit Prior Authorization Medication List, #034
- Medical Utilization Management and Pharmacy Prior Authorization, #033

Click on the link for InterQual spine procedures that require prior authorization:
- Change Healthcare InterQual Criteria Subsets and SmartSheets

Requesting Prior Authorization Using Authorization Manager

Providers will need to use Authorization Manager to submit initial authorization requests for services. Authorization Manager, available 24/7, is the quickest way to review authorization requirements, request authorizations, submit clinical documentation, check existing case status, and view/print the decision letter. For commercial members, the requests must meet medical policy guidelines.

To ensure the request is processed accurately and quickly:
- Enter the facility's NPI or provider ID for where services are being performed.
- Enter the appropriate surgeon's NPI or provider ID as the servicing provider, *not* the billing group.

Authorization Manager Resources

- Refer to our Authorization Manager page for tips, guides, and video demonstrations.

List of Medical Policies that Require Prior Authorization

Policy Number and Title	Products	Procedure codes
008 Zolgensma (onasemnogene abeparvovec-xioi) for Spinal Muscular Atrophy Complete Prior Authorization Request Form for Zolgensma (085) using Authorization Manager	All commercial products	C9399, J3490, J3590: Prior authorization is required; in effect. J3399: Prior authorization is required effective 7.1.2020.
009 Elzonris (tagraxofusp-erzs) for the Treatment of Blastic Plasmacytoid Dendritic Cell Neoplasm Complete Prior Authorization Request Form for Elzonris (928) using Authorization Manager	All commercial products	J9269: Prior authorization is required; in effect.
022 Gene Therapies for Duchenne Muscular Dystrophy.pdf Complete Prior Authorization Request Form for Elevidys (delandistrogene moxparvovec-rokl) (025) using Authorization Manager	All commercial products	No specific J codes. See policy for additional information
028 Omidubicel as Adjunct Treatment for Hematologic Malignancies	All commercial products	No specific J codes. See policy for additional information

Complete Prior Authorization Request Form for Omidubicel (067) using Authorization Manager		
035 Temporomandibular Joint Disorder Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	Commercial HMO and POS	21010, 21050, 21060, 21073, 21116, 21240, 21242, 21243, 29800, 29804: Prior authorization is required; in effect.
	Commercial PPO/EPO	21010, 21050, 21060, 21073, 21116, 21240, 21242, 21243, 29800, 29804: Prior authorization is required. Effective 6.1.2022
043 Suction lipectomy for lipedema.pdf Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	Commercial HMO and POS	15832, 15833, 15834, 15835, 15836, 15878, 15879 Prior authorization is required. Effective 5.1.2024
	Commercial PPO/EPO	15832, 15833, 15834, 15835, 15836, 15878, 15879 Prior authorization is required. Effective 5.1.2024
050 Gene Therapies for Sickle Cell Disease.pdf Complete Prior Authorization Request Form using Authorization Manager Gene Therapies for Sickle Cell Disease Prior Authorization Request Form for Casgevy ™ (Exagamglogene autotemcel), (055)	All commercial products	J3394 Prior authorization is required. Effective 7.1.2024.
066 Chimeric Antigen Receptor Therapy for Leukemia and Lymphoma.pdf Complete Prior Authorization Request Form using Authorization Manager ▪ CAR T-Cell Therapy Services for Treatment of Diffuse Large B-cell Lymphoma (924) ▪ CAR T-Cell Therapy Services for B-cell Acute Lymphoblastic Leukemia (tisagenlecleucel) (925) ▪ CAR T-Cell Therapy Services for Mantle Cell Lymphoma (Brexucabtagene Autoleucel) (940) ▪ CAR T-Cell Therapy Services for Non-Hodgkin Lymphoma (Lisocabtagene Maraleucel) (941)	All commercial products	Q2041, Q2042, Q2053; Q2054: Prior authorization is required; in effect.

