MASSACHUSETTS

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Medical Policy
Outpatient Prior Authorization Code List
Policy Number: 072

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 by clicking on the link provided.
- If there is no policy-specific prior authorization request form, providers should complete **either** of the following:
  - Massachusetts Collaborative Prior Authorization Form **or**
  - Blue Cross Blue Shield of Massachusetts Pre-certification Request Form

Policy Number and Title	Products	Procedure codes
008 Zolgensma (onasemnogene abeparvovec-xioi) for Spinal Muscular Atrophy *085 Prior Authorization Request Form for Zolgensma*	All 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 *928 Prior Authorization Request Form for Elzonris*	All products	J9269: Prior authorization is required; in effect.
028 Therapeutic Radiopharmaceuticals in Oncology *958 Prior Authorization Request Form for Therapeutic Radiopharmaceuticals in Oncology Lutetium 177*	All products	A9513: Prior authorization is required; in effect.

035 Temporomandibular Joint Disorder *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	Commercial Managed Care (HMO and POS)	20605, 21010, 21050, 21060, 21073, 21116, 21240, 21242, 21243, 29800, 29804: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	20605, 21010, 21050, 21060, 21073, 21116, 21240, 21242, 21243, 29800, 29804: Prior authorization is required; in effect.
	Medicare PPO Blue	Prior authorization is not required.
066 Chimeric Antigen Receptor Therapy for Hematologic Malignancies *924 Prior Authorization Request Form for CAR T-Cell Therapy Services for Treatment of Diffuse Large B-cell Lymphoma* *925 Prior Authorization Request Form for CAR T-Cell Therapy Services for B-cell Acute Lymphoblastic Leukemia (tisagenlecleucel)*	All products	Q2041, Q2042: Prior authorization is required; in effect.
068 Plastic Surgery *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	Commercial Managed Care (HMO and POS)	15780, 15781, 15782, 15783, 30400, 30410, 30420, 30430, 30435, 30450, 15830, 15847, 15876, 15877, 15878, 15879: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	15780, 15781, 15782, 15783, 30400, 30410, 30420, 30430, 30435, 30450, 15830, 15847: Prior authorization is required; in effect.
	Medicare PPO Blue	Prior authorization is not required.
074 Hematopoietic Stem Cell Transplantation for Chronic Lymphocytic Leukemia and Small Lymphocytic Lymphoma *Massachusetts Collaborative Prior Authorization Form* ***OR***	All products	38240, S2142, S2150: Prior authorization is required; in effect.

Blue Cross Blue Shield of Massachusetts Pre-certification Request Form		
075 Hematopoietic Cell Transplantation for Plasma Cell Dyscracias, Including Multiple Myeloma and POEMS Syndrome *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	All products	38241, S2150: Prior authorization is required; in effect.
076 Hematopoietic Cell Transplantation for Acute Lymphoblastic Leukemia *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	All products	38240, 38241, S2142, S2150: Prior authorization is required; in effect.
086 Assisted Reproductive Services Infertility Services *694 Assisted Reproductive Technology Services Prior Authorization Request Form*	Commercial Managed Care (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.
	Medicare HMO Blue	Prior authorization is not required.
	Medicare PPO Blue	Prior authorization is not required.

087 Esketamine Nasal Spray (Spravato) and Intravenous Ketamine for Treatment Resistant Depression *094 Prior Authorization Request Form for Esketamine Nasal Spray (Spravato) and Intravenous Ketamine*	All products	G2082, G2083: Prior authorization is required effective 4.1.2020.
088 Preimplantation Genetic Testing *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	Commercial Managed Care (HMO and POS) Commercial PPO Indemnity	89290, 89291: Prior authorization is required; in effect.
	Medicare HMO Blue	Prior authorization is not required.
	Medicare PPO Blue	Prior authorization is not required.
097 Bone Morphogenetic Protein *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	Commercial Managed Care (HMO and POS)	20930: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	20930: Prior authorization is required; in effect.
	Medicare PPO Blue	Prior authorization is not required.
107 Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid and Artificial Pancreas Device Systems *845 Prior Authorization Request Form*	Commercial Managed Care (HMO and POS)	A9277, K0553, S1036: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	A9277, K0553, S1036: Prior authorization is required; in effect.
	Medicare PPO Blue	Prior authorization is not required.
110 Meniscal Allografts and Other Meniscal Implants *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	Commercial Managed Care (HMO and POS)	29868: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	Prior authorization is not required.

