

RMHP Prior Authorization List

Effective October 1, 2017 V5 Revised 10/9/2018



*This list applies to all services for which RMHP is the primary payer.

* Services that are not a benefit of the Member's Evidence of Coverage will not be authorized.

* To request prior authorization for services listed:

RMHP providers submit requests and supporting documentation to RMHP: web [access/RMHP Provider Portal](http://access/RMHPProviderPortal)

Non-participating providers may fax requests and documentation to 800-262-2567 or 970-255-5681

eviCore healthcare: web www.evicore.com phone 800-792-8750

For Behavioral Health Services (including mental health and substance use disorders), call phone 888-282-8801

NOTIFICATION by the ADMITTING FACILITY 800-416-2157, option 4 or 970-248-5197
Call On Admission – Acute Inpatient Prior Authorization required before TRANSFER from one Acute Care Hospital to another Acute Care Hospital – CALL FOR CM NURSE REVIEW Prior Authorization required before Long Term Acute Care (LTAC); Rehabilitation; Skilled Nursing Facility – CALL FOR CM NURSE REVIEW Prior Authorization required before ADMISSION for Inpatient Pediatric Feeding Program
NOTIFICATION by the ADMITTING FACILITY – BEHAVIORAL HEALTH – CALL PHONE NUMBER 888-282-8801
Call On Admission – Acute Inpatient Psych; Inpatient Detox; Observation; Residential Treatment; Structured Outpatient/Intensive Outpatient Program; Partial Hospitalization; Outpatient Detox Prior Authorization required for ALL behavioral health admissions, inpatient residential treatment stays, partial stays, and intensive outpatient treatments
COSMETIC PROCEDURES – PAGE 28
Surgical procedures often are done to correct a functional defect resulting from an injury, sickness, or surgery, or to correct cleft lip or palate. In many cases, the same procedures might be performed for cosmetic reasons. The Cosmetic Section of the Prior Authorization List labels the most commonly performed potentially cosmetic procedures so that you will know if the procedure is not covered, requires prior authorization, or will be covered without prior authorization. This is not a complete listing of every procedure that could be cosmetic.
DME, ORTHOTICS, PROSTHETICS; OXYGEN EQUIPMENT AND CONTENTS
* Refer to the DME Prior authorization Schedule
EXPERIMENTAL PROCEDURES – CLINICAL TRIALS – PAGE 35
* Prior authorization is required for all potentially experimental or investigational procedures. * Experimental and/or investigational procedures, items and treatments are generally excluded from coverage, but may be covered when mandated by the state or federal law. * Participation in clinical research studies may be covered when criteria are met according to the Member's health care plan. * Services that RMHP considers to be experimental are listed in a separate section. The list is not all encompassing because new procedures are developed regularly. Procedures that are outdated or of unproven value also are listed. * Procedures that are considered to be experimental and are reported with an unlisted code are listed in a separate section. Page 44. * These Category III codes do not require prior authorization: 0042T, 0159T, 0184T, 0249T (0159T non-covered for Medicaid eff 1/1/18)
UNLISTED PROCEDURE CODES
* Prior authorization is required for ALL codes having a descriptor meaning "unlisted or unspecified procedure", done alone or in conjunction with other procedures.
Out of Plan – CHP+, Commercial HMO, Medicare, RMHP Prime, BH RAE plans
Prior authorization is required before a provider directs a Commercial HMO, Medicare, RMHP Prime, and/or BH RAE Member to a non-participating provider and before non-emergent/urgent services are received. Medicare Members may access Original Medicare benefits without prior authorization and will be liable for deductibles, co-pay, and coinsurance.
Health First Colorado (Medicaid) – Regional Organization/RAE Prior Authorization
Prior Authorization for Members enrolled with RMHP as the Regional Organization: <ul style="list-style-type: none"> • Prior Authorization requests for behavioral health services (including mental health and substance use disorders) submit to RMHP • Prior Authorization requests for physical health services submit to Health First Colorado through ColoradoPAR following Medicaid rules (http://www.coloradopar.com)
Out of Plan - PPO plans
The PPO Member is responsible for obtaining authorization for services listed on the Prior authorization List when those services are rendered by an out of network provider. Failure to obtain prior authorization when required will result in a significant benefit reduction or denial of payment by RMHP. Refer to Member's Evidence of Coverage for additional information.
PHARMACY
Pharmacy prior authorization is not addressed in this document. Refer to the RMHP Web site (www.rmhp.org) or call 800-641-8921 for the RMHP Pharmacy Help desk.
INSTRUCTIONS for searching this document electronically:
Procedure codes are listed by range. Searching only on the five digit code may fail to find the exact code. By limiting the search to three characters, you will locate all codes, including those in the middle of a range. <ul style="list-style-type: none"> * Select CTRL F * Type the first 3 characters of the code you are searching and hit "enter" throughout the entire document to determine if the code you are searching is on this list.

RMHP Prior Authorization List
Effective October 1, 2017 V5 Revised 10/9/2018



Additional information about the prior authorization process is found at <https://www.rmhp.org/i-am-a-provider/provider-resources>. If you have any questions, please contact Customer Service at 800-854-4558. Mesa County physicians may also contact the MCPIPA office at 970-248-8031.

PRIOR AUTHORIZATION is required for the following services. Prior authorization is the responsibility of the participating provider ordering or rendering the services. Failure to preauthorize required services will result in denial of claim.

Category	Service	CPT or HCPCS Code(s)
Ambulance/Air Transportation	Non-emergent transports/transfers	A0021-A0210, A0426, A0428, A0430 - A0431, A0499, A0435-A0436, A0999
Behavioral Health Services (Commercial, CHP+, Medicare) Submit request to Call Phone: 888-282-8801 Codes followed by asterisk * are available for prior auth to contracted providers via RMHP online portal (link on page 1). Neuropsychological Testing for a medical evaluation : Submit request to RMHP	Intensive Behavioral Therapy (IBT) / Applied Behavioral Analysis (ABA) for Autism Spectrum Disorders - commercial plans only, not CHP+ or Medicare; RAE / RMHP Prime submit to Colorado State Medicaid	0359T – 0374T S5108, S5110 H2012
	Electric Shock Therapy / Electroconvulsive Therapy (ECT)	Professional 90870*
	Psychological or Neuropsychological Testing Except for 96118, 96119, or 96120 when Dx is F06.8, F07.81, S06.0x0A-S06.0x9S	96101*, 96102*, 96103*, 96111, 96116, 96118, 96119, 96120
	Extended session for outpatient therapy	90837*, 90785*
	Transcranial magnetic stimulation for depression/other neurologic disorders	90867*, 90868*, 90869*
Behavioral Health Services (Health First Colorado, Colorado Medicaid – RAE and RAE Prime) Submit request to Call Phone: 888-282-8801*	Acute Treatment Unit (ATU)	H0017
	Electroconvulsive Therapy (ECT)	Professional 90870
	Inpatient Hospitalization	All admissions to free standing inpatient psychiatric facilities, and when primary diagnosis is a covered psychiatric/mental health diagnosis.
	Outpatient Behavioral Health Day Treatment Intensive outpatient programming for SUD Intensive outpatient programming	H2012 H0015 S9480
	Partial Hospitalization	H0035 Rev code 0900
	Residential Treatment Short-Term Long-Term Psychiatric	H0018 H0019 H0017
	Psychological and Neuropsychological Testing ***Clarification: Two distinct benefit categories exist for these services – 1) Behavioral and 2) Medical.	96101, 96102, 96103, 96116, 96118, 96119, 96120 requires prior auth for RAE and for RAE Prime 96111 is NOT covered for RAE 96111 requires prior auth for RAE Prime
*Neuropsychological Testing for a medical evaluation: RAE Prime: Submit <i>medical evaluation</i> request to RMHP RAE: Submit <i>medical evaluation</i> request to ColoradoPAR Program		
Cardiac Surgery/Cardiovascular	Implant of patient-activated cardiac event recorder	33282
	Common carotid intima-media thickness (IMT) study for evaluation of atherosclerotic burden or coronary heart disease risk factor assessment	0126T

RMHP Prior Authorization List
Effective October 1, 2017 V5 Revised 10/9/2018



PRIOR AUTHORIZATION is required for the following services. Prior authorization is the responsibility of the participating provider ordering or rendering the services. Failure to preauthorize required services will result in denial of claim.

Category	Service	CPT or HCPCS Code(s)
	Endovascular repair of iliac artery bifurcation . . . using bifurcated endoprograft from the common iliac artery into both the external and internal iliac artery, . . . unilateral	0254T
	Endovascular repair of visceral aorta . . . by deployment of a fenestrated visceral aortic endograft	34841, 34842, 34843, 34844,
	Endovascular repair of visceral aorta and infrarenal abdominal aorta . . . with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft	34845, 34846, 34847, 34848
	External patient-activated, physician- or other qualified health care profession-prescribed, electrocardiographic rhythm derived event recorder, without 24 hour attended monitoring . . .	0497T, 0498T
	Implantation of catheter-delivered prosthetic pulmonary valve, endovascular approach	33477
	Insertion, removal, repositioning of SQ implantable defibrillator Programming device evaluation and/or adjustment	33270, 33271, 33272, 33273 93260, 93261, 93644
	Partial left ventriculectomy (e.g., Batista procedure)	33542
	Percutaneous transcatheter closure of left atrial appendage w/implant, transseptal puncture, cath, left atrial angiography left atrial appendage angiography rad supervision/interpretation	33340
	Signal Averaged ECG (SAECG)	93278
	Surgical ventricular restoration procedure, includes prosthetic patch, when performed (e.g., ventricular remodeling, SVR, SAVER, DOR procedures	33548
	Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion	36516
	Transcatheter Aortic Valve Replacement	33361-33369
	Transcatheter insertion of stent of common carotid artery or innominate artery via percutaneous approach	37218
	Transcatheter insertion or replacement of permanent leadless pacemaker, ventricular and associated ciodes for programming and evalution	0387T, 0389T, 0390T, 0391T are covered for Medicare plans ONLY when patient is enrolled in Clinical Trial NCT03039712. Non payable for Medicaid plans. Not a Benefit - Experimental for all other plans.
	Limited coverage in CMS approved CED studies per NCD 20.8.4	
	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve . . .	0483T, 0484T
	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	33418
	Transcatheter mitral valve repair with prosthetic valve via percutaneous approach	33419
	Transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s)	0075T, 0076T
	Transcatheter placement of wireless physiologic sensor aneurysmal sac endovascular repair	34806
	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation	0234T, 0235T, 0236T, 0237T, 0238T

RMHP Prior Authorization List
Effective October 1, 2017 V5 Revised 10/9/2018



PRIOR AUTHORIZATION is required for the following services. Prior authorization is the responsibility of the participating provider ordering or rendering the services. Failure to preauthorize required services will result in denial of claim.		
Category	Service	CPT or HCPCS Code(s)
	Treatment of varicose veins, including but not limited to, radiofrequency ablation, sclerotherapy, stripping and ligation, endolaser therapy	36465-36479, 37700-37785
Chiropractic Care Submit request to Evicore www.evicore.com phone 800-792-8750 Contact Customer Service Call Center 800-638-4557 for Member's Chiropractic benefit coverage that may be included in the health plan and separate from a chiropractic rider	ALL Radiological Exams performed in a Chiropractic Office require prior authorization (except for PERACare plans) Spinal Manipulation and Other Services – Non-Medicare Plans Chiropractic care is limited to 20 visits per calendar year when received from a network chiropractor. Chiropractors who participate with eviCore (formerly Landmark) are network providers. The first 8 visits are covered automatically. After that, the chiropractor must receive prior authorization for continued visits. This prior authorization is done by eviCore. Claims will be paid by RMHP and all chiro visits count toward the 20 visit limit. Spinal Manipulation and Other Services – Medicare Plans do not require prior authorization.	71100-73660 98940-98943 and all codes representing visits or services by a chiropractor after 8 visits up to 20 th visit per year maximum RMHP follows the guidelines found in the current active LCD (Medicare Local Coverage Determination publication)
Dental and Orthognathic Related Services	All dental and orthognathic services, including surrounding services such as anesthesia, facility, or appliances. Please refer to the Member's EOC or contact Customer Service to determine if dental services are covered.	
	Transfer, free toe joint, with microvascular anastomosis for TMJ disorder (Dx M26.60-M26.69)	20957, 20972, 20973, 26556
Dermatology	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands . . .	0489T, 0490T
	Total Body Integumentary Photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma	96904
Diagnostic Imaging Use this list when the procedure will be performed outside of Delta or Montrose county Submit request to eviCore healthcare: Web www.evicore.com Phone 800-792-8750	CT Scans; CT Angiography; CT Colonography Low dose CT scan for lung cancer screening for smokers Electron Beam CT Scans, CT Coronary Angiography	70450-70498; 71250-71275; 72125-72133; 72191-72194; 73200-73206; 73700-73706; 74150-74178; 74261-74263; 75571-75574; 75635; 76380; G0297
	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed concurrent with primary interpretation	0174T
	Magnetic Resonance Angiography (MRA)	70544-70549; 71555; 72159; 72198; 73225; 73725; 74185
	Magnetic Resonance Imaging (MRI), Functional MRI Magnetic Resonance Spectroscopy Magnetic Source Imaging (MSI) somatosensory testing	70336; 70540-70543; 70551-70555; 71550-71552; 72141-72158; 72195-72197; 73218-73223; 73718-73723; 74181-74183; 74712,74713; 75557-75563; 76390; 77058-77059; 77084; S8035
	3D rendering of CT Scan, MRI, US, or other tomographic modality	76376, 76377