▪ CAR T-Cell Therapy Services for Follicular Lymphoma (Axicabtagene Ciloleucel) (944) ▪ CAR T-Cell Therapy Services for B-cell Acute Lymphoblastic Leukemia (Brexucabtagene Autoleucel) Prior Authorization Request Form (945)		
068 Plastic Surgery Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	Commercial HMO and POS	15780, 15781, 15782, 15783, 30400, 30410, 30420, 30430, 30435, 30450, 15830, 15876, 15877, 15878, 15879: Prior authorization is required; in effect.
	Commercial PPO/EPO	15780, 15781, 15782, 15783, 30400, 30410, 30420, 30430, 30435, 30450, 15830, 15876, 15877, 15878, 15879: Prior authorization is required. Effective 6.1.2022
074 Hematopoietic Stem Cell Transplantation for Chronic Lymphocytic Leukemia and Small Lymphocytic Lymphoma Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	All commercial products	38240, S2142, S2150: Prior authorization is required; in effect.
075 Hematopoietic Cell Transplantation for Plasma Cell Dyscracias, Including Multiple Myeloma and POEMS Syndrome Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	All commercial products	38241, S2150: Prior authorization is required; in effect.
076 Hematopoietic Cell Transplantation for Acute Lymphoblastic Leukemia	All commercial products	38240, 38241, S2142, S2150: Prior authorization is required; in effect.

Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form		
077 Scenesse afamelanotide for the treatment of Erythropoietic protoporphyria Complete Prior Authorization Request Form for Scenesse (160) using Authorization Manager	All commercial products	J7352: Prior authorization is required effective 2.1.2021.
086 Assisted Reproductive Services Infertility Services Complete Prior Authorization Request Form for Assisted Reproductive Technology Services (694) using Authorization Manager	Commercial HMO and POS	Click here for CPT codes Prior authorization is required; in effect. Prior authorization is **not required** for Diagnostic Testing. Prior authorization **is required** for Infertility Treatment.
	Commercial PPO Indemnity	Click here for CPT codes Prior authorization is required; in effect. Prior authorization is **not required** for Diagnostic Testing. Prior authorization **is required** for Infertility Treatment.
087 Esketamine Nasal Spray (Spravato) and Intravenous Ketamine for Treatment Resistant Depression Complete Prior Authorization Request Form for Esketamine Nasal Spray (Spravato) and Intravenous Ketamine (094) using Authorization Manager	All commercial products	G2082, G2083: Prior authorization is required effective 4.1.2020.
088 Preimplantation Genetic Testing Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR**	All commercial products	89290, 89291: Prior authorization is required; in effect.

▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form		
089 Adoptive Cell Therapies for Melanoma Complete Prior Authorization Request Form using Authorization Manager Prior Authorization Request Form for Lifileucel (Amtagvi), #096	Commercial Managed Care (HMO and POS) Commercial PPO and Indemnity	See policy for coding information. Prior authorization is required. Effective 8.1.2024.
091 Applied Behavioral Analysis (ABA).pdf Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form	Commercial Managed Care (HMO and POS) Commercial PPO and Indemnity	97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0373T, 0362T Prior authorization is required, in effect.
110 Meniscal Allografts and Other Meniscal Implants Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	Commercial HMO and POS	29868: Prior authorization is required; in effect.
	Commercial PPO/EPO	29868: Prior authorization is required. Effective 6.1.2022.
111 Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	All commercial products	27415, 27416, 28446, 29866, 29867: Prior authorization is required; in effect.
121 Closure Devices for Patent Foramen Ovale and Atrial Septal Defects Complete Prior Authorization Request Form using Authorization Manager	All commercial products	93580: Prior authorization is required; in effect.

▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form		
130 Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome 068 Plastic Surgery prn.pdf Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	Commercial HMO and POS	21193, 21194, 21195, 21196, 21198, 21199, 21206, 21685, 42145: Prior authorization is required; in effect.
	Commercial PPO/EPO	21193, 21194, 21195, 21196, 21198, 21199, 21206, 21685, 42145: Prior authorization is required. Effective 6.1.2022.
133 Microprocessor Controlled Prostheses for the Lower Limb Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	Commercial HMO and POS)	K1014, L5856, L5857, L5858: Prior authorization is required; in effect.
	Commercial PPO/EPO	K1014, L5856, L5857, L5858: Prior authorization is required. Effective 6.1.2022.
142 Air Ambulance Transport Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	Commercial HMO and POS	A0430, A0431, S9960, S9961: Prior authorization is **required** for air ambulance transport; in effect. Note: As air ambulance transport is normally of an urgent or emergency nature, a retrospective review of documentation will be performed prior to payment authorization.
	Commercial PPO and Indemnity	Prior authorization is not required. However, all air ambulance transport claims must be submitted with supporting documentation and reviewed for medical necessity. Note: As air ambulance transport is normally of an urgent or emergency nature, a retrospective review of documentation will be performed prior to payment authorization.