	Medicare PPO Blue	Prior authorization is not required.
111 Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	All products	27415, 27416, 28446, 29866, 29867: Prior authorization is required; in effect.
121 Closure Devices for Patent Foramen Ovale and Atrial Septal Defects *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	All products	93580: Prior authorization is required; in effect.
130 Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	Commercial Managed Care (HMO and POS)	21193, 21194, 21195, 21196, 21198, 21199, 21206, 21685, 42145: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required
	Medicare HMO Blue	21193, 21194, 21195, 21196, 21198, 21199, 21206, 21685, 42145: Prior authorization is required; in effect.
	Medicare PPO Blue	Prior authorization is not required
133 Microprocessor Controlled Prostheses for the Lower Limb *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	Commercial Managed Care (HMO and POS)	L5856, L5857, L5858: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	Prior authorization is not required.
	Medicare PPO Blue	Prior authorization is not required.

143 Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	All products	38240, 38241, S2142, S2150: Prior authorization is required; in effect.
147 ZulressoTM (Brexanolone) for the Treatment of Post-Partum Depression prn.pdf *148 Prior Authorization Request Form for Zulresso (Brexanalone) for the Treatment of Postpartum Depression prn.pdf*	All products	See policy for CPT codes
150 Hematopoietic Cell Transplantation for Acute Myeloid Leukemia *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	All products	38240, 38241, S2142, S2150: Prior authorization is required; in effect.
151 Neuropsychological and Psychological testing *Massachusetts Collaborative Prior Authorization Form*	Commercial Managed Care (HMO and POS)	96130, 96131, 96132, 91333: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	Prior authorization is not required.
	Medicare PPO Blue	Prior authorization is not required.
155 Allogeneic Hematopoietic Cell transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms *Massachusetts Collaborative Prior Authorization Form* ***OR***	All products	38240, S2150: Prior authorization is required; in effect.

Blue Cross Blue Shield of Massachusetts Pre-certification Request Form		
163 Intensity-Modulated Radiation Therapy - IMRT - of the Breast and Lung *325 Request for Clinical Exception to BCBSMA Intensity Modulated Radiation Therapy - IMRT - Policy and Notification*	Commercial Managed Care (HMO and POS)	77301, 77338, 77385, 77386 G6015, G6016: Prior authorization is required; in effect.
	Commercial PPO Indemnity	77301, 77338, 77385, 77386 G6015, G6016: Prior authorization is required; in effect.
	Medicare HMO Blue	Prior authorization is not required.
	Medicare PPO Blue	Prior authorization is not required.
165 Intensity-Modulated Radiation Therapy - IMRT - Abdomen and Pelvis *325 Request for Clinical Exception to BCBSMA Intensity Modulated Radiation Therapy - IMRT - Policy and Notification*	Commercial Managed Care (HMO and POS)	77301, 77338, 77385, 77386 G6015, G6016: Prior authorization is required; in effect.
	Commercial PPO Indemnity	77301, 77338, 77385, 77386 G6015, G6016: Prior authorization is required; in effect.
	Medicare HMO Blue	Prior authorization is not required.
	Medicare PPO Blue	Prior authorization is not required.
181 Hematopoietic Cell Transplantation for Primary Amyloidosis *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	All products	38241, S2150: Prior authorization is required; in effect.
189 Gender Affirming Services (Transgender Services) *901 Prior Authorization Request Form for Gender Affirming Services (Transgender Services)* ***OR*** *902 Prior Authorization Request Form for Electrolysis for Gender Affirming Services*	Commercial Managed Care (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.
	Medicare HMO Blue	Click here for CPT codes Prior authorization is required; in effect.

		Prior authorization is required for speech therapy and/or voice training services only.
	Medicare PPO Blue	Prior authorization is not required.
190 Allogeneic Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	All products	38240, S2142, S2150: Prior authorization is required; in effect.
192 Hematopoietic Cell Transplantation for Autoimmune Diseases *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	All products	38241, S2150: Prior authorization is required; in effect.
205 Hematopoietic Cell Transplantation for CNS Embryonal Tumors and Ependymoma *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	All products	S2150: Prior authorization is required; in effect.
207 Hematopoietic Cell Transplantation for Hodgkin Lymphoma *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	All products	38241, S2142, S2150: Prior authorization is required; in effect.