RMHP Prior Authorization List
Effective October 1, 2017 V5 Revised 10/9/2018



PRIOR AUTHORIZATION is required for the following services. Prior authorization is the responsibility of the participating provider ordering or rendering the services. Failure to preauthorize required services will result in denial of claim.		
Category	Service	CPT or HCPCS Code(s)
	Near-infrared spectroscopy studies of lower extremity wounds (eg, for oxyhemoglobin measurement)	0493T
	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease . . .	0501T, 0502T, 0503T, 0504T
	Nuclear Cardiology	78451-78454; 78466-78483; 78494-78496
	Nuclear Medicine	78012-78104; 78185; 78195; 78201-78266; 78278; 78290-78320; 78428-78445; 78456-78458; 78579-78607; 78610-78710; 78730-78807
	Optical coherence tomography (OCT) of middle ear, with interpretation and report	0485T, 0486T
	All PET Scans	78459; 78491-78492; 78608-78609; 78811-78816, G0219, G0235, G0252, 0482T
	Investigational Procedures and Unlisted Codes	S8080-S8092; 76497; 76498; 78099; 78199; 78299; 78399; 78499; 78599; 78699; 78799; 78999
Diagnostic Imaging Use this list when the procedure will be performed <u>in</u> Delta or Montrose county Submit request to RMHP	Electron Beam CT Scans, CT Coronary Angiography	75571, 75572, 75573, 75574
	All PET scans	78459, 78491-78492, 78608-78609, 78811-78816, G0219, G0235, G0252, 0482T
	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed concurrent with primary interpretation	0174T
	CT Colonography	74261, 74262, 74263
	Functional MRI	70554, 70555
	Near-infrared spectroscopy studies of lower extremity wounds (eg, for oxyhemoglobin measurement)	0493T
	Optical coherence tomography (OCT) of middle ear, with interpretation and report	0485T, 0486T
	SPECT scans of the brain	78607
	Investigational Procedures and Unlisted Codes	S8080-S8092; 76497; 76498; 78099; 78199; 78299; 78399; 78499; 78599; 78699; 78799; 78999

RMHP Prior Authorization List
Effective October 1, 2017 V5 Revised 10/9/2018



PRIOR AUTHORIZATION is required for the following services. Prior authorization is the responsibility of the participating provider ordering or rendering the services. Failure to preauthorize required services will result in denial of claim.		
Category	Service	CPT or HCPCS Code(s)
ENT	Osseointegrated Hearing Device and Implantation/Replacement (CHP+ Members age <18 years) and RMHP Medicare Members ONLY. Submit to RMHP. Not a benefit of any Commercial plans. RMHP Prime – Procedures 69710-69718 do not need prior auth. Devices L8690-L8694 not covered. Wrap around service. Submit to Colorado State Medicaid.	69710-69718, L8690 – L8694
	Cochlear device implant. (Commercial, CHP+, and RMHP Medicare Members ONLY. RMHP Prime submit to Colorado State Medicaid	69930, L8614 - L8629
	Nasal function studies, e.g., Rhinomanometry	92512
	Nasal/sinus endoscopy, with dilatation (balloon dilatation)	31295, 31296, 31297, 31298
	Rhinoplasty with/without septal repair - except for nasal deformity secondary to congenital cleft lip and/or palate	30400-30450; 30465
	<i>Surgeries and Procedures for snoring, obstructive sleep apnea syndrome, and upper airway resistance syndrome in adults</i> Partial glossectomy; Hemiglossectomy Repose tongue suspension system Submucosal ablation of tongue base, radiofrequency (radiofrequency assisted uvulopalatoplasty (RAUP); Submucosal radiofrequency uvulopalatoplasty (SRUP), Somnoplasty, Tongue reduction surgery) Uvulectomy; Uvulopalatopharyngoplasty (UPPP)	41120, 41130, 41512, 41530, 42140, 42145, 42160, S2080 or any unlisted code
Fetal Surgery	All fetal surgeries require prior authorization.	59072, 59074, 59076, 59897 S2400, S2401, S2402, S2403, S2404, S2405, S2409, S2411
Gastroenterology and General Surgery	Abdominoplasty, Lipectomy, Panniculectomy	15830-15839, 15847, 15876-15879
	Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s)	93702
	Breast related procedures: Reconstruction, Reduction, Augmentation, Breast Implant or Removal, Removal or Replacement of tissue expander (No prior authorization required if Member has had a medically necessary mastectomy).	11970, 11971, 19300, 19316-19499
	Breath hydrogen or methane test (only allowed with dx E73.0-E73.9 after failed 2 week trial of lactose-free diet)	91065
	Electrogastrography, diagnostic, transcutaneous OR with provocative testing	91132, 91133
	Gastric electrical stimulation <ul style="list-style-type: none"> • Implantation, replacement, or removal of gastric neurostimulator electrodes, antrum; laparoscopic or open • Insertion, replacement, or removal of peripheral or gastric neurostimulator pulse generator or receiver • Electronic analysis of gastric neurostimulator pulse generator/transmitter system 	43647, 43648, 43881, 43882, 64590, 64595, 95980, 95981, 95982
	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report	91112

RMHP Prior Authorization List
Effective October 1, 2017 V5 Revised 10/9/2018



PRIOR AUTHORIZATION is required for the following services. Prior authorization is the responsibility of the participating provider ordering or rendering the services. Failure to preauthorize required services will result in denial of claim.		
Category	Service	CPT or HCPCS Code(s)
	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement or removal of sphincter augmentation device, including curoplasty	43284, 43285
	Obesity related surgeries: All surgeries related to obesity, including but not limited to bariatric surgeries, lipectomy, or excision of skin due to weight loss	15830-15839, 15847, 15876-15879, 43644, 43645, 43770-43775, 43842-43848, 43886-43888, S2083
	Optical endomicroscopy	43206, 43252
	Repair of anorectal fistula with plug [e.g., porcine small intestine submucosa (SIS)]	46707
	Transesophageal endoscopic therapies or Transoral Incisionless Fundoplication (TIF) for gastroesophageal reflux disease (Stretta procedure, Gatekeeper device, EndoCinch, EsophyX)	43210, 43257
Genitourinary	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance	55706
	Insertion or replacement of penile prosthesis	54400 - 54405; 54408 - 54411; 54416, 54417
	Implant of neurostimulator electrodes; sacral nerve; Insertion, replacement, or revision of peripheral neurostimulator pulse generator or receiver	64561, 64581, 64585, 64590, 64595
	Penile revascularization for impotence	37788
	Penile venous occlusion surgery	37790
	Percutaneous posterior tibial nerve stimulation	64566
	Temporary prostatic stent (e.g., Spanner stent)	53855
GYN	Focused ultrasound ablation of uterine leiomyomata, including MR guidance	0071T, 0072T
	Biomechanical mapping, transvaginal, with report	0487T
	Clitoroplasty or vaginoplasty for intersex state Construction of artificial vagina, with or without graft Revision (including removal) of prosthetic vaginal graft, open	56805, 57335 57291, 57292 57296
Hearing Aids or Repairs Commercial and CHP+ Plans	Hearing Aids or Repairs of Hearing Aids for Children less than 18 years of age	V5014, V5030-V5080, V5100, V5120-V5150, V5170-V5190, V5210-V5230, V5242-V5261
Hematology	Injection(s), autologous white blood cell concentrate (autologous protein solution) . . .	0481T
Home Infusion services	Prior authorization required for drugs listed on RMHP Formulary. Drugs that require prior authorization and the appropriate forms are obtained from the RMHP Web site (www.rmhp.org), or call 800-641-8921 for the RMHP Pharmacy Help desk.	
Interventional Cancer Treatment	Cytoreduction, hyperthermic intraperitoneal chemotherapy (HIPEC)	96446 with 77605 or 77620; unlisted code

RMHP Prior Authorization List
Effective October 1, 2017 V5 Revised 10/9/2018



PRIOR AUTHORIZATION is required for the following services. Prior authorization is the responsibility of the participating provider ordering or rendering the services. Failure to preauthorize required services will result in denial of claim.

Category	Service	CPT or HCPCS Code(s)
	Cryosurgical ablation of solid tumors Cryosurgical ablation of tumors other than liver (47371, 47381), kidney (50250, 50542, 50593), bone (20983), or prostate (55873)	19105, 31641, 32994 or unspecified codes
	Radiation Oncology Proton Beam Therapy for uveal melanomas Stereotactic body radiation therapy Thoracic target(s) delineation for stereotactic body radiation therapy High dose rate electronic brachytherapy, skin surface application High dose rate electronic brachytherapy, interstitial or intracavitary treatment	32701, 77373, 77435, 77520, 77522, 77523, 77525, G0339, G0340, 0394T, 0395T
	Radioembolization with Yttrium-90 Microspheres (e.g. SIR-spheres, TheraSpheres) except for unresectable primary hepatocellular carcinoma (HCC) or unresectable metastatic liver tumors	S2095, C2616
Laboratory Tests – GENETIC TESTING Submit genetic testing requests to eviCore healthcare: Web www.evicore.com Phone 800-792-8750	Genetic testing procedure codes are listed starting on page 16	
Laboratory Tests that are NOT genetic testing Submit laboratory test requests to RMHP See Experimental List for additional tests	Allergen specific IgG, quantitative or semi-quantitative, each allergen	86001
	Apolipoprotein	82172
	Breath test for heart transplant rejection	0085T
	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood);	86152
	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); interpretation and report	86153
	Coenzyme Q-10	82542
	Endocrinology (type 2 diabetes) biochemical assays of 7 analytes	81506
	Exhaled breath condensate pH	83987
	FIBROSpect II®, HCV, ASH, or NASH FibroSURE™ EXCEPT when used for evaluation of Hepatitis C (Dx B15.0-B19.9; K70.0-K70.9; K73.0-K75.81; K76.0; K76.89; K76.9)	0001M, 0002M, 0003M 83883
	Galectin-3	82777
	Growth stimulation expressed gene 2 (ST2, Interleukin 1 receptor like-1)	83006
	Human epididymis protein 4 (HE4)	86305
	Leukocyte Histamine Release (LHRT)	86343
	Lipoprotein(a) enzyme immunoassay (Lp[a])	83695

RMHP Prior Authorization List
Effective October 1, 2017 V5 Revised 10/9/2018



PRIOR AUTHORIZATION is required for the following services. Prior authorization is the responsibility of the participating provider ordering or rendering the services. Failure to preauthorize required services will result in denial of claim.

Category	Service	CPT or HCPCS Code(s)
	Lipoprotein, blood; electrophoretic separation and quantitation	83700
	Lipoprotein, blood; electrophoretic separation and quantitation	83704
	Lipoprotein-associated phospholipase A2 (Lp-PLA2, PLAC)	83698
	Long-chain (C20-22) omega-3 fatty acids in red blood cell (RBC) membranes	0111T
	Measurement of Long-chain Omega-3 Fatty Acids in Red Blood Cell	82726
	Nephelometry, each analyte not elsewhere specified	83883
	Omega-3 fatty acids	82542
	Oncoprotein; des-gamma-carboxy-prothrombin (DCP)	83951
	Optical endomicroscopic image(s), interpretation and report	88375
	Plasma myeloperoxidase (MPO)	83876
	Thromboxane metabolite(s), including thromboxane if performed, urine	84431
Neurosurgery	Arthrodesis, lumbar and cervical spine, excludes codes 22800 - 22819 and related instrumentation for those codes	22533-22554,22558-22585,22590-22600,22612-22634
	Arthrodesis, pre-sacral interbody technique, disc space preparation, discectomy, without instrumentation, with image guidance, includes bone graft when performed	0195T, 0196T
	Bone or Soft Tissue Healing and Fusion Enhancement Products, including but not limited to: <ul style="list-style-type: none"> • Bone Morphogenic Protein (e.g. BMP, rhBMP-2, BMP-7) • Bone Void Filler; Ceramic-Based products (e.g. b-TCP, Vitoss) • Cell-Based Products (e.g. mesenchymal stem cells, Osteocel, Trinity Evolution) • Demineralized Bone matrix (DBM) • Epifix or Epicord • OptiMesh • Xenografts 	20930, 20931, 22899 C9359, C9362 Q4100, Q4131
	Deep Brain Stimulation	61850-61888, 95978, 95979
	Covered for idiopathic Parkinson's disease, essential tremor, and primary dystonia ONLY. Non-covered/Experimental for secondary Parkinsonism, secondary dystonia. Non-covered/Experimental for behavioral health	Submit request to RMHP for Medical DBS.
	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar	62380
	Intracranial angioplasty/stenting (Neurolink System, Wingspan TM Stent System)	61630, 61635

RMHP Prior Authorization List
Effective October 1, 2017 V5 Revised 10/9/2018



PRIOR AUTHORIZATION is required for the following services. Prior authorization is the responsibility of the participating provider ordering or rendering the services. Failure to preauthorize required services will result in denial of claim.