		We recommend submitting authorization requests electronically. For more information, please refer to the Utilization Management section of our Blue Cross Blue Book. Claims payment is based on eligibility at the time of service, availability of benefits at the time of claim receipt, and medical necessity. All covered services, even those that don't require authorization, are subject to the plan's medical necessity requirements and may be subject to audit or review, including after the service was rendered or after the claim has been paid.
143 Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	All commercial products	38240, 38241, S2142, S2150: Prior authorization is required; in effect.
146 Ground Ambulance Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	Commercial Managed Care (HMO and POS) For Managed care members (HMO Blue, Blue Choice, Access Blue)	A0426; A0428: Prior authorization is **required**; in effect. • All non-emergent ambulance transports from a member's home or residence[1] to a contracted facility or provider • Chair car/van Prior authorization is **not required for:** • Emergency transports • Non-emergency ambulance transports between facilities when the patient is an inpatient • Involuntary transport to a psychiatric facility [1] A member's "residence" is defined as the place where he or she makes their home and dwells permanently, or for an extended period of time.
	Commercial PPO and Indemnity	Prior authorization is **not required for:** • Any ground ambulance services

		• Involuntary transport to a psychiatric facility • Air ambulances Note: all air ambulance claims must be submitted with supporting documentation and will be reviewed for medical necessity.
147 Zulresso™ (Brexanolone) for the Treatment of Post-Partum Depression prn.pdf Complete Prior Authorization Request Form for Zulresso (Brexanalone) for the Treatment of Postpartum Depression (148) using Authorization Manager	All commercial products	See policy for CPT codes
150 Hematopoietic Cell Transplantation for Acute Myeloid Leukemia Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	All commercial products	38240, 38241, S2142, S2150: Prior authorization is required; in effect.
151 Neuropsychological and Psychological testing Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form	Commercial HMO and POS	96130, 96131, 96132, 96133: Prior authorization is required; in effect.
	Commercial PPO/EPO Indemnity	Prior authorization is not required.
155 Allogeneic Hematopoietic Cell transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	All commercial products	38240, S2150: Prior authorization is required; in effect.

158 Outpatient Pediatric Pain Rehabilitation Centers Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	All commercial products	For CPT codes, see policy 158 Prior authorization is required; in effect
159 Gene Therapies for Bladder Cancer Complete Prior Authorization Request Form for Adstiladrin (nadofaragene firadenovec-vncg) (193) using Authorization Manager	All commercial products	For CPT codes, see policy 159. Prior authorization is required. Effective 6.8.2023.
168 Gene Therapies for Hemophilia A or B Complete Prior Authorization Request Form for Gene Therapies using Authorization Manager for: • Hemophilia B Hemgenix® (Etranacogene dezaparvovec) (169) • Hemophilia A Roctavian® (Valoctocogene roxaparvovec-rvox), (#166)	All commercial products	J1411, J1412: Prior authorization is required. Effective 4.3.2023.
179 Orthognathic Surgery Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	All commercial products	21193, 21194, 21195, 21196,21198 21199, 21206, 21240, 21242, 21243: Prior authorization is required; in effect
181 Hematopoietic Cell Transplantation for Primary Amyloidosis Complete Prior Authorization Request Form using Authorization Manager	All commercial products	38241, S2150: Prior authorization is required; in effect.

▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form		
189 Gender Affirming Services (Transgender Services) Complete Prior Authorization Request Form for Gender Affirming Services (901) using Authorization Manager Complete Prior Authorization Request Form for **Electrolysis** for Gender Affirming Services (902) using Authorization Manager	Commercial HMO and POS	Click here for CPT codes Prior authorization is required; in effect.
	Commercial PPO Indemnity	Click here for CPT codes Prior authorization is required; in effect.
190 Allogeneic Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	All commercial products	38240, S2142, S2150: Prior authorization is required; in effect.
192 Hematopoietic Cell Transplantation for Autoimmune Diseases Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	All commercial products	38241, S2150: Prior authorization is required; in effect.
205 Hematopoietic Cell Transplantation for CNS Embryonal Tumors and Ependymoma Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR**	All commercial products	S2150: Prior authorization is required; in effect.

▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form		
207 Hematopoietic Cell Transplantation for Hodgkin Lymphoma Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	All commercial products	38241, S2142, S2150: Prior authorization is required; in effect.
208 Hematopoietic Cell Transplantation for Solid Tumors of Childhood Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	All commercial products	38241, S2150: Prior authorization is required; in effect.
211 Intraoperative Neurophysiologic Monitoring Sensory-Evoked Potentials, Motor-Evoked Potentials, EEG Monitoring Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	All commercial products	95940, 95941, G0453: Prior authorization is required; in effect.
212 Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	All commercial products	38240, S2142, S2150: Prior authorization is required; in effect.

215 Gene Therapies for Thalassemia Complete Prior Authorization Request Form using Authorization Manager ▪ Gene Therapies for Thalassemia Prior Authorization Request Form for Zynteglo for Betibeglogene (216) ▪ Gene Therapies for Thalassemia Prior Authorization Request Form for Casgevy™ (Exagamglogene autotemcel) for Beta thalassemia, #217	All commercial products	Zynteglo J3393 Prior authorization is required. Effective 7.1.2024. Casgevy: See policy for coding information. Prior authorization is required. Effective 8.1.2024.
227 Myoelectric Prosthetic and Orthotic Components for the Upper Limb Complete Prior Authorization Request Form for Myoelectric Prosthetic and Components for the Upper Limb (973) using Authorization Manager	Commercial HMO and POS	L6026, L6925, L6935, L6945, L6955, L6965, L6975, L7007, L7008, L7009, L7045, L7180, L7181, L7190, L7191: Prior authorization is required; in effect.
	Commercial PPO/EPO	L6026, L6925, L6935, L6945, L6955, L6965, L6975, L7007, L7008, L7009, L7045, L7180, L7181, L7190, L7191: Prior authorization is required. Effective 6.1.2022.
238 Treatment of Varicose Veins/Venous Insufficiency Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	Commercial HMO and POS	36465, 36466, 36470, 36471, 36475, 36476, 36478, 36479, 36482, 36483,37500, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766, 37780, 37785, S2202: Prior authorization is required; in effect.
	Commercial PPO/EPO	36465, 36466, 36470, 36471, 36475, 36476, 36478, 36479, 36482, 36483,37500, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766, 37780, 37785, S2202: Prior authorization is required. Effective 6.1.2022.
241 Gene Therapies for Cerebral Adrenoleukodystrophy Complete Prior Authorization Request Form for Cerebral Adrenoleukodystrophy Skysona® (Elivaldogene autotemcel) (242) using Authorization Manager	All commercial products	See policy for coding information. Prior authorization is required. Effective 2.1.2023.

247 Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	All commercial products	38241, S2150: Prior authorization is required; in effect.
284 Bronchial Thermoplasty Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	Commercial HMO and POS	31660, 31661: Prior authorization is required; in effect.
	Commercial PPO/EPO	31660, 31661: Prior authorization is required. Effective 6.1.2022.
297 Transcranial Magnetic Stimulation as a Treatment of Depression and Other Psychiatric Neurologic Disorders Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	Commercial HMO and POS	90867, 90868, 90869: Prior authorization is required; in effect.
	Commercial PPO/EPO Indemnity	90867, 90868, 90869: Prior authorization is required. Effective 7.1.2024.
320 Diagnosis and Treatment of Sacroiliac Joint Pain Complete Prior Authorization Request Form for Diagnosis and Treatment of Sacroiliac Joint Pain (927) using Authorization Manager	Commercial HMO and POS	27279: Prior authorization is required; in effect.
	Commercial PPO/EPO	27279: Prior authorization is required. Effective 6.1.2022.
322 Hematopoietic Stem-Cell Transplantation for Waldenstrom Macroglobulinemia Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR**	All commercial products	38241, S2150: Prior authorization is required; in effect.

▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form		
365 Manual and Power Operated Wheelchairs Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	Commercial Managed Care (HMO and POS) and Commercial PPO/EPO products	Power Operated Wheelchairs: K0813; K0814; K0815; K0816; K0820; K0821; K0822; K0823 K0824; K0825; K0826; K0827; K0828; K0829; K0830; K0831; K0835; K0836; K0837; K0838; K0839; K0840; K0841; K0842; K0843; K0848; K0849; K0850; K0851; K0852; K0853; K0854; K0855; K0856; K0857; K0858; K0859; K0860; K0861; K0862; K0863; K0864; K0890; K0891; K0898: Prior authorization is required. 6.1.2022.
379 Medical and Surgical Management of Obesity including Anorexiants Complete Prior Authorization Request Form for Surgical Management of Obesity (047) using Authorization Manager	Commercial Managed Care (HMO and POS)	43644; 43770, 43775, 43845, 43846, 43848: Prior authorization is required; in effect.
	Commercial PPO/EPO	43644; 43770, 43775, 43845, 43846, 43848: Prior authorization is required. Effective 6.1.2022.
428 Reconstructive Breast Surgery/Management of Breast Implants 703 Reduction Mammaplasty for Breast-Related Symptoms prn.pdf Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	Commercial HMO and POS	11970, 11971, 19316, 19318, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19371, 19380, 19396, S2066, S2067: Prior authorization is required; in effect.
	Commercial PPO/EPO	11970, 11971, 19316, 19318, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19367, 19368, 19369, 19371, 19380, 19396, S2066, S2067; L6955, L6965: Prior authorization is required. Effective 6.1.2022.
485 Intraosseous Basivertebral Nerve Ablation Complete Prior Authorization Request Form for Intraosseous Basivertebral Nerve Ablation (486) using Authorization Manager	Commercial HMO and POS	64628, 64629 Prior authorization is required. Effective 2.1.2024
	Commercial PPO/EPO	64628, 64629 Prior authorization is required. Effective 2.1.2024

703 Reduction Mammaplasty for Breast-Related Symptoms Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	Commercial HMO and POS	19318: Prior authorization is required; in effect.
	Commercial PPO/EPO	19318: Prior authorization is required. Effective 6.1.2022.
740 Blepharoplasty, Blepharoptosis Repair Complete Prior Authorization Request Form using Authorization Manager ▪ Massachusetts Collaborative Prior Authorization Form **OR** ▪ Blue Cross Blue Shield of Massachusetts Precertification Request Form	Commercial HMO and POS	15820, 15821, 15822, 15823, 67900, 67901, 67902, 67903, 67904, 67906, 67908: Prior authorization is required; in effect.
	Commercial PPO/EPO	15820, 15821, 15822, 15823, 67900, 67901, 67902, 67903, 67904, 67906, 67908: Prior authorization is required. Effective 6.1.2022.
911 Gene Therapy for Inherited Retinal Dystrophy Complete Prior Authorization Request Form for Gene Therapy for Inherited Retinal Dystrophy (926) using Authorization Manager	All commercial products	J3398: Prior authorization is required; in effect.
920 Magnetic Esophageal Ring to Treat Gastroesophageal Reflux Disease - GERD Complete Prior Authorization Request Form for Surgical and Transesophageal Endoscopic Procedures to Treat Gastroesophageal Reflux Disease (956)	Commercial HMO and POS	43210, 43284: Prior authorization is required; in effect.
	Commercial PPO/EPO	43210, 43284: Prior authorization is required. Effective 6.1.2022.
942 Chimeric Antigen Receptor Therapy for Multiple Myeloma Complete Prior Authorization Request Form for CAR T-Cell Therapy Services for Multiple Myeloma (Idecabtagene vicleucel) (943) using Authorization Manager	All commercial products	Q2055: Prior authorization is required. Effective 1.1.2022. Q2056: Prior authorization is required. Effective 10.1.2022. See policy for additional information
946 Monoclonal Antibodies for Treatment of Alzheimer's Disease	All commercial products	J0174: Prior authorization is required. Effective 6.1.2024

Complete Prior Authorization Request Form for Lecanemab (Leqembi®) and Donanemab (Kisunla™) for Alzheimer's Disease (949) using Authorization Manager		J0175: Prior authorization is required. Effective 8.1.2024

Prior authorization is required for the following Gender Affirming Transgender codes for Commercial Managed Care (HMO and POS), Commercial PPO, and Indemnity:

Male to Female Surgery	
17380	Electrolysis epilation, each 30 minutes
19325	Mammaplasty, augmentation; with prosthetic implant
19350	Nipple/areola reconstruction
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
19380	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
54120	Amputation of penis; partial
54125	Amputation of penis; complete
54300	Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra
55970	Intersex surgery; male to female
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
Facial Feminization/ Masculinization	
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
Brow Lift	
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
Blepharoplasty	
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
Rhinoplasty	
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
Cheek Augmentation	
21270	Malar augmentation, prosthetic material