208 Hematopoietic Cell Transplantation for Solid Tumors of Childhood *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	All products	38241, 38243, S2150: Prior authorization is required; in effect.
211 Intraoperative Neurophysiologic Monitoring Sensory-Evoked Potentials, Motor-Evoked Potentials, EEG Monitoring *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	All products	95940, 95941, G0453: Prior authorization is required; in effect.
212 Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	All products	38240, S2142, S2150: Prior authorization is required; in effect.
227 Myoelectric Prosthetic and Orthotic Components for the Upper Limb *938 Prior Authorization Request Form for Myoelectric Prosthetic and Components for the Upper Limb*	Commercial Managed Care (HMO and POS)	L6026, L6925, L6935, L6945, L6975, L7007, L7008, L7009, L7045, L7180, L7181, L7190, L7191: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	Prior authorization is not required.
	Medicare PPO Blue	Prior authorization is not required.
238 Treatment of Varicose Veins/Venous Insufficiency	Commercial Managed Care (HMO and POS)	36465, 36466, 36470, 36471, 36475, 36476, 36478, 36479, 36482, 36483,37500, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766,

Massachusetts Collaborative Prior Authorization Form ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*		37780, 37785, S2202: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	36465, 36466, 36470, 36471, 36475, 36476, 36478, 36479, 36482, 36843, 37500, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766, 37780, 37785, S2202: Prior authorization is required; in effect.
	Medicare PPO Blue	Prior authorization is not required.
247 Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	All products	38241, 38243, S2150: Prior authorization is required; in effect.
284 Bronchial Thermoplasty *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	Commercial Managed Care (HMO and POS)	31660, 31661: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	Prior authorization is not required.
	Medicare PPO Blue	Prior authorization is not required.
285 Placental or Umbilical Cord Blood as a Source of Stem Cells *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	All products	S2142, S2150: Prior authorization is required; in effect.
297 Transcranial Magnetic Stimulation as a Treatment of Depression and Other Psychiatric Neurologic Disorders	Commercial Managed Care (HMO and POS)	90867, 90868, 90869: Prior authorization is required; in effect.

Massachusetts Collaborative Prior Authorization Form ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	90867, 90868, 90869: Prior authorization is required; in effect.
	Medicare PPO Blue	90867, 90868, 90869: Prior authorization is required; in effect.
320 Diagnosis and Treatment of Sacroiliac Joint Pain *927 Preauthorization Request Form for Diagnosis and Treatment of Sacroiliac Joint Pain*	Commercial Managed Care (HMO and POS)	27279: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	Prior authorization is not required.
	Medicare PPO Blue	Prior authorization is not required.
322 Hematopoietic Stem-Cell Transplantation for Waldenstrom Macroglobulinemia *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	All products	38241, 38243, S2150: Prior authorization is required; in effect.
374 Autologous Chondrocyte Implantation *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	All products	27412: Prior authorization is required; in effect.
379 Medical and Surgical Management of Obesity including Anorexiants *047 Preauthorization Request Form for 379 Surgical Management of Obesity*	Commercial Managed Care (HMO and POS)	43644; 43770, 43775, 43845, 43846, 43848: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	43644; 43770, 43775, 43845, 43846;43847: Prior authorization is required; in effect.

	Medicare PPO Blue	Prior authorization is not required.
428 Reconstructive Breast Surgery/Management of Breast Implants *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	Commercial Managed Care (HMO and POS)	11970, 11971, 19316, 19318, 19324, 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 Indemnity	Prior authorization is not required.
	Medicare HMO Blue	11970, 11971, 19316, 19318, 19324, 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.
	Medicare PPO Blue	Prior authorization is not required.
437 Charged-Particle - Proton or Helium Ion - Radiation Therapy *678 Request for Clinical Exception to BCBSMA Charged Particle - Proton Beam - Policy and Notification*	Commercial Managed Care (HMO and POS)	77520, 77522, 77523, 77525: Prior authorization is required; in effect.
	Commercial PPO Indemnity	77520, 77522, 77523, 77525: Prior authorization is required; in effect.
	Medicare HMO Blue	Prior authorization is not required.
	Medicare PPO Blue	Prior authorization is not required.
465 Lipid Apheresis *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	Commercial Managed Care (HMO and POS)	36516, S2120: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	36516, S2120: Prior authorization is required; in effect.
	Medicare PPO Blue	Prior authorization is not required.
472 Spinal Cord and Dorsal Root Ganglion Stimulation *Massachusetts Collaborative Prior Authorization Form* ***OR***	Commercial Managed Care (HMO and POS)	63655; 63685: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.