Category	Service	CPT or HCPCS Code(s)
	Laminectomy, lumbar and cervical	63001, 63005, 63011, 63012, 63015, 63017, 63045, 63047, 63180 to 63200, 63250, 63252, 63265, 63267, 63268, 63270, 63271, 63272, 63273, 63275, 63277, 63278, 63280, 63282, 63283, 63285
	Percutaneous lumbar discectomy	62287, 63020, 63030, 63035
	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used	0200T, 0201T
	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s)	0221T, 0222T
	Total disc arthroplasty (artificial disc) including revision, removal	22856, 22857, 22858, 22861, 22862, 22864, 22865, 0095T, 0098T, 0375T, 0163T, 0164T, 0165T
	Spinal cord stimulation	63650, 63655, 63663, 63664, 63685, 63688 L8680-L8689
	Vagus nerve stimulation	61885, 61886, 64553, 64568-64570
Nutritional Products/Services	Medical Foods/ Enteral Nutrition	B4149-B4162, S9340-S9343, S9433-S9435
	Home Total Parenteral Nutrition; Lipids	B4164-B4216, B5000-B5200, S9364-S9368
	Inpatient Pediatric Feeding Program	No specific code
Ophthalmology	Corneal hysteresis determination, by air impulse stimulation, bilateral, with interpretation and report	92145
	Implantation of intrastromal corneal ring segments Collagen cross-linking of cornea	65785; 0402T
	Insertion of anterior segment aqueous drainage device	0191T, 0253T, 0376T, 0474T
	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space	0449T, 0450T
	Insertion of ocular telescope prosthesis including removal of crystalline lens	0308T
	Keratoprosthesis	65770
	Oculoplastic Surgery: Blepharoplasty, Eyebrow Ptosis Repair	15820-15823, 67900-67911
	Measurement of intraocular blood flow by repetitive intraocular pressure sampling, with interpretation and report	0198T
	Placement of intraocular radiation source applicator	0190T
	Probing Nasolacrimal Duct with transluminal balloon catheter dilatation. Applies only when Member is 10 years of age or older	68816
	Subconjunctival retinal prosthesis (only covered for Medicare as part of a clinical trial)	0100T
	Assessment of field of vision with concurrent data analysis and data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days (limited Medicare coverage only)	0378T
	Transpupillary thermoplasty	67299

RMHP Prior Authorization List
Effective October 1, 2017 V5 Revised 10/9/2018



PRIOR AUTHORIZATION is required for the following services. Prior authorization is the responsibility of the participating provider ordering or rendering the services. Failure to preauthorize required services will result in denial of claim.

Category	Service	CPT or HCPCS Code(s)
Orthopedics	Arthroplasty, ankle; with implant (total ankle)	27702
	Arthroplasty, hip or hip resurfacing	27130, 27132, 27134, 27137, 27138 27299, S2118
	Arthroplasty, knee	27445, 27446, 27447, 27486, 27487
	Arthroplasty, shoulder	23472, 23473, 23474
	Arthrodesis, pre-sacral interbody technique, disc space preparation, discectomy, without instrumentation, with image guidance, includes bone graft when performed	0195T, 0196T
	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive	27279
	Arthrodesis, lumbar and cervical spine, excludes codes 22800 - 22819 and related instrumentation for those codes	22533-22554, 22558-22585, 22590- 22600, 22612-22634
	Arthroscopy, knee, surgical; meniscal transplantation, medial or lateral	29868
	Autologous Chondrocyte Implant, including harvesting of chondrocytes	27412, J7330, S2112
	Bone or Soft Tissue Healing and Fusion Enhancement Products, including but not limited to: <ul style="list-style-type: none"> • Bone Morphogenic Protein (e.g. BMP, rhBMP-2, BMP-7) • Bone Void Filler; Ceramic-Based products (e.g. b-TCP, Vitoss) • Cell-Based Products (e.g. mesenchymal stem cells, Osteocel, Trinity Evolution) • Demineralized Bone matrix (DBM) • Epifix or Epicord • OptiMesh • Xenografts 	20930, 20931, 22899 C9359, C9362 Q4100, Q4131
	Core hip decompression	27299, S2325
	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar	62380
	Extracorporeal shock wave, high energy	0101T, 0102T
	Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed	0232T
	Intradiscal electrothermal therapy (IDET) Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)	22526 22527
	Insertion of posterior spinous process distraction device	22867, 22868, 22869, 22870

RMHP Prior Authorization List
Effective October 1, 2017 V5 Revised 10/9/2018



PRIOR AUTHORIZATION is required for the following services. Prior authorization is the responsibility of the participating provider ordering or rendering the services. Failure to preauthorize required services will result in denial of claim.		
Category	Service	CPT or HCPCS Code(s)
	Laminectomy, lumbar and cervical	63001, 63005, 63011, 63012, 63015, 63017, 63045, 63047, 63180 to 63200, 63250, 63252, 63265, 63267, 63268, 63270, 63271, 63272, 63273, 63275, 63277, 63278, 63280, 63282, 63283, 63285
	Low-intensity ultrasound stimulation to aid bone healing, non-invasive (nonoperative)	20979
	Open osteochondral autograft, talus	28446
	Percutaneous Lumbar Discectomy	62267, 62287, 63030
	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used	0200T, 0201T
	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s)	0221T, 0222T
	Total disc arthroplasty (artificial disc), cervical or lumbar, including revision/removal	22856, 22857, 22858, 22861, 22862, 22864, 22865, 0095T, 0098T, 0375T, 0163T, 0164T, 0165T
Outpatient Services	Actigraphy testing, recording, analysis and interpretation (minimum of 72 hours to 14 consecutive days of recording)	95803
	Allergy immunotherapy; sublingual, oral	No specific code
	Allergy testing: Conjunctival Challenge Test (ophthalmic mucous membrane test)	95060
	Allergy testing: Direct nasal mucous membrane testing	95065
	Bone Growth Stimulation for bone healing: Electrical or Low intensity US stimulation	20974, 20975, 20979
	Brachytherapy to reduce risk of a de novo restenosis in conjunction with a PTCA, with or without stent placement	No specific code
	Breath condensate test for asthma and other respiratory disorders	95012
	Bronchoscopy, rigid or flexible, with: - balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion - removal of bronchial valve(s) - bronchial thermoplasty	31647, 31651 31648, 31649 31660, 31661
	Chelation Therapy for Non-Overload Conditions; Chemical Endarterectomy, except with diagnoses specific to heavy metal poisoning or toxicity: R78.71-R78.79; T454X1A-T454X4S; T56.xxxA-T57.xxxA	M0300, S9355 J0600, J0470, J0895, J3520
	Cineradiography/videography	76120, 76125
	Hyperbaric Oxygen Therapy	99183, G0277
	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report (Automated point-of-care nerve conduction studies)	95905

RMHP Prior Authorization List
Effective October 1, 2017 V5 Revised 10/9/2018



PRIOR AUTHORIZATION is required for the following services. Prior authorization is the responsibility of the participating provider ordering or rendering the services. Failure to preauthorize required services will result in denial of claim.		
Category	Service	CPT or HCPCS Code(s)
	Ocular photoscreening (e.g., PhotoScreener), except 12 months through 36 months of age	99174, 99177
	Orthoptics (eye exercises) for learning disabilities and traumatic brain injury	92065
	Outpatient Habilitative Therapy: RMHP Prime only Habilitative services will help a person RETAIN, LEARN, OR IMPROVE SKILLS AND FUNCTIONS FOR DAILY LIVING. Rehabilitative services will help RESTORE FUNCTIONAL ABILITY THAT HAS BEEN LOST due to injury or illness.	
	Habilitative Speech Therapy – Prior authorization needed for adults age 21 or older	92507, 92508, 92520-92526, 92597, 92605-92614, 92626, 92627, 96105, 96111,
	Habilitative Physical and Occupational Therapy – ALL habilitative PT/OT services require prior authorization	97010-97039, 97110-97124, 97127, 97140-97546, 97161-97168, 97750, 97799
	Outpatient Rehabilitative Therapy: RMHP Prime only Prior authorization needed when exceeding 48 units of any combination of rehabilitative PT/OT per 12 month period.	97161-97168, 97010-97039, 97110-97124, 97140-97546, 97750, 97799, G0515
	Sensory Integration Therapy - CHP+, Commercial, Medicare	97533
	Vision therapy for the treatment of learning disabilities and mild traumatic brain injury	92065
Pain Management – Spinal Pain	Destruction by neurolytic agent, paravertebral facet joint nerve(s)	64633 – 64636, 64999
	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance	0228T, 0229T, 0230T, 0231T
	Injection(s), paravertebral facet joint or nerves innervating joint	0213T – 0218T; 64461-64463; 64490 - 64495
	Percutaneous lysis of epidural adhesions using solution injection or mechanical means (eg, catheter) including radiologic localization, multiple adhesiolysis sessions	62263, 62264
	Spinal manipulation under anesthesia	22505
Photopheresis	Covered without prior authorization for a diagnosis D89.813 (Graft versus host disease)	36522
Plastic, Reconstructive, and/or Cosmetic Procedures Refer to page 28 for examples of potentially cosmetic procedures.	Abdominoplasty, Lipectomy, Panniculectomy	15830-15839, 15847, 15876-15879
	Breast related procedures: Reconstruction, Reduction, Augmentation, Breast Implant or Removal, Removal or Replacement of tissue expander (No prior authorization required if Member has had a medically necessary mastectomy).	11970, 11971, 19300, 19316-19499
	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement . . .	0479T, 0480T
	Laser treatment for inflammatory skin disease, except for diagnosis of psoriasis (L40.0-L40.9)	96920, 96921, 96922
	Oculoplastic Surgery: Blepharoplasty/Eyebrow Ptosis Repair	15820-15823, 67900-67911
	Rhinoplasty with/without septal repair - except for nasal deformity secondary to congenital cleft lip and/or palate	30400-30450; 30465

RMHP Prior Authorization List
Effective October 1, 2017 V5 Revised 10/9/2018



PRIOR AUTHORIZATION is required for the following services. Prior authorization is the responsibility of the participating provider ordering or rendering the services. Failure to preauthorize required services will result in denial of claim.		
Category	Service	CPT or HCPCS Code(s)
	Treatment of varicose veins, including but not limited to, radiofrequency ablation, sclerotherapy, stripping and ligation, endolaser therapy	36465, 36466, 36468-36479, 36482, 36483, 37700-37785
Transplant related services, including initial consult and evaluations	All transplant services, including artificial heart (33927, 33928, 33929), beginning with initial physician consultation, transplant evaluation, including testing, and transplant procedures (except corneal transplants). This is for all Members, including PPO, and includes cat III codes 0494T, 0495T, 0496T.	
Urology	Cystourethroscopy, with mechanical dilation and urethral therapeutic drug delivery for urethral stricture or stenosis . . .	0499T
Wound Care Clinic	Services provided in a Wound Care Clinic, including but not limited to: Debridement Electrical Stimulation or Electromagnetic therapy Negative Pressure Wound Therapy Low frequency, non-contact, non-thermal ultrasound Ablative laser treatment, non-contact, full field and fractional ablation, open wound, per day . . .	97597-97610 G0281 G0329 0491T, 0492T

RMHP Prior Authorization List
Effective October 1, 2017 V5 Revised 10/9/2018



PRIOR AUTHORIZATION is required for the following services. Prior authorization is the responsibility of the participating provider ordering or rendering the services. Failure to preauthorize required services will result in denial of claim.

Category	Service	CPT or HCPCS Code(s)
Wound Care Products; Bioengineered Skin Substitute and Wound Care Products Bioengineered skin substitutes not listed in Novitas Solutions, Inc. LCD 35041 in tandem with Article A54117 are non-payable for Medicare Codes followed by asterisk * are new for 2018 with Medicare and Medicaid coverage determinations PENDING as of publication date		
Affinity, per square centimeter – Q4159 Alloderm – Q4116 (Medicare only: Not separately payable L35041) Allopatch HD; Flex HD – Q4128 Alloskin – Q4115 Alloskin AC, per sq cm – Q4141 Alloskin RT, per sq cm – Q4123 Amnioband or guardian, per square centimeter – Q4151 Amnioexcel or Biodexcel, per sq cm – Q4137 Amniowound, per square centimeter – Q4181 * Amniopro, bioskin, biorenew, woundex, amniogen-45, amniogen-200, per square centimeter – Q4163 Apligraf – Q4101 Architect extracellular matrix, per sq cm – Q4147 Artiss BioBrane Biosynthetic Dressing Bio-ConneKt wound matrix, per square centimeter – Q4161 BioDfence, per sq cm – Q4140 Biovance, per square centimeter – Q4154 Cytal, per square centimeter - Q4166 DermACELL, per sq cm – Q4122 Dermagraft – Q4106 Dermapure, per square centimeter – Q4152 DermaSpan – Q4126 Dermavest, per square centimeter – Q4153 Epicel EZderm, per sq cm – Q4136 Floweramnioflo, 0.1cc – Q4177 * Floweramniopatch, per square centimeter – Q4178 * Flowerderm, per square centimeter – Q4179 * GammaGraft, per sq cm – Q4111 Grafix core and Grafixpl core, per sq cm – Q4132 Grafix prime and Grafixpl prime, per sq cm – Q4133 GRAFTJACKET; GRAFTJACKET Regenerative Tissue Matrix – Q4107 Helicoll, per square centimeter – Q4164 HMatrix, per sq cm – Q4134 Hyalomatrix – Q4117	Integra Bilayer Matrix Wound Dressing – Q4104 Integra Dermal Regeneration Template (drt) or integra omnigraft dermal Regeneration Matrix, per sq cm – Q4105 Integra Matrix, per sq cm – Q4108 Integra Meshed Bilayer Wound Matrix Keramatrix, per square centimeter – Q4165 Kerecis Omega3, per square centimeter – Q4158 Matristem micromatrix – Q4118 Mediskin, per sq cm – Q4135 Memoderm/derma/tranz/integup – Q4126 Neopatch, per square centimeter – Q4176 * Neox 100 or Clarix 100, per square centimeter – Q4156 Neox 1k, Neox cord RT or Clarix cord 1K per sq cm – Q4148 Nushield, per square centimeter – Q4160 Oasis burn matrix, per sq cm – Q4103 Oasis tri-layer wound matrix – Q4124 Oasis Wound Matrix – Q4102 Orcel (bilayered cellular matrix) Primatrix – Q4110 PuraPly or PuraPly AM, per square centimeter - Q4172 Regranex – S0157 Revita, per square centimeter – Q4180 * Revitalon, per square centimeter – Q4157 Skin substitute, NOS – Q4100 Talymed – Q4127 Tensix, per sq cm – Q4146 Theraskin, per square centimeter – Q4121 TissueMend, per sq cm TransCyte, per square centimeter – Q4182 * (allogeneic human dermal fibroblasts)	

RMHP Prior Authorization List
Genetic Testing
Effective October 1, 2017 V5 Revised 10/9/2018

Certain services or items may be specific exclusions of the Member's EOC.