21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
Jaw Reconstruction	
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
Chin Reconstruction	
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
Face Lift: These codes are covered when required as part of medically necessary facial feminization procedure	
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
Liposuction: These codes are covered when required as part of medically necessary facial feminization procedure	
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
Trachea Shave/Thyroid Cartilage Reduction	
31599	Unlisted procedure, larynx
Chest and Genital Surgery for Feminization Surgery	
17380	Electrolysis epilation, each 30 minutes
19325	Mammaplasty, augmentation; with prosthetic implant
19350	Nipple/areola reconstruction
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
19380	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
54120	Amputation of penis; partial
54125	Amputation of penis; complete
54300	Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra
54125	Amputation of penis; complete
54300	Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
55970	Intersex surgery; male to female

56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57335	Vaginoplasty for intersex state
Chest and Genital Surgery for Masculinization Surgery	
19303	Mastectomy, simple, complete
19316	Mastopexy
19350	Nipple/areola reconstruction
53430	Urethroplasty, reconstruction of female urethra
54660	Insertion testicular prosthesis
55175	Scrotoplasty; simple
55180	Scrotoplasty; complex
55980	Intersex surgery; female to male
56620	Vulvectomy; simple
56625	Vulvectomy; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
56810	Perineoplasty, repair of perineum, nonobstetrical
57110	Vaginectomy; complete removal of vaginal wall
57111	Vaginectomy; with removal of paravaginal tissue (radical vaginectomy)

Prior authorization is required for the following Assisted Reproductive Services codes for Commercial Managed Care (HMO and POS), Commercial PPO, and Indemnity:

Professional Providers	
54900	Epididymovasostomy, anastomosis of epididymis to vas deferens; unilateral
54901	Epididymovasostomy, anastomosis of epididymis to vas deferens; bilateral
S4026	Procurement of donor sperm from sperm bank Type of service 5, and 1 unit of service, for procurement of donor sperm from a sperm bank, for each vial procured (1 unit = 1vial)
55870	Electroejaculation
S4028	Microsurgical epididymal sperm aspiration (MESA) Type of service 2 **Note:** MESA is payable only for congenital absence or congenital obstruction of the vas deferens**.**
58974	Embryo transfer, intrauterine
58976	Gamete, zygote, or embryo intrafallopian transfer, any method
59866	Multifetal pregnancy reduction
58825	Transposition, ovary(s)
89255	Preparation of embryo for transfer (any method)
89257	Sperm identification from aspiration (other than seminal fluid)
89258	Cryopreservation; embryo(s)
89259	Cryopreservation; sperm
89260	Sperm isolation; simple prep (eg. per col gradient, albumin gradient) for insemination or diagnosis with semen analysis
89261	Sperm isolation; complex prep (eg, per col gradient, albumin gradient) for insemination or diagnosis with semen analysis
89264	Sperm identification from testis tissue, fresh or cryopreserved
89268	Insemination of eggs
89272	Extended culture of egg(s)/embryo(s), 4-7 days
89280	Assisted egg fertilization, microtechnique; less than or equal to 10 egg

89281	Assisted egg fertilization, microtechnique; greater than 10 eggs
89321	Semen analysis, presence and/or motility of sperm
89335	Cryopreservation, reproductive tissue, testicular (Covered effective 11/1/2009)
89337	Cryopreservation, mature egg(s)
89342	Storage, (per year); embryo(s)
89343	Storage, (per year); sperm/semen
89346	Storage, (per year); egg
89352	Thawing for cryopreserved; embryo(s)
89353	Thawing of cryopreserved; sperm/semen, each aliquot
89356	Thawing of cryopreserved; egg(s), each aliquot
The following codes are considered **non-covered for all Commercial Plans** as they do not meet our Medical Technology Assessment Guidelines and if billed will reject leaving *no* patient balance	
89344	Storage, (per year); reproductive tissue, testicular/ovarian (except for authorized TESE)
89354	Thawing of cryopreserved; reproductive tissue, testicular/ovarian (except for authorized TESE)
Reproductive Specialist Providers	
58970	Follicle puncture for egg retrieval, any method
S4011	In vitro fertilization, including but not limited to identification and incubation of mature eggs, fertilization with sperm, incubation of embryo(s), and subsequent visualization, determination of development Type of service 2
89250	Culture of egg(s)/embryo(s), less than 4 days; **Note:** This procedure may be billed **once** per cycle.
89253	Assisted embryo hatching, microtechniques (any method)
89254	Egg identification from follicular fluid **Note:** This procedure may be billed once per cycle.
Contracted Sperm Banks	
S4030	Sperm procurement & cryopreservation services; initial visit Type of service L **Note:** This procedure is limited to one visit per lifetime.
S4031	Sperm procurement & cryopreservation services; subsequent visits Type of service L
89259	Annual sperm storage due to other medical treatment rendering a member infertile Type of service L **Note:** This procedure may be billed **once per year.** The procedure may be covered for members in active infertility treatment, post microsurgical epididymal sperm aspiration (MESA), performed for congenital absence of the vas deferens.