Blue Cross Blue Shield of Massachusetts Pre-certification Request Form		
	Medicare HMO Blue	63655; 63685: Prior authorization is required; in effect.
	Medicare PPO Blue	Prior authorization is not required.
484 Percutaneous Vertebroplasty and Sacroplasty *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	Commercial Managed Care (HMO and POS)	22510,22511, 22512: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	22510, 22511, 22512: Prior authorization is required; in effect.
	Medicare PPO Blue	Prior authorization is not required.
485 Percutaneous Balloon Kyphoplasty, Radiofrequency Kyphoplasty, and Mechanical Vertebral Augmentation *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	Commercial Managed Care (HMO and POS)	22513, 22514, 22515: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	22513, 22514, 22515: Prior authorization is required; in effect.
	Medicare PPO Blue	Prior authorization is not required.
543 Negative Pressure Wound Therapy in the Outpatient Setting *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	Commercial Managed Care (HMO and POS)	97605, 97606: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	97605, 97606: Prior authorization is required; in effect.
	Medicare PPO Blue	Prior authorization is not required.
585 Artificial Intervertebral Disc: Cervical Spine *952 Prior Authorization Request Form for Artificial Intervertebral Disc Cervical Spine*	Commercial Managed Care (HMO and POS)	22856, 22858: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.

	Medicare HMO Blue	22856, 22858: Prior authorization is required; in effect.
	Medicare PPO Blue	Prior authorization is not required.
661 Surgical and Non-surgical Treatment of Gynecomastia *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	Commercial Managed Care (HMO and POS)	19300: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	19300: Prior authorization is required; in effect.
	Medicare PPO Blue	Prior authorization is not required.
653 Hyperbaric Oxygen Therapy *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	Commercial Managed Care (HMO and POS)	99183: Prior authorization is required; in effect. G0277: Prior authorization is required. Effective 11.1.2020
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	99183: Prior authorization is required; in effect. G0277: Prior authorization is required. Effective 11.1.2020
	Medicare PPO Blue	Prior authorization is not required.
703 Reduction Mammaplasty for Breast-Related Symptoms *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*	Commercial Managed Care (HMO and POS)	19318: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	19318: Prior authorization is required; in effect.
	Medicare PPO Blue	Prior authorization is not required.
740 Blepharoplasty, Blepharoptosis Repair *Massachusetts Collaborative Prior Authorization Form* ***OR***	Commercial Managed Care (HMO and POS)	15820, 15821, 15822, 15823, 67900, 67901, 67902, 67903, 67904, 67906, 67908: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.

Blue Cross Blue Shield of Massachusetts Pre-certification Request Form		
	Medicare HMO Blue	15820, 15821, 15822, 15823, 67900, 67901, 67902, 67903, 67904, 67906, 67908: Prior authorization is required; in effect.
	Medicare PPO Blue	Prior authorization is not required.
910 Intensity Modulated Radiotherapy (IMRT) Central Nervous System Tumors *325 Request for Clinical Exception to BCBSMA Intensity Modulated Radiation Therapy - IMRT - Policy and Notification*	Commercial Managed Care (HMO and POS)	77301, 77338, 77385, 77386 G6015, G6016: Prior authorization is required; in effect.
	Commercial PPO Indemnity	77301, 77338, 77385, 77386 G6015, G6016: Prior authorization is required; in effect.
	Medicare HMO Blue	Prior authorization is not required.
	Medicare PPO Blue	Prior authorization is not required.
911 Gene Therapy for Inherited Retinal Dystrophy *Gene Therapy for Inherited Retinal Dystrophy Preauthorization Request Form #926*	All products	J3398: Prior authorization is required; in effect.
920 Magnetic Esophageal Ring to Treat Gastroesophageal Reflux Disease - GERD *956 Prior Authorization Request Form for Surgical and Transesophageal Endoscopic Procedures to Treat Gastroesophageal Reflux Disease*	Commercial Managed Care (HMO and POS)	43210, 43284: Prior authorization is required; in effect.
	Commercial PPO Indemnity	Prior authorization is not required.
	Medicare HMO Blue	43210, 43284: Prior authorization is required; in effect.
	Medicare PPO Blue	Prior authorization is not required.

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

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
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54690	Laparoscopy, surgical; orchiectomy
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
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
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
54690	Laparoscopy, surgical; orchiectomy
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
19304	Mastectomy, subcutaneous
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)
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 gms or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58275	Vaginal hysterectomy, with total or partial vaginectomy
58290	Vaginal hysterectomy, for uterus greater than 250 g
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

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
58321	Artificial insemination; intra-cervical
58322	Artificial insemination; intra-uterine
58323	Sperm washing for artificial insemination
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography
76831	Saline infusion sonohysterography (SIS), including color flow Doppler, when performed
74740	Hysterosalpingography, radiological supervision and interpretation
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 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

11/2020	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.