	Prior Authorization is required through eviCore healthcare for the genetic testing procedures marked "Yes". Web www.evicore.com Note: RMHP Prime: NAB= Not a Benefit NIC= Not in Contract (codes not listed on RMHP Prime Fee Schedule – Not payable)			
CPT/HCPCS Codes	Description	CHP+ Commercial	RMHP Prime	Medicare
0004M	Scoliosis, DNA analysis of 53 single nucleotide polymorphisms (SNPs), using saliva, prognostic algorithm reported as a risk score	YES	NIC	YES
0006M	Oncology (hepatic), mRNA expression levels of 161 genes, utilizing fresh hepatocellular carcinoma tumor tissue, with alpha-fetoprotein level, algorithm reported as a risk classifier	YES	NIC	YES
0007M	Oncology (gastrointestinal neuroendocrine tumors), real-time PCR expression analysis of 51 genes, utilizing whole peripheral blood, algorithm reported as a nomogram of tumor disease index	YES	NIC	YES
0009M	Fetal aneuploidy (trisomy 21, and 18) DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy	YES	NAB	YES
0011M	Oncology, prostate cancer, mRNA expression assay of 12 genes (10 content and 2 housekeeping), RT-PCR test utilizing blood plasma and/or urine, algorithms to predict high-grade prostate cancer risk	YES	NIC	NAB
0012M	Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and XCR2), utilizing urine, algorithm reported as a risk score for having urothelial carcinoma	YES	NIC	NAB
0013M	Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma	YES	NIC	NAB
0001U	Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis	YES	NIC	YES
0012U	Germline disorders, gene rearrangement detection by whole genome next generation sequencing, DNA, whole blood, report of specific gene rearrangement(s)	YES	NIC	YES
0013U	Oncology (solid organ neoplasia) gene rearrangement detection by whole genome next generation sequencing, DNA, fresh or frozen tissue or cells, report of specific gene rearrangement(s)	YES	NIC	YES
0014U	Hematology (hematolymphoid neoplasia), gene rearrangement detection by whole genome next generation sequencing, DNA, report of specific gene rearrangement(s)	YES	NIC	YES
0018U	ThyraMIR Interpace Diagnostics ONC THYR 10 MICRORNA SEQ +/- RSLT MOD HI RSK MAL	YES	NIC	NAB
0019U	OncoTarget/OncoTreat Columbia University Department of Pathology and Cell Biology Darwin Health ONC RNA WHL TRANSCRIPTOME SEQ TISS PREDCT ALG	YES	NIC	NAB
0022U	Oncomine™ Dx Target Test Thermo Fisher Scientific TRGT GEN SEQ ALYS NONSM LNG NEO DNA&RNA 23 GENES	YES	NIC	NAB
0024U	Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative	YES	NIC	NAB
0025U	Tenofovir, by liquid chromatography with tandem mass spectrometry (LC-MS/MS), urine, quantitative	YES	NIC	NAB
0026U	Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy")	YES	NIC	NAB
0027U	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15	YES	NIC	NAB
0028U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, copy number variants, common variants with reflex to targeted sequence analysis	YES	NIC	NAB
0029U	Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, SLCO1B1, VKORC1 and rs12777823)	YES	NIC	NAB
0030U	Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823)	YES	NIC	NAB

Effective October 1, 2017 V5 Revised 10/9/2018

Certain services or items may be specific exclusions of the Member's EOC.

	Prior Authorization is required through eviCore healthcare for the genetic testing procedures marked "Yes". Web www.evicore.com Note: RMHP Prime: NAB= Not a Benefit NIC= Not in Contract (codes not listed on RMHP Prime Fee Schedule – Not payable)			
CPT/HCPCS Codes	Description	CHP+ Commercial	RMHP Prime	Medicare
0031U	CYP1A2 (cytochrome P450 family 1, subfamily A, member 2)(eg, drug metabolism) gene analysis, common variants (ie, *1F, *1K, *6, *7)	YES	NIC	NAB
0032U	COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G>A (rs4680) variant	YES	NIC	NAB
0033U	HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5-hydroxytryptamine receptor 2C) (eg, citalopram metabolism) gene analysis, common variants (ie, HTR2A rs7997012 [c.614-2211T>C], HTR2C rs3813929 [c.-759C>T] and rs1414334 [c.551-3008C>G])	YES	NIC	NAB
0034U	TPMT (thiopurine S-methyltransferase), NUDT15 (nudix hydroxylase 15)(eg, thiopurine metabolism), gene analysis, common variants (ie, TPMT *2, *3A, *3B, *3C, *4, *5, *6, *8, *12; NUDT15 *3, *4, *5)	YES	NIC	NAB
0036U	Exome (ie, somatic mutations), paired formalin-fixed paraffin-embedded tumor tissue and normal specimen, sequence analyses (EXACT-1 Whole Exome Testing, Lab of Oncology-Molecular Detection Weill Cornell Medicine- Clinical Genomics Laboratory)	YES	NIC	NAB
0037U	Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden (FoundationOne CDxTM (F1CDx) Foundation Medicine, Inc.)	YES	NIC	NAB
0045U	Oncology (breast ductal carcinoma in situ), mRNA, gene expression profiling by realtime RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence score	YES	NIC	NAB
0047U	Oncology (prostate), mRNA, gene expression profiling by real-time RT-PCR of 17 genes (12 content and 5 housekeeping), utilizing formalin-fixed paraffin- embedded tissue, algorithm reported as a risk score	YES	NIC	NAB
0048U	Oncology (solid organ neoplasia), DNA, targeted sequencing of protein-coding exons of 468 cancer-associated genes, including interrogation for somatic mutations and microsatellite instability, matched with normal specimens, utilizing formalin-fixed paraffin-embedded tumor tissue, report of clinically significant mutation(s)	YES	NIC	NAB
0050U	Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants, copy number variants or rearrangements	YES	NIC	NAB
0053U	Oncology (prostate cancer), FISH analysis of 4 genes (ASAP1, HDAC9, CHD1 and PTEN), needle biopsy specimen, algorithm reported as probability of higher tumor grade	YES	NIC	NAB
0055U	Cardiology (heart transplant), cell-free DNA, PCR assay of 96 DNA target sequences (94 single nucleotide polymorphism targets and two control targets), plasma	YES	NIC	NAB
0056U	Hematology (acute myelogenous leukemia), DNA, whole genome nextgeneration sequencing to detect gene rearrangement(s), blood or bone marrow, report of specific gene rearrangement(s)	YES	NIC	NAB
0057U	Oncology (solid organ neoplasia), mRNA, gene expression profiling by massively parallel sequencing for analysis of 51 genes, utilizing formalin-fixed paraffinembedded tissue, algorithm reported as a normalized percentile rank	YES	NIC	NAB
0060U	Twin zygosity, genomic targeted sequence analysis of chromosome 2, using circulating cell-free fetal DNA in maternal blood	YES	NIC	NAB
0500T	Infectious agent detection by nucleic acid (DNA or RNA), human papillomavirus (HPV) for five or more separately reported high-risk HPV types . . . (ie, genotyping)	Not a Benefit Experimental	NIC	YES (status C)
81105	Human Platelet Antigen 1 genotyping (HPA-1), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-1a/b (L33P)	YES	YES	YES
81106	Human Platelet Antigen 2 genotyping (HPA-2), GP1BA (glycoprotein Ib [platelet], alpha polypeptide [GPIba]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-2a/b (T145M)	YES	YES	YES

RMHP Prior Authorization List
Genetic Testing
Effective October 1, 2017 V5 Revised 10/9/2018
Certain services or items may be specific exclusions of the Member's EOC.

	Prior Authorization is required through eviCore healthcare for the genetic testing procedures marked "Yes". Web www.evicore.com Note: RMHP Prime: NAB= Not a Benefit NIC= Not in Contract (codes not listed on RMHP Prime Fee Schedule – Not payable)			
CPT/HCPCS Codes	Description	CHP+ Commercial	RMHP Prime	Medicare
81107	Human Platelet Antigen 3 genotyping (HPA-3), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex], antigen CD41 [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-3a/b (I843S)	YES	YES	YES
81108	Human Platelet Antigen 4 genotyping (HPA-4), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-4a/b (R143Q)	YES	YES	YES
81109	Human Platelet Antigen 5 genotyping (HPA-5), ITGA2 (integrin, alpha 2 [CD49B, alpha 2 subunit of VLA-2 receptor] [GPIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant (eg, HPA-5a/b (K505E))	YES	YES	YES
81110	Human Platelet Antigen 6 genotyping (HPA-6w), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa, antigen CD61] [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-6a/b (R489Q)	YES	YES	YES
81111	Human Platelet Antigen 9 genotyping (HPA-9w), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex, antigen CD41] [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-9a/b (V837M)	YES	YES	YES
81112	Human Platelet Antigen 15 genotyping (HPA-15), CD109 (CD109 molecule) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-15a/b (S682Y)	YES	YES	YES
81120	IDH1 (isocitrate dehydrogenase 1 [NADP+], soluble) (eg, glioma), common variants (eg, R132H, R132C)	YES	YES	YES
81121	IDH2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial) (eg, glioma), common variants (eg, R140W, R172M)	YES	YES	YES
81161	DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	NO	NIC	YES
81162	BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis	YES	YES	YES
81170	ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (eg, acquired imatinib tyrosine kinase inhibitor resistance), gene analysis, variants in the kinase domain	YES	YES	YES
81175	ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; full gene sequence	YES	YES	YES
81176	ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; targeted sequence analysis (eg, exon 12)	YES	YES	YES
81200	ASPA (aspartoacylase) (eg, Canavan disease) gene analysis, common variants (eg, E285A, Y231X)	NO	YES	YES
81201	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence	YES	YES	YES
81202	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants	YES	YES	NO
81203	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants	YES	YES	YES
81205	BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (eg, Maple syrup urine disease) gene analysis, common variants (eg, R183P, G278S, E422X)	NO	NIC	YES
81209	BLM (Bloom syndrome, RecQ helicase-like) (eg, Bloom syndrome) gene analysis, 2281del6ins7 variant	NO	NO	YES
81210	BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant	NO	NO	YES

Effective October 1, 2017 V5 Revised 10/9/2018

Certain services or items may be specific exclusions of the Member's EOC.

	Prior Authorization is required through eviCore healthcare for the genetic testing procedures marked "Yes". Web www.evicore.com Note: RMHP Prime: NAB= Not a Benefit NIC= Not in Contract (codes not listed on RMHP Prime Fee Schedule – Not payable)			
CPT/HCPCS Codes	Description	CHP+ Commercial	RMHP Prime	Medicare
81211	BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants in BRCA1 (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)	YES	YES	YES
81212	BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC, 6174delT variants	YES	YES	YES
81213	BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; uncommon duplication/deletion variants	YES	YES	YES
81214	BRCA1 (breast cancer 1) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)	YES	YES	YES
81215	BRCA1 (breast cancer 1) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	YES	YES	YES
81216	BRCA2 (breast cancer 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	YES	YES	YES
81217	BRCA2 (breast cancer 2) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	YES	YES	YES
81218	CEBPA (CCAAT/enhancer binding protein [C/EBP], alpha) (eg, acute myeloid leukemia), gene analysis, full gene sequence	YES	YES	YES
81219	CALR (calreticulin) (eg, myeloproliferative disorders), gene analysis, common variants in exon 9	YES	YES	YES
81220	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)	NO	NO	YES
81221	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants	NO	NO	YES
81222	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants	YES	YES	YES
81223	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence	YES	YES	YES
81224	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)	NO	NO	YES
81225	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	YES	NAB	YES
81226	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)	YES	NAB	YES
81227	CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)	YES	NAB	YES
81228	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants (eg, Bacterial Artificial Chromosome [BAC] or oligo-based comparative genomic hybridization [CGH] microarray analysis)	YES	YES	YES
81229	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities	YES	YES	YES
81230	CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (eg, drug metabolism), gene analysis, common variant(s) (eg, *2, *22)	YES	NIC	YES
81231	CYP3A5 (cytochrome P450 family 3 subfamily A member 5) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *7)	YES	NIC	YES

RMHP Prior Authorization List**Genetic Testing****Effective October 1, 2017 V5 Revised 10/9/2018****Certain services or items may be specific exclusions of the Member's EOC.**