Policy History

11/2024	MP 543 Negative Pressure Wound Therapy in the Outpatient Setting. Prior authorization requirements removed. Effective 11/1/2024.
10/2024	MP 107 Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid and Artificial Pancreas Device Systems. Prior authorization requirements removed. Effective 10/1/2024.
8/2024	MP 089 Adoptive Cell Therapies for Melanoma. Prior authorization is required for Amtagvi. Effective 8/1/2024. MP 215 Gene Therapies for Thalassemia. Prior authorization is required for Casgevy. Effective 8/1/2024. MP 946 Monoclonal Antibodies for Treatment of Alzheimer's Disease. Prior authorization is required for Kisunla. Effective 8/1/2024.
7/2024	MP 050 Gene Therapies for Sickle Cell Disease. Prior authorization is required for code J3394. Effective 7/1/2024. MP 215 Gene Therapies for Thalassemia. Prior authorization is required for code J3393. Effective 7/1/2024.

	MP 297 Transcranial Magnetic Stimulation as a Treatment of Depression and Other Psychiatric Neurologic Disorders.: Prior authorization is required for codes 90867, 90868, 90869 for commercial PPO products. Effective 7.1.2024.
6/2024	MP 946 Monoclonal Antibodies for Treatment of Alzheimer's Disease. Prior authorization is required for code J0174. Effective 6/1/2024.
5/2024	MP 043 Suction Lipectomy for Lipedema added. Prior authorization is required for codes 15832, 15833, 15834, 15835, 15836, 15878, 15879. Effective 5/1/2024.
4/2024	MP 097 Bone Morphogenetic Protein. Prior authorization requirements removed. CPT 20930 does not require prior authorization. Effective 4/1/2024. MP 028 Omidubicel as Adjunct Treatment for Hematologic Malignancies. Policy revised to include medically necessary and investigational indications. Prior authorization is required. Effective 4/1/2024.
3/2024	MP 374 Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions retired. The policy will no longer be available on the Blue Cross website. To submit authorization requests through InterQual, use Authorization Manager. Effective 3/1/2024. MP 050 Gene Therapies for Sickle Cell Disease added. Effective 1/1/2024. MP 055 Gene Therapies for Sickle Cell Disease Prior Authorization Request Form for Casgevy ™ (Exagamglogene autotemcel) added. Effective 1/1/2024. MP 168 Gene Therapies for Hemophilia A or B. Added HCPCS code J1412
2/2024	MP 485 Intraosseous Basivertebral Nerve Ablation added. Effective 2.1.2024.
12/2023	Policy revised to remove orchiectomy and hysterectomy procedure codes from MP 189. Prior authorization is not required for the following codes: Orchiectomy codes: 54520; 54690. Hysterectomy codes: 58150; 58180; 58260 58262; 58275; 58290 58291; 58541; 58542; 58543; 58544; 58550 58552; 58553; 58554; 58570; 58571; 58572; 58573. Effective 12/1/2023.
11/2023	Policy clarified to include prior authorization request form for Gene Therapies for Hemophilia A Roctavian MP 166.
9/2023	Policy clarified to include prior authorization requests for services listed in MP 072 are to be submitted using Authorization Manager.
9/2023	MP 022 Gene Therapies for Duchenne Muscular Dystrophy added. Effective 8/9/2023.
7/2023	MP 028 Therapeutic Radiopharmaceuticals removed. Policy 028 was retired in October 2022.
7/2023	MP 159 Gene Therapies for Bladder Cancer added. Effective 6/8/2023. Prior authorization is no longer required for 58321, 58322, 58323; 74740. These codes were removed from MP #072. 6/7/2023
5/2023	MP 320 Diagnosis and Treatment of Sacroiliac Joint Pain reinstated and added.
4/2023	MP 168 Gene Therapies for Hemophilia B added. Prior authorization is required for code J1411. Effective 4/3/2023.
4/2023	Musculoskeletal medical policies retired effective April 1, 2023. These policies will no longer be available on the Blue Cross website. To submit authorization requests through InterQual use Authorization Manager. MP 585 Artificial Intervertebral Disc - Cervical Spine MP 320 Diagnosis and Treatment of Sacroiliac Joint Pain MP 690 Epidural Steroid Injections MP 485 Percutaneous Balloon Kyphoplasty, Radiofrequency Kyphoplasty and Mechanical Vertebral Augmentation MP 484 Percutaneous Vertebroplasty and Sacroplasty MP 472 Spinal Cord and Dorsal Root Ganglion Stimulation
3/2023	Policy #179 Orthognathic Surgery added.
2/2023	MP 241 Gene Therapies for Cerebral Adrenoleukodystrophy added. Effective 2/1/2023.
1/2023	MP#107- removed K0553 as it was deleted and replaced with A4239. Effective 1/1/2023.