	Prior Authorization is required through eviCore healthcare for the genetic testing procedures marked "Yes". Web www.evicore.com Note: RMHP Prime: NAB= Not a Benefit NIC= Not in Contract (codes not listed on RMHP Prime Fee Schedule – Not payable)			
CPT/HCPCS Codes	Description	CHP+ Commercial	RMHP Prime	Medicare
81232	DPYD (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis, common variant(s) (eg, *2A, *4, *5, *6)	YES	NIC	YES
81235	EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)	NO	NO	YES
81238	F9 (coagulation factor IX) (eg, hemophilia B), full gene sequence	YES	YES	YES
81240	F2 (prothrombin, coagulation factor II)(e.g. hereditary hypercoagulability) gene analysis, 20210G>A variant	YES	YES	YES
81242	FANCC (Fanconi anemia, complementation group C) (eg, Fanconi anemia, type C) gene analysis, common variant (eg, IVS4+4A>T)	NO	NO	YES
81243	FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	NO	NO	YES
81244	FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and methylation status)	NO	NO	YES
81245	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; internal tandem duplication (ITD) variants (ie, exons 14,15)	NO	NO	YES
81246	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; tyrosine kinase domain (TKD) variants (eg, D835, I836)	NO	NAB	YES
81247	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; common variant(s) (eg, A, A-)	YES	NIC	YES
81248	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; known familial variant(s)	YES	YES	YES
81249	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; full gene sequence	YES	YES	YES
81250	G6PC (glucose-6-phosphatase, catalytic subunit) (eg, Glycogen storage disease, Type 1a, von Gierke disease) gene analysis, common variants (eg, R83C, Q347X)	NO	NO	YES
81251	GBA (glucosidase, beta, acid) (eg, Gaucher disease) gene analysis, common variants (eg, N370S, 84GG, L444P, IVS2+1G>A)	NO	NO	YES
81252	GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence	NO	NO	YES
81253	GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants	NO	NO	YES
81254	GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis, common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])	NO	NO	YES
81255	HEXA (hexosaminidase A [alpha polypeptide]) (eg, Tay-Sachs disease) gene analysis, common variants (eg, 1278insTATC, 1421+1G>C, G269S)	NO	NO	YES
81256	HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis, common variants (eg, C282Y, H63D)	NO	NO	YES
81257	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, and Constant Spring)	NO	NO	YES
81258	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; known familial variant	YES	YES	YES
81259	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; full gene sequence	YES	YES	YES

	Prior Authorization is required through eviCore healthcare for the genetic testing procedures marked "Yes". Web www.evicore.com Note: RMHP Prime: NAB= Not a Benefit NIC= Not in Contract (codes not listed on RMHP Prime Fee Schedule – Not payable)			
CPT/HCPCS Codes	Description	CHP+ Commercial	RMHP Prime	Medicare
81260	IKBKAP (inhibitor of kappa light polypeptide gene enhancer in B-cells, kinase complex-associated protein) (eg, familial dysautonomia) gene analysis, common variants (eg, 2507+6T>C, R696P)	NO	NO	YES
81263	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis	NO	NAB	YES
81265	Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)	NO	NO	YES
81266	Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure)	NO	NO	YES
81269	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; duplication/deletion variants	YES	YES	YES
81272	KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, gastrointestinal stromal tumor [GIST], acute myeloid leukemia, melanoma), gene analysis, targeted sequence analysis (eg, exons 8, 11, 13, 17, 18)	NO	NO	YES
81273	KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, mastocytosis), gene analysis, D816 variant(s)	NO	NO	YES
81275	KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene) (eg, carcinoma) gene analysis, variants in codons 12 and 13	NO	NO	YES
81276	KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; additional variant(s) (eg, codon 61, codon 146)	NO	NO	YES
81283	IFNL3 (interferon, lambda 3) (eg, drug response), gene analysis, rs12979860 variant	YES	YES	YES
81287	MGMT (O-6-methylguanine-DNA methyltransferase) (eg, glioblastoma multiforme), methylation analysis	YES	NIC	YES
81288	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; promoter methylation analysis	NO	NAB	YES
81290	MCOLN1 (mucolipin 1) (eg, Mucopolidosis, type IV) gene analysis, common variants (eg, IVS3-2A>G, del6.4kb)	NO	NO	YES
81291	MTHFR (5-10-methylenetetrahydrofolate reductase) eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)	YES	NAB	YES
81292	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	YES	YES	YES
81293	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	YES	YES	YES
81294	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	YES	YES	YES
81295	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	YES	YES	YES

Effective October 1, 2017 V5 Revised 10/9/2018

Certain services or items may be specific exclusions of the Member's EOC.

	Prior Authorization is required through eviCore healthcare for the genetic testing procedures marked "Yes". Web www.evicore.com Note: RMHP Prime: NAB= Not a Benefit NIC= Not in Contract (codes not listed on RMHP Prime Fee Schedule – Not payable)			
CPT/HCPCS Codes	Description	CHP+ Commercial	RMHP Prime	Medicare
81296	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis, known familial variance	NO	YES	YES
81297	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	YES	YES	YES
81298	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	YES	YES	YES
81299	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis; known familial variants	YES	YES	YES
81300	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	YES	YES	YES
81302	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis	NO	NO	YES
81303	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variant	NO	NO	YES
81304	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants	NO	NO	YES
81311	NRAS (neuroblastoma RAS viral [v-ras] oncogene homolog) (eg, colorectal carcinoma), gene analysis, variants in exon 2 (eg, codons 12 and 13) and exon 3 (eg, codon 61)	NO	NO	YES
81313	PCA3/KLK3 (prostate cancer antigen 3 [non-protein coding]/kallikrein-related peptidase 3 [prostate specific antigen]) ratio (eg, prostate cancer)	YES	NAB	YES
81317	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	YES	YES	YES
81319	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	YES	YES	YES
81321	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis	YES	YES	YES
81323	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant	YES	YES	YES
81324	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; duplication/deletion analysis	NO	YES	YES
81325	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; full sequence analysis	YES	YES	YES
81326	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; known familial variant	NO	NO	YES
81327	SEPT9 (Septin9) (eg, colorectal cancer) methylation analysis	YES	YES	YES
81328	SLCO1B1 (solute carrier organic anion transporter family, member 1B1) (eg, adverse drug reaction), gene analysis, common variant(s) (eg, *5)	YES	NIC	YES
81330	SMPD1(sphingomyelin phosphodiesterase 1, acid lysosomal) (eg, Niemann-Pick disease, Type A) gene analysis, common variants (eg, R496L, L302P, fsP330)	NO	NO	YES
81331	SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis	NO	NO	YES
81332	SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)	NO	NO	YES

Effective October 1, 2017 V5 Revised 10/9/2018

Certain services or items may be specific exclusions of the Member's EOC.

	Prior Authorization is required through eviCore healthcare for the genetic testing procedures marked "Yes". Web www.evicore.com Note: RMHP Prime: NAB= Not a Benefit NIC= Not in Contract (codes not listed on RMHP Prime Fee Schedule – Not payable)			
CPT/HCPCS Codes	Description	CHP+ Commercial	RMHP Prime	Medicare
81334	RUNX1 (runt related transcription factor 1) (eg, acute myeloid leukemia, familial platelet disorder with associated myeloid malignancy), gene analysis, targeted sequence analysis (eg, exons 3-8)	YES	YES	YES
81335	TPMT (thiopurine S-methyltransferase) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3)	YES	NIC	YES
81346	TYMS (thymidylate synthetase) (eg, 5-fluorouracil/5-FU drug metabolism), gene analysis, common variant(s) (eg, tandem repeat variant)	YES	NIC	YES
81350	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)	NO	NAB	YES
81355	VKORC1 (vitamin K epoxide reductase complex, subunit 1)(e.g., warfarin metabolism), gene analysis, common variant(s) (e.g., 1639G>A, c.173+1000C>T)	YES	NIC	YES
81361	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); common variant(s) (eg, HbS, HbC, HbE)	YES	NIC	YES
81362	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); known familial variant(s)	YES	NIC	YES
81363	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); duplication/deletion variant(s)	YES	NIC	YES
81364	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence	YES	NIC	YES
81400	Molecular pathology procedure, Level 1 (eg, identification of single germline variant[eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)	YES	YES	YES
81401	Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)	YES	YES	YES
81402	Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants of 1 exon, loss of heterozygosity [LOH], uniparental disomy [UPD])	YES	YES	YES
81403	Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)	YES	YES	YES
81404	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)	YES	YES	YES
81405	Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons, regionally targeted cytogenomic array analysis)	YES	YES	YES
81406	Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)	YES	YES	YES
81407	Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of > 50 exons, sequence analysis of multiple genes on 1 platform)	YES	YES	YES
81408	Molecular pathology procedure, Level 9 (eg, analysis of > 50 exons in a single gene by DNA sequence analysis)	YES	YES	YES
81410	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); genomic sequence analysis panel, must include sequencing of at least 9 genes, including FBN1, TGFBR1, TGFBR2, COL3A1, MYH11, ACTA2, SLC2A10, SMAD3, and MYLK	YES	NIC	YES

Effective October 1, 2017 V5 Revised 10/9/2018

Certain services or items may be specific exclusions of the Member's EOC.

	Prior Authorization is required through eviCore healthcare for the genetic testing procedures marked "Yes". Web www.evicore.com Note: RMHP Prime: NAB= Not a Benefit NIC= Not in Contract (codes not listed on RMHP Prime Fee Schedule – Not payable)			
CPT/HCPCS Codes	Description	CHP+ Commercial	RMHP Prime	Medicare
81411	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); duplication/deletion analysis panel, must include analyses for TGFB1, TGFB2, MYH11, and COL3A1	YES	NAB	YES
81412	Ashkenazi Jewish associated disorders (eg, Bloom syndrome, Canavan disease, cystic fibrosis, familial dysautonomia, Fanconi anemia group C, Gaucher disease, Tay-Sachs disease), genomic sequence analysis panel, must include sequencing of at least 9 genes, including ASPA, BLM, CFTR, FANCC, GBA, HEXA, IKBKAP, MCOLN1, and SMPD1	YES	YES	YES
81413	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); genomic sequence analysis panel, must include sequencing of at least 10 genes, including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A	YES	YES	YES
81414	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); duplication/deletion gene analysis panel, must include analysis of at least 2 genes, including KCNH2 and KCNQ1	YES	YES	YES
81415	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis	YES	NAB	YES
81416	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (eg, parents, siblings) (List separately in addition to code for primary procedure)	YES	NAB	YES
81417	Exome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained exome sequence (eg, updated knowledge or unrelated condition/syndrome)	YES	NAB	YES
81420	Fetal chromosomal aneuploidy (eg, trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18, and 21	YES	YES	YES
81422	Fetal chromosomal microdeletion(s) genomic sequence analysis (eg, DiGeorge syndrome, Cri-du-chat syndrome), circulating cell-free fetal DNA in maternal blood	YES	YES	YES
81425	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis	YES	NAB	YES
81426	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator genome (eg, parents, siblings) (List separately in addition to code for primary procedure)	YES	NAB	YES
81427	Genome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained genome sequence (eg, updated knowledge or unrelated condition/syndrome)	YES	NAB	YES
81430	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); genomic sequence analysis panel, must include sequencing of at least 60 genes, including CDH23, CLRN1, GJB2, GPR98, MTRNR1, MYO7A, MYO15A, PCDH15, OTOF, SLC26A4, TMC1, TMPRSS3, USH1C, USH1G, USH2A, and WFS1	YES	NAB	YES
81431	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); duplication/deletion analysis panel, must include copy number analyses for STRC and DFNB1 deletions in GJB2 and GJB6 genes	YES	NAB	YES
81432	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 10 genes, always including BRCA1, BRCA2, CDH1, MLH1, MSH2, MSH6, PALB2, PTEN, STK11, and TP53	YES	YES	YES
81433	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); duplication/deletion analysis panel, must include analyses for BRCA1, BRCA2, MLH1, MSH2, and STK11	YES	YES	YES

Effective October 1, 2017 V5 Revised 10/9/2018

Certain services or items may be specific exclusions of the Member's EOC.

	Prior Authorization is required through eviCore healthcare for the genetic testing procedures marked "Yes". Web www.evicore.com Note: RMHP Prime: NAB= Not a Benefit NIC= Not in Contract (codes not listed on RMHP Prime Fee Schedule – Not payable)			
CPT/HCPCS Codes	Description	CHP+ Commercial	RMHP Prime	Medicare
81434	Hereditary retinal disorders (eg, retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy), genomic sequence analysis panel, must include sequencing of at least 15 genes, including ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31, PRPH2, RDH12, RHO, RP1, RP2, RPE65, RPGR, and USH2A	YES	YES	YES
81435	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis); genomic sequence analysis panel, must include sequencing of at least 10 genes, including APC, BMPR1A, CDH1, MLH1, MSH2, MSH6, MUTYH, PTEN, SMAD4, and STK11	YES	NAB	YES
81436	Hereditary colon cancer syndromes (eg, Lynch syndrome, familial adenomatosis polyposis); duplication/deletion analysis panel, must include analysis of at least 5 genes, including MLH1, MSH2, EPCAM, SMAD4, and STK11	YES	NAB	YES
81437	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); genomic sequence analysis panel, must include sequencing of at least 6 genes, including MAX, SDHB, SDHC, SDHD, TMEM127, and VHL	YES	YES	YES
81438	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); duplication/deletion analysis panel, must include analyses for SDHB, SDHC, SDHD, and VHL	YES	YES	YES
81439	Hereditary cardiomyopathy (eg, hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy) genomic sequence analysis panel, must include sequencing of at least 5 cardiomyopathy-related genes, including (eg, DSG2, MYBPC3, MYH7, PKP2, and TTN	YES	YES	YES
81440	Nuclear encoded mitochondrial genes (eg, neurologic or myopathic phenotypes), genomic sequence panel, must include analysis of at least 100 genes, including BCS1L, C10orf2, COQ2, COX10, DGUOK, MPV17, OPA1, PDSS2, POLG, POLG2, RRM2B, SCO1, SCO2, SLC25A4, SUCLA2, SUCLG1, TAZ, TK2, and TYMP	YES	NAB	YES
81442	Noonan spectrum disorders (eg, Noonan syndrome, cardio-facio-cutaneous syndrome, Costello syndrome, LEOPARD syndrome, Noonan-like syndrome), genomic sequence analysis panel, must include sequencing of at least 12 genes, including BRAF, CBL, HRAS, KRAS, MAP2K1, MAP2K2, NRAS, PTPN11, RAF1, RIT1, SHOC2, and SOS1	YES	YES	YES
81445	Targeted genomic sequence analysis panel, solid organ neoplasm, DNA analysis, and RNA analysis when performed, 5-50 genes (eg, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, NRAS, MET, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, if performed	YES	NAB	YES
81448	Hereditary peripheral neuropathies (eg, Charcot-Marie-Tooth, spastic paraplegia), genomic sequence analysis panel, must include sequencing of at least 5 peripheral neuropathy-related genes (eg, BSCL2, GJB1, MFN2, MPZ, REEP1, SPAST, SPG11, SPTLC1)	YES	NIC	YES
81450	Targeted genomic sequence analysis panel, hematolymphoid neoplasm or disorder, DNA analysis and RNA analysis when performed, 5-50 genes (eg, BRAF, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KRAS, KIT, MLL, NRAS, NPM1, NOTCH1), interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed	YES	NAB	YES
81455	Targeted genomic sequence analysis panel, solid organ or hematolymphoid neoplasm, DNA analysis and RNA analysis when performed, 51 or greater genes (eg, ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MLL, NPM1, NRAS, MET, NOTCH1, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, if performed	YES	NAB	YES

Effective October 1, 2017 V5 Revised 10/9/2018

Certain services or items may be specific exclusions of the Member's EOC.

	Prior Authorization is required through eviCore healthcare for the genetic testing procedures marked "Yes". Web www.evicore.com Note: RMHP Prime: NAB= Not a Benefit NIC= Not in Contract (codes not listed on RMHP Prime Fee Schedule – Not payable)			
CPT/HCPCS Codes	Description	CHP+ Commercial	RMHP Prime	Medicare
81460	Whole mitochondrial genome (eg, Leigh syndrome, mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes [MELAS], myoclonic epilepsy with ragged-red fibers [MERFF], neuropathy, ataxia, and retinitis pigmentosa [NARP], Leber hereditary optic neuropathy [LHON]), genomic sequence, must include sequence analysis of entire mitochondrial genome with heteroplasmy detection	YES	NAB	YES
81465	Whole mitochondrial genome large deletion analysis panel (eg, Kearns-Sayre syndrome, chronic progressive external ophthalmoplegia), including heteroplasmy detection, if performed	YES	NAB	YES
81470	X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); genomic sequence analysis panel, must include sequencing of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, RPS6KA3, and SLC16A2	YES	NAB	YES
81471	X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); duplication/deletion gene analysis, must include analysis of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, RPS6KA3, and SLC16A2	YES	NAB	YES
81479	Unlisted molecular pathology procedure	YES	NIC	YES
81490	Autoimmune (rheumatoid arthritis), analysis of 12 biomarkers using immunoassays, utilizing serum, prognostic algorithm reported as a disease activity score	YES	YES	YES
81493	Coronary artery disease, mRNA, gene expression profiling by real-time RT-PCR of 23 genes, utilizing whole peripheral blood, algorithm reported as a risk score	YES	YES	YES
81500	Oncology (ovarian), biochemical assays of two proteins (CA-125 and HE4), utilizing serum, with menopausal status, algorithm reported as a risk score	YES	NIC	YES
81503	Oncology (ovarian), biochemical assays of five proteins (CA-125, apolipoprotein A1, beta-2 microglobulin, transferrin, and pre-albumin), utilizing serum, algorithm reported as a risk score	YES	NIC	YES
81504	Oncology (tissue of origin), microarray gene expression profiling of > 2000 genes, utilizing formalin-fixed paraffin embedded tissue, algorithm reported as tissue similarity scores	YES	NIC	YES
81507	Fetal aneuploidy (trisomy 21, 18, and 13) DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy	YES	YES	YES
81519	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 21 genes, utilizing formalin-fixed paraffin embedded tissue, algorithm reported as recurrence score	YES	YES	YES
81520	Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence risk score [Prosigna Breast Cancer Assay, NanoString Technologies]	YES	YES	YES
81521	Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and 465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis [MammaPrint, Agendia, Inc.]	YES	YES	YES
81525	Oncology (colon), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence score	YES	YES	YES
81528	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result	YES	YES	YES
81535	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; first single drug or drug combination	YES	YES	YES

RMHP Prior Authorization List
Genetic Testing
Effective October 1, 2017 V5 Revised 10/9/2018
Certain services or items may be specific exclusions of the Member's EOC.

	Prior Authorization is required through eviCore healthcare for the genetic testing procedures marked "Yes". Web www.evicore.com Note: RMHP Prime: NAB= Not a Benefit NIC= Not in Contract (codes not listed on RMHP Prime Fee Schedule – Not payable)			
CPT/HCPCS Codes	Description	CHP+ Commercial	RMHP Prime	Medicare
81536	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; each additional single drug or drug combination (List separately in addition to code for primary procedure)	YES	YES	YES
81538	Oncology (lung), mass spectrometric 8-protein signature, including amyloid A, utilizing serum, prognostic and predictive algorithm reported as good versus poor overall survival	YES	YES	YES
81539	Oncology (high-grade prostate cancer), biochemical assay of four proteins (Total PSA, Free PSA, Intact PSA, and human kallikrein-2 [hK2]), utilizing plasma or serum, prognostic algorithm reported as a probability score	YES	YES	YES
81540	Oncology (tumor of unknown origin), mRNA, gene expression profiling by real-time RT-PCR of 92 genes (87 content and 5 housekeeping) to classify tumor into main cancer type and subtype, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a probability of a predicted main cancer type and subtype	YES	YES	YES
81541	Oncology (prostate), mRNA gene expression profiling by real-time RT-PCR of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality risk score [Prolaris, Myriad Genetic Laboratories, Inc.]	YES	YES	YES
81545	Oncology (thyroid), gene expression analysis of 142 genes, utilizing fine needle aspirate, algorithm reported as a categorical result (eg, benign or suspicious)	YES	YES	YES
81551	Oncology (prostate), promoter methylation profiling by real-time PCR of 3 genes (GSTP1, APC, RASSF1), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a likelihood of prostate cancer detection on repeat biopsy [ConfirmMDx for Prostate Cancer, MDxHealth, Inc.]	YES	YES	YES
81595	Cardiology (heart transplant), mRNA, gene expression profiling by real-time quantitative PCR of 20 genes (11 content and 9 housekeeping), utilizing subfraction of peripheral blood, algorithm reported as a rejection risk score	YES	YES	YES
81599	Unlisted multianalyte assay with algorithmic analysis	YES	NIC	YES
84999	Unlisted chemistry procedure	YES	NIC	YES
G9143	Warfarin responsiveness testing by genetic technique using any method, any number of specimens	YES	NAB	YES
S3800	Genetic testing for amyotrophic lateral sclerosis (als)	YES	YES	NON-COVERED
S3840	Dna analysis for germline mutations of the ret proto-oncogene for susceptibility to multiple endocrine neoplasia type 2	YES	YES	NON-COVERED
S3841	Genetic testing for retinoblastoma	YES	YES	NON-COVERED
S3842	Genetic testing for von hippel-lindau disease	YES	YES	NON-COVERED
S3844	Dna analysis of the connexin 26 gene (gjb2) for susceptibility to congenital, profound deafness	NO	YES	NON-COVERED
S3845	Genetic testing for alpha-thalassemia	YES	YES	NON-COVERED
S3846	Genetic testing for hemoglobin E beta-thalassemia	YES	YES	NON-COVERED
S3849	Genetic Testing for Niemann-Pick disease	NO	YES	NON-COVERED
S3850	Genetic testing for sickle cell anemia	NO	YES	NON-COVERED

RMHP Prior Authorization List**Genetic Testing****Effective October 1, 2017 V5 Revised 10/9/2018****Certain services or items may be specific exclusions of the Member's EOC.**

	Prior Authorization is required through eviCore healthcare for the genetic testing procedures marked "Yes". Web www.evicore.com Note: RMHP Prime: NAB= Not a Benefit NIC= Not in Contract (codes not listed on RMHP Prime Fee Schedule – Not payable)			
CPT/HCPCS Codes	Description	CHP+ Commercial	RMHP Prime	Medicare
S3852	Dna analysis for apoe epsilon 4 allele for susceptibility to alzheimer's disease	YES	YES	NON-COVERED
S3853	Genetic testing for myotonic muscular dystrophy	NO	YES	NON-COVERED
(S3854) see 81519	Gene expression profiling panel for use in the management of breast cancer treatment	YES	YES	NON-COVERED
S3861	Genetic testing, sodium channel, voltage-gated, type v, alpha subunit (scn5a) and variants for suspected brugada syndrome	YES	YES	NON-COVERED
S3865	Comprehensive gene sequence analysis for hypertrophic cardiomyopathy	YES	YES	NON-COVERED
S3866	Genetic analysis for a specific gene mutation for hypertrophic cardiomyopathy (hcm) in an individual with a known hcm mutation in the family	YES	YES	NON-COVERED
S3870	CGH test developmental delay	YES	YES	NON-COVERED

RMHP Prior Authorization List**Cosmetic Procedures****Effective October 1, 2017 V5 Revised 10/9/2018****Certain services or items may be specific exclusions of the Member's EOC.**

CPT/HCPCS Code(s)	Descriptions	Prior authorization Requirement
00102	Anesthesia for procedures involving plastic repair of cleft lip	No prior authorization required
00103	Anesthesia for reconstructive procedures of eyelid (eg, blepharoplasty, ptosis surgery)	Prior authorization required
00120	Anesthesia for procedures on external, middle, and inner ear including biopsy; not otherwise specified	Prior authorization required
00402	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; reconstructive pr	Prior authorization required
10040	Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)	Cosmetic
11055	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion	No prior authorization required
11056	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 - 4 lesions	No prior authorization required
11057	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions	No prior authorization required
11200	Removal of skin tags, multiple fibrocuteaneous tags, any area; up to and including 15 lesions	No prior authorization required
+11201	11200 plus each additional 10 lesions	No prior authorization required
11400 - 11446	Excision benign lesions except skin tags, varying sizes and locations	No prior authorization required
11300 - 11313	Shaving of epidermal or dermal lesions - varying sizes and locations	No prior authorization required
11719	Trimming of nondystrophic nails, any number	No prior authorization required
11900	Injection, intralesional; up to and including 7 lesions	No prior authorization required
+11901	11900; more than 7 lesions	No prior authorization required
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmen	Cosmetic except following a medically necessary mastectomy No prior authorization required
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmen	Cosmetic except following a medically necessary mastectomy No prior authorization required
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmen	Cosmetic except following a medically necessary mastectomy No prior authorization required
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	Cosmetic
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc	Cosmetic
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc	Cosmetic
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	Cosmetic
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion	Prior authorization required
11970	Replacement of tissue expander with permanent prosthesis	Prior authorization required
11971	Removal of tissue expander(s) without insertion of prosthesis	Prior authorization required
15730	Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)	No prior authorization required
15733	Muscle, myocutaneous, or fasciocutaneous flap; head and neck w/named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)	No prior authorization required
15775	Punch graft for hair transplant; 1 to 15 punch grafts	Cosmetic
15776	Punch graft for hair transplant; more than 15 punch grafts	Cosmetic
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	Cosmetic
15781	Dermabrasion; segmental, face	Cosmetic
15782	Dermabrasion; regional, other than face	Cosmetic
15783	Dermabrasion; superficial, any site, (eg, tattoo removal)	Cosmetic
15786	Abrasion; single lesion (eg, keratosis, scar)	Prior authorization required

RMHP Prior Authorization List**Cosmetic Procedures****Effective October 1, 2017 V5 Revised 10/9/2018****Certain services or items may be specific exclusions of the Member's EOC.**

CPT/HCPCS Code(s)	Descriptions	Prior authorization Requirement
15787	Abrasion; each additional four lesions or less (List separately in addition to code for primary procedure)	Prior authorization required
15788	Chemical peel, facial; epidermal	Cosmetic
15789	Chemical peel, facial; dermal	Cosmetic
15790	Chemical Peel Total Face	Cosmetic
15791	Chemical Peel Reg Face Hnd Other	Cosmetic
15792	Chemical peel, nonfacial; epidermal	Cosmetic
15793	Chemical peel, nonfacial; dermal	Cosmetic
15810	Salabrasion 20 Sq Cmor Less	Cosmetic
15811	Salabrasion Over 20 Sq Cm	Cosmetic
15819	Cervicoplasty	Cosmetic
15820	Blepharoplasty, lower eyelid;	Prior authorization required
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	Prior authorization required
15822	Blepharoplasty, upper eyelid;	Prior authorization required
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	Prior authorization required
15824	Rhytidectomy; forehead	Cosmetic
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	Cosmetic
15826	Rhytidectomy; glabellar frown lines	Cosmetic
15828	Rhytidectomy; cheek, chin, and neck	Cosmetic
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	Cosmetic
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	Prior authorization required
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	Cosmetic
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	Cosmetic
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	Cosmetic
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	Cosmetic
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	Cosmetic
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	Cosmetic
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	Cosmetic
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	Cosmetic
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication)	Prior authorization required
15876	Suction assisted lipectomy; head and neck	Cosmetic
15877	Suction assisted lipectomy; trunk	Cosmetic
15878	Suction assisted lipectomy; upper extremity	Cosmetic
15879	Suction assisted lipectomy; lower extremity	Cosmetic
17106 - 17108	Destruction of cutaneous vascular proliferative lesions, including propranolol treatment for infant hemangiomas	Prior authorization required
17200	Electrodestruction Skin Tags (1-15)	No prior authorization required
17201	Electrosurg Dest Mult Tag Ea Add 10	No prior authorization required
17340	Cryotherapy (CO2 slush, liquid N2) for acne	Cosmetic
17360	Chemical exfoliation for acne (eg, acne paste, acid)	Cosmetic