12/2022	MP#107- removed S1036. Prior authorization is no longer required for this code.
10/2022	Policy clarified. Hyperlink to InterQual spine procedures that require prior authorization added. Code Q2056 added under #942 Chimeric Antigen Receptor Therapy for Multiple Myeloma.
6/2022	Policy #653 removed. Prior authorization is no longer required for MP 653 HBO Therapy. Effective 6/1/2022.
6/2022	Policy updated to include prior authorization requirements for Commercial PPO. Effective 6/1/2022.
4/2022	Policy #465 was removed. Prior authorization is no longer required for #465 Lipid Apheresis.
3/2022	Policy #091 Applied Behavioral Analysis (ABA) added.
10/2021	HCPCS code C9081 & Q2054 added.
6/2021	Prior authorization is required for #942 Chimeric Antigen Receptor Therapy for Multiple Myeloma. Effective 6/4/2021.
5/2021	Prior authorization requirements clarified: L6955; L6965; 43847 in effect. C1062 added effective 1/1/2021.
4/2021	Prior authorization is clarified: #142 Air Ambulance Transport; #146 Ground Ambulance; #158 Outpatient Pediatric Pain Rehabilitation Centers. Clarified coding information.
3/2021	Policy #285 Placental or Umbilical Cord Blood as a Source of Stem Cells retired; outpatient prior authorization requirements removed. Effective 3/1/2021.
2/2021	Prior authorization is required for #077 Scenesse (afamelanotide) for Treatment of Erythropoietic Protoporphyria. Effective 2/1/2021.
1/2021	Prior authorization information for Medicare Advantage transferred into Policy # 132, Medicare Advantage Management. Links to the following pharmacy policies were added: ▪ Medical Benefit Prior Authorization Medication List 034 ▪ Medical Utilization Management and Pharmacy Prior Authorization Policy 033.
11/2021	HCPCS code G0277 added. Prior authorization is required. Policy #653 Hyperbaric Oxygen Therapy. Effective 11/1/2020.
10/2020	Prior authorization for policy #088 Preimplantation Genetic Testing is not required for Medicare Advantage. Effective 10/23/2020.
7/2020	HCPCS code J3399 added. Effective 7/1/2020.
5/2020	HCPCS code J2001 removed. The code is not specific to policy #087 Esketamine Nasal Spray (Spravato) and Intravenous Ketamine for Treatment Resistant Depression. This code does not require prior authorization. Effective 5/1/2020.
4/2020	The following codes were added: G2082, G2083, J2001. Policy #087 Esketamine Nasal Spray (Spravato) and Intravenous Ketamine for Treatment-Resistant Depression. Effective 4/1/2020.
4/2020	The following codes were removed: 38205; 38206; 38230; 38232; S2140. Effective 4/1/2020.
2/2020	New document #072 issued. Effective 2/1/2020.