RMHP Prior Authorization List**Cosmetic Procedures****Effective October 1, 2017 V5 Revised 10/9/2018****Certain services or items may be specific exclusions of the Member's EOC.**

CPT/HCPCS Code(s)	Descriptions	Prior authorization Requirement
17380	Electrolysis epilation, each 30 minutes	Cosmetic
19300	Mastectomy For Gynecomastia	Prior authorization required
19316	Mastopexy	Prior authorization required
19318	Reduction mammoplasty	Prior authorization required
19324	Mammoplasty, augmentation; without prosthetic implant	Cosmetic except following a medically necessary mastectomy No prior authorization required
19325	Mammoplasty, augmentation; with prosthetic implant	Cosmetic except following a medically necessary mastectomy No prior authorization required
19328	Removal of intact mammary implant	Prior authorization required
19330	Removal of mammary implant material	Prior authorization required
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	Cosmetic except following a medically necessary mastectomy No prior authorization required
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	Cosmetic except following a medically necessary mastectomy No prior authorization required
19355	Correction of inverted nipples	Cosmetic except following a medically necessary mastectomy No prior authorization required
19370	Open periprosthetic capsulotomy, breast	Cosmetic except following a medically necessary mastectomy No prior authorization required
19371	Periprosthetic capsulectomy, breast	Cosmetic except following a medically necessary mastectomy No prior authorization required
19380	Revision of reconstructed breast	Cosmetic except following a medically necessary mastectomy No prior authorization required
21029	Removal by contouring of benign tumor of facial bone (eg, fibrous dysplasia)	Prior authorization required
21031	Excision of torus mandibularis	Prior authorization required
21076	Impression and custom preparation; surgical obturator prosthesis	Prior authorization required
21077	Impression and custom preparation; orbital prosthesis	Prior authorization required
21079	Impression and custom preparation; interim obturator prosthesis	Prior authorization required
21080	Impression and custom preparation; definitive obturator prosthesis	Prior authorization required
21081	Impression and custom preparation; mandibular resection prosthesis	Prior authorization required
21082	Impression and custom preparation; palatal augmentation prosthesis	Prior authorization required
21083	Impression and custom preparation; palatal lift prosthesis	Prior authorization required
21084	Impression and custom preparation; speech aid prosthesis	Prior authorization required
21085	Impression and custom preparation; oral surgical splint	Prior authorization required
21086	Impression and custom preparation; auricular prosthesis	Prior authorization required
21087	Impression and custom preparation; nasal prosthesis	Prior authorization required
21088	Impression and custom preparation; facial prosthesis	Prior authorization required
21089	Unlisted maxillofacial prosthetic procedure	Prior authorization required

RMHP Prior Authorization List**Cosmetic Procedures****Effective October 1, 2017 V5 Revised 10/9/2018****Certain services or items may be specific exclusions of the Member's EOC.**

CPT/HCPCS Code(s)	Descriptions	Prior authorization Requirement
21100	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)	Prior authorization required
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	Cosmetic
21121	Genioplasty; sliding osteotomy, single piece	Cosmetic
21122	Genioplasty; sliding osteotomies, two or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical ch	Cosmetic
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)	Cosmetic
21125	Augmentation, mandibular body or angle; prosthetic material	Cosmetic
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)	Cosmetic
21137	Reduction forehead; contouring only	Cosmetic
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)	Cosmetic
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall	Cosmetic
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without	Prior authorization required except for emergent care
21142	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, without bone graft	Prior authorization required except for emergent care
21143	Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, without bone graft	Prior authorization required except for emergent care
21144	Recon Midface Lefort I Intrusion 1 Piece	Prior authorization required except for emergent care
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtai	Prior authorization required except for emergent care
21146	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, requiring bone grafts (includes obtaini	Prior authorization required except for emergent care
21147	Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, requiring bone grafts (includ	Prior authorization required except for emergent care
21150	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)	Prior authorization required
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	Prior authorization required except for emergent care
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with	Prior authorization required except for emergent care
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with	Prior authorization required except for emergent care
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone gr	Prior authorization required except for emergent care
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone gr	Prior authorization required except for emergent care
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (inclu	Prior authorization required
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephal	Prior authorization required
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	Prior authorization required

RMHP Prior Authorization List**Cosmetic Procedures****Effective October 1, 2017 V5 Revised 10/9/2018****Certain services or items may be specific exclusions of the Member's EOC.**

CPT/HCPCS Code(s)	Descriptions	Prior authorization Requirement
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	Prior authorization required
21181	Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial	Prior authorization required
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign	Prior authorization required
21183	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign	Prior authorization required
21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign	Prior authorization required
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	Prior authorization required
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft	Prior authorization required
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)	Prior authorization required
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	Prior authorization required
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	Prior authorization required
21198	Osteotomy, mandible, segmental;	Prior authorization required
21199	Osteotomy, mandible, segmental; with genioglossus advancement	Prior authorization required
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	Prior authorization required
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	Prior authorization required
21209	Osteoplasty, facial bones; reduction	Prior authorization required
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	Prior authorization required
21215	Graft, bone; mandible (includes obtaining graft)	Prior authorization required
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)	Prior authorization required
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	Prior authorization required
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)	Prior authorization required
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	Prior authorization required
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	Prior authorization required
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial	Prior authorization required
21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete	Prior authorization required
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)	Prior authorization required
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-	Prior authorization required
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach	Prior authorization required
21261	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach	Prior authorization required
21263	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement	Prior authorization required
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach	Prior authorization required

RMHP Prior Authorization List**Cosmetic Procedures****Effective October 1, 2017 V5 Revised 10/9/2018****Certain services or items may be specific exclusions of the Member's EOC.**

CPT/HCPCS Code(s)	Descriptions	Prior authorization Requirement
21268	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach	Prior authorization required
21270	Malar augmentation, prosthetic material	Prior authorization required
21275	Secondary revision of orbitocraniofacial reconstruction	Prior authorization required
21280	Medial canthopexy (separate procedure)	Prior authorization required
21282	Lateral canthopexy	Prior authorization required
21295	Reduction of masseter muscle and bone (e.g. for treatment of benign masseteric hypertrophy); extraoral approach	Prior authorization required
21296	Reduction of masseter muscle and bone (e.g. for treatment of benign masseteric hypertrophy); intraoral approach	Prior authorization required
21299	Unlisted craniofacial and maxillofacial procedure	Prior authorization required
21497	Interdental wiring, for condition other than fracture	Prior authorization required
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	Prior authorization required
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of	Prior authorization required
30420	Rhinoplasty, primary; including major septal repair	Prior authorization required
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	Prior authorization required
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	Prior authorization required
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)	Prior authorization required
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip o	No prior authorization required
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip,	No prior authorization required
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)	Prior authorization required
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)	Prior authorization required
36468	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk	Prior authorization required
36469	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); face	Prior authorization required
36470	Injection of sclerosing solution; single vein	Prior authorization required
36471	Injection of sclerosing solution; multiple veins, same leg	Prior authorization required
40700	Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral	No prior authorization required
40701	Plastic repair of cleft lip/nasal deformity; primary bilateral, one stage procedure	No prior authorization required
40702	Plastic repair of cleft lip/nasal deformity; primary bilateral, one of two stages	No prior authorization required
40720	Plastic repair of cleft lip/nasal deformity; secondary, by recreation of defect and reclosure	No prior authorization required
40740	Rep Lip Cleft Secondary Bil	No prior authorization required
40761	Plastic repair of cleft lip/nasal deformity; with cross lip pedicle flap (Abbe-Estlander type), including sectioning and	No prior authorization required
40806	Incision of labial frenum (frenotomy)	Prior authorization required
41010	Incision of lingual frenum (frenotomy)	No prior authorization required
41520	Frenoplasty (surgical revision of frenum, eg, with Z-plasty)	No prior authorization required
42200	Palatoplasty for cleft palate, soft and/or hard palate only	No prior authorization required
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only	No prior authorization required
42210	Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining gra	No prior authorization required
42215	Palatoplasty for cleft palate; major revision	No prior authorization required

RMHP Prior Authorization List**Cosmetic Procedures****Effective October 1, 2017 V5 Revised 10/9/2018****Certain services or items may be specific exclusions of the Member's EOC.**

CPT/HCPCS Code(s)	Descriptions	Prior authorization Requirement
42220	Palatoplasty for cleft palate; secondary lengthening procedure	No prior authorization required
42225	Palatoplasty for cleft palate; attachment pharyngeal flap	No prior authorization required
49999	Diastasis Recti Repair	Cosmetic
66225	Repair of scleral staphyloma; with graft	No prior authorization required
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	Prior authorization required
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)	Prior authorization required
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	Prior authorization required
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	Prior authorization required
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	Prior authorization required
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	Prior authorization required
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)	Prior authorization required
67909	Reduction of overcorrection of ptosis	Prior authorization required
67911	Correction of lid retraction	Prior authorization required
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)	No prior authorization required
67916	Repair of ectropion; excision tarsal wedge	No prior authorization required
67917	Repair of ectropion; extensive (eg, tarsal strip operations)	No prior authorization required
67923	Repair of entropion; excision tarsal wedge	No prior authorization required
67924	Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)	No prior authorization required
67950	Canthoplasty (reconstruction of canthus)	No prior authorization required
69090	Ear piercing	Cosmetic
69300	Otoplasty, protruding ear, with or without size reduction	Prior authorization required
C9749	Repair of nasal vestibular lateral wall stenosis with implant(s)	Prior authorization required
C9800; Q2028	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies	NAB for Commercial or RMHP Prime. Allowed for Medicare only with Dx B20, (HIV) AND E88.1 (lipodystrophy)
D2610	Inlay-Porcelain/Ceramic-One Surface	Prior authorization required when service is a benefit
D2620	Inlay-Porcelain/Ceramic-Two Surfaces	Prior authorization required when service is a benefit
D2630	Inlay-Porcelain/Ceramic-Three Or More Surfaces	Prior authorization required when service is a benefit
D2642	Onlay - Porcelain/Ceramic - Two Surfaces	Prior authorization required when service is a benefit
D2643	Onlay - Porcelain/Ceramic - Three Surfaces	Prior authorization required when service is a benefit
D2644	Onlay - Porcelain/Ceramic - Four Or More Surfaces	Prior authorization required when service is a benefit
D2740	Crown-Porcelain/Ceramic Substrate	Prior authorization required when service is a benefit
D2750	Crown-Porcelain Fused To High Noble Metal	Prior authorization required when service is a benefit

RMHP Prior Authorization List**Cosmetic Procedures****Effective October 1, 2017 V5 Revised 10/9/2018****Certain services or items may be specific exclusions of the Member's EOC.**

CPT/HCPCS Code(s)	Descriptions	Prior authorization Requirement
D2751	Crown-Proceldain Fused To Predominantly Base Metal	Prior authorization required when service is a benefit
D2752	Crown-Porcelain Fused To Noble Metal	Prior authorization required when service is a benefit
G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)	NAB for Commercial or RMHP Prime. Allowed for Medicare only with Dx B20, (HIV) AND E88.1 (lipodystrophy)
Q2026	Injection, Radiesse, 0.1ML Effective date 3/23/2010	NAB for Commercial or RMHP Prime. Allowed for Medicare only with Dx B20, (HIV) AND E88.1 (lipodystrophy)
Q2027	Injection, Sculptra, 0.1ML Effective date 3/23/2010	NAB for Commercial or RMHP Prime. Allowed for Medicare only with Dx B20, (HIV) AND E88.1 (lipodystrophy)

RMHP Prior Authorization List**Experimental/Investigational Procedures****Effective October 1, 2017 V5 Revised 10/9/2018 Certain services or items may be specific exclusions of the Member's EOC.**

The procedures listed below are never payable for any line of business. RMHP considers them experimental. Some procedures are not payable based on other guidance, which is shown on the table. This list does NOT include all procedures that are not covered or not payable.

- Experimental – RMHP has reviewed the procedure and determined that there is insufficient evidence to demonstrate the procedure has value in health care outcomes.
- Not a Benefit – The procedure is specifically designated as non-covered.
 - o Medicare: The code has status N (non-covered) or status I (invalid for Medicare) on the Medicare Physician Fee Schedule (MPFS) or is designated as “not reasonable or necessary in a Medicare LCD, NCD, or other guidance
 - o Medicaid: The code is listed as Not a Benefit on the Medicaid Fee Schedule
 - o All lines of business: The code is an exclusion under the Member's health care coverage
- Not Payable
 - o The code is absent from the Medicaid Fee Schedule, so is not payable to the provider
 - o Packaged/Bundled – The code is designated as not separately payable, e.g. bundled or packaged with payment for other services
 - o The code is priced at \$0.00 per fee schedule

Code	Procedure Name	Medicare	Medicaid	Commercial, CHP+
0002U	Oncology (colorectal), quantitative assessment of three urine metabolites	Not a Benefit - Experimental	Not Payable	Non-Covered - Screening
0003U	Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, . . .	Not a Benefit - Experimental	Not Payable	Not a Benefit - Experimental
0005U	Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes	Not a Benefit - Experimental	Not Payable	Not a Benefit - Experimental
0006U	Prescription drug monitoring, 120 or more drugs and substances, definitive tandem mass spectrometry with chromatography, urine	Not a Benefit - Experimental	Not Payable	Not a Benefit - Experimental
0007U	Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine . . .	Not a Benefit - Experimental	Not Payable	Not a Benefit - Experimental
0008U	Helicobacter pylori detection and antibiotic resistance, DNA, 16S and 23S rRNA, gyrA, pbp1, rdxA and rpoB, next generation . . .	Not a Benefit - Experimental	Not Payable	Not a Benefit - Experimental
0009U	Oncology (breast cancer), ERBB2 (HER2) copy number by FISH, tumor cells from formalin fixed paraffin embedded tissue . . .	Not a Benefit - Experimental	Not Payable	Not a Benefit - Experimental
0010U	Infectious disease (bacterial), strain typing by whole genome sequencing, phylogenetic-based report of strain relatedness . . .	Not a Benefit - Experimental	Not Payable	Not a Benefit - Experimental
0011U	Prescription drug monitoring, evaluation of drugs present by LCMS/MS, using oral fluid, reported as a comparison . . .	Not a Benefit - Experimental	Not Payable	Not a Benefit - Experimental
0012U	Germline disorders, gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood . . .	Not a Benefit - Experimental	Not Payable	Not a Benefit - Experimental
0013U	Oncology (solid organ neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA . . .	Not a Benefit - Experimental	Not Payable	Not a Benefit - Experimental
0014U	Hematology (hematolymphoid neoplasia), gene rearrangement detection by whole genome nextgeneration sequencing, DNA . . .	Not a Benefit - Experimental	Not Payable	Not a Benefit - Experimental
0016U	Oncology (hematolymphoid neoplasia), RNA, BCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR . . .	Not a Benefit - Experimental	Not Payable	Not a Benefit - Experimental
0017U	Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood . . .	Not a Benefit - Experimental	Not Payable	Not a Benefit - Experimental

RMHP Prior Authorization List**Experimental/Investigational Procedures****Effective October 1, 2017 V5 Revised 10/9/2018 Certain services or items may be specific exclusions of the Member's EOC.**

Code	Procedure Name	Medicare	Medicaid	Commercial, CHP+
0035U	Neurology (prion disease), cerebrospinal fluid, detection of prion protein by quaking-induced conformational conversion, qualitative (Real-time quaking-induced conversion for prion detection (RT-QuIC), National Prion Disease Pathology Surveillance Center)	Not Payable	Not Payable	Not a Benefit - Experimental
0038U	Vitamin D, 25 hydroxy D2 and D3, by LC- MS/MS, serum microsample, quantitative (Sensieva™ Droplet 25OH Vitamin D2/D3 Microvolume LC/MS Assay, InSource Diagnostics)	Not Payable	Not Payable	Not a Benefit - Experimental
0039U	Deoxyribonucleic acid (DNA) antibody, double stranded, high avidity (Anti-dsDNA, High Salt/Avidity, University of Washington, Department of Laboratory Medicine, Bio-Rad)	Not Payable	Not Payable	Not a Benefit - Experimental
0040U	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis, major breakpoint, quantitative (MRDx BCR-ABL Test, MolecularMD)	Non-Payable	Non-Payable	Not a Benefit - Experimental
0041U	Borrelia burgdorferi, antibody detection of 5 recombinant protein groups, by immunoblot, IgM (Lyme ImmunoBlot IgM, IGeneX Inc, ID-FISH Technology Inc. (ASR) (Lyme ImmunoBlot IgM Strips Only)	Non-Payable	Non-Payable	Not a Benefit - Experimental
0042U	Borrelia burgdorferi, antibody detection of 12 recombinant protein groups, by immunoblot, IgG (Lyme ImmunoBlot IgG, IGeneX Inc, ID-FISH Technology Inc. (ASR) (Lyme ImmunoBlot IgG Strips Only)	Non-Payable	Non-Payable	Not a Benefit - Experimental
0043U	Tick-borne relapsing fever Borrelia group, antibody detection to 4 recombinant protein groups, by immunoblot, IgM (Tick-Borne Relapsing Fever (TBRF) Borrelia ImmunoBlots IgM Test, IGeneX Inc, ID-FISH Technology Inc. (Provides TBRF ImmunoBlot IgM Strips)	Non-Payable	Non-Payable	Not a Benefit - Experimental
0044U	Tick-borne relapsing fever Borrelia group, antibody detection to 4 recombinant protein groups, by immunoblot, IgG (Tick-Borne Relapsing Fever (TBRF) Borrelia ImmunoBlots IgG Test, IGeneX Inc, ID-FISH Technology Inc. (Provides TBRF ImmunoBlot IgG Strips)	Non-Payable	Non-Payable	Not a Benefit - Experimental
0051U	Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, urine, 31 drug panel, reported as quantitative results, detected or not detected, per date of service (UCompliDx, Elite Medical Laboratory Solutions, LLC Elite Medical Laboratory Solutions, LLC (LDT)	Non-Payable	Non-Payable	Not a Benefit - Experimental
0052U	Lipoprotein, blood, high resolution fractionation and quantitation of lipoproteins, including all five major lipoprotein classes and subclasses of HDL, LDL, and VLDL by vertical auto profile ultracentrifugation (VAP Cholesterol Test, VAP Diagnostics Laboratory, Inc.)	Non-Payable	Non-Payable	Not a Benefit - Experimental
0054U	Prescription drug monitoring, 14 or more classes of drugs and substances, definitive tandem mass spectrometry with chromatography, capillary blood, quantitative report with therapeutic and toxic ranges, including steady-state range for the prescribed dose when detected, per date of service (AssuranceRx Micro Serum, Firstox Laboratories, LLC)	Non-Payable	Non-Payable	Not a Benefit - Experimental

RMHP Prior Authorization List**Experimental/Investigational Procedures****Effective October 1, 2017 V5 Revised 10/9/2018 Certain services or items may be specific exclusions of the Member's EOC.**

Code	Procedure Name	Medicare	Medicaid	Commercial, CHP+
0058U	Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus oncoprotein (small T antigen), serum, quantitative (Merkel SmT Oncoprotein Antibody Titer, University of Washington, Department of Laboratory Medicine)	Non-Payable	Non-Payable	Not a Benefit - Experimental
0059U	Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus capsid protein (VP1), serum, reported as positive or negative (Merkel Virus VP1 Capsid Antibody, University of Washington, Department of Laboratory Medicine)	Non-Payable	Non-Payable	Not a Benefit - Experimental
0061U	Transcutaneous measurement of five biomarkers (tissue oxygenation [StO ₂], oxyhemoglobin [ctHbO ₂], deoxyhemoglobin [ctHbR], papillary and reticular dermal hemoglobin concentrations [ctHb1 and ctHb2]), using spatial frequency domain imaging (SFDI) and multi-spectral analysis (Transcutaneous multispectral measurement of tissue oxygenation and hemoglobin using Spatial Frequency Domain Imaging (SFDI), Modulated Imaging, Inc.)	Non-Payable	Non-Payable	Not a Benefit - Experimental
0058T	Cryopreservation; reproductive tissue, ovarian	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0106T	Quantitative Sensory Testing (QST) (including but not limited to reflex symptomatic dystrophy, diabetic neuropathy); Medi-Dx 7000; Pressure-Specifies Sensory Testing	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0107T	Quantitative Sensory Testing (QST) (including but not limited to reflex symptomatic dystrophy, diabetic neuropathy); Medi-Dx 7000; Pressure-Specifies Sensory Testing	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0108T	Quantitative Sensory Testing (QST) (including but not limited to reflex symptomatic dystrophy, diabetic neuropathy); Medi-Dx 7000; Pressure-Specifies Sensory Testing	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0109T	Quantitative Sensory Testing (QST) (including but not limited to reflex symptomatic dystrophy, diabetic neuropathy); Medi-Dx 7000; Pressure-Specifies Sensory Testing	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0110T	Quantitative Sensory Testing (QST) (including but not limited to reflex symptomatic dystrophy, diabetic neuropathy); Medi-Dx 7000; Pressure-Specifies Sensory Testing	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0175T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0188T	Remote real-time interactive video-conferenced critical care, evaluation and management of the critically ill or critically injured patient; first 30- 74 minutes	Not a benefit Status N on MPFS	Not a benefit	Not a Benefit - Experimental

RMHP Prior Authorization List**Experimental/Investigational Procedures****Effective October 1, 2017 V5 Revised 10/9/2018 Certain services or items may be specific exclusions of the Member's EOC.**

Code	Procedure Name	Medicare	Medicaid	Commercial, CHP+
0189T	Remote real-time interactive video-conferenced critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)	Not a benefit Status N on MPFS	Not a benefit	Not a Benefit - Experimental
0202T	Posterior vertebral joint(s) arthroplasty (eg, facet joint(s) replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0205T	Intravascular catheter-based coronary vessel or graft spectroscopy (eg, infrared) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation, and report, each vessel (List separately in addition to code for	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0206T	Computerized database analysis of multiple cycles of digitized cardiac electrical data from two or more ECG leads, including transmission to a remote center, application of multiple nonlinear mathematical transformations, with coronary artery obstruction	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0207T	Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0208T	Pure tone audiometry (threshold), automated (includes use of computer-assisted device); air only	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0209T	Pure tone audiometry (threshold), automated (includes use of computer-assisted device); air and bone	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0210T	Speech audiometry threshold, automated (includes use of computer-assisted device)	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0211T	Speech audiometry threshold, automated (includes use of computer-assisted device); with speech recognition	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0212T	Comprehensive audiometry threshold evaluation and speech recognition (0209T, 0211T combined), automated (includes use of computer-assisted device)	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0219T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0220T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0263T	Intramuscular autologous bone marrow cell therapy w/prep of harvest cells multi inject 1 leg includ US guidance, complete proced includ uni/bilateral bone marrow harvest	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0264T	Intramuscular autologous bone marrow cell therapy w/prep of harvest cells, multi inject, 1 leg, includ ultrasound guidance complete proced excl bone marrow harvest	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental

RMHP Prior Authorization List**Experimental/Investigational Procedures****Effective October 1, 2017 V5 Revised 10/9/2018 Certain services or items may be specific exclusions of the Member's EOC.**

Code	Procedure Name	Medicare	Medicaid	Commercial, CHP+
0265T	Intramuscul autologous marrow cell thpy w/prep of harvest cells multi inject, 1 leg, US guidance, uni/bilateral marrow harvest for intramuscular autologous marrow cell thpy	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0266T	Implant/replace carotid sinus baroreflex activation device total syst (includ generator placemnt uni/bilateral lead placemnt intraop interrogation program & reposit)	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0267T	Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning)	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning)	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0269T	Revision/removal carotid sinus baroreflex activat device total system (includ generator placemnt uni/bilateral lead placemnt intraop interrogation programming & reposition)	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0270T	Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and reposition)	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0271T	Revision/removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0272T	Interrogation device eval carotid sinus baroreflex activat syst telemetric iterative communicat w/implant device to monitor diagnos&program thpy values w/interpret&report	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0273T	InterrogationDeviceEvalCarotid sinus baroreflex activation syst telemetric iterative comm w/implantDevice toMonitor diagnos&program thpy values w/interpret&report w/program	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0274T	Percutaneous laminotomy/laminectomy for decompress of neural elements, indirect image guidance W/orW/Out use of endoscope sgl or multi levels uni/bilateral cervical/thoracic	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0275T	Percutaneous laminotomy/laminectomy for decompress of neural elements, under indirect image guidance W/orW/Out use of endoscope sgl/multi levels, uni/bilateral lumbar	Coverage ONLY under clinical trial	Not a benefit	Not a Benefit - Experimental
0278T	Transcutaneous electrical modulation pain reprocessing (eg, scrambler therapy), each treatment session (includes placement of electrodes)	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0290T	Corneal incisions in the recipient cornea created using a laser, in preparation for penetrating or lamellar keratoplasty (add on code)	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0312T	Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior/posterior vagal trunks adjacent to EGJ, pulse generator	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0313T	Vagus nerve blocking therapy (morbid obesity); laparoscopic revision/replacement of vagal trunk neurostimulator electrode array, incl connection to existing pulse generator	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental

RMHP Prior Authorization List**Experimental/Investigational Procedures****Effective October 1, 2017 V5 Revised 10/9/2018 Certain services or items may be specific exclusions of the Member's EOC.**

Code	Procedure Name	Medicare	Medicaid	Commercial, CHP+
0314T	Vagus nerve blocking therapy (morbid obesity); laparoscopic removal of vagal trunk neurostimulator electrode array and pulse generator	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0315T	Vagus nerve blocking therapy (morbid obesity); removal of pulse generator	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0316T	Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0317T	Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0329T	Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0330T	Tear film imaging, unilateral or bilateral, with interpretation and report	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0333T	Visual evoked potential, screening of visual acuity, automated, with report	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0335T	Extra-osseous subtalar joint implant for talotarsal stabilization	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0337T	Endothelial function assessment, using peripheral vascular response to reactive hyperemia, non-invasive	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0338T	Transcatheter renal sympathetic denervation, percutaneous approach	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0339T	Transcatheter renal sympathetic denervation, percutaneous approach	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0340T	Ablation, pulmonary tumor(s), including pleura or chest wall when involved by tumor extension, percutaneous, cryoablation, unilateral, include imaging guidance	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0341T	Quantitative pupillometry with interpretation and report, unilateral or bilateral	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0342T	Therapeutic apheresis with selective HDL delipidation and plasma reinfusion	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0345T	Transcatheter mitral valve repair percutaneous approach via the coronary sinus	Coverage ONLY under clinical trial	Not payable	Not a Benefit - Experimental
0346T	Ultrasound, elastography (List separately in addition to code for primary procedure)	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0347T	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental

RMHP Prior Authorization List**Experimental/Investigational Procedures****Effective October 1, 2017 V5 Revised 10/9/2018 Certain services or items may be specific exclusions of the Member's EOC.**

Code	Procedure Name	Medicare	Medicaid	Commercial, CHP+
0348T	Radiologic examination, radiostereometric analysis (RSA); spine, (includes cervical, thoracic and lumbosacral, when performed)	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0349T	Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow, and wrist, when performed)	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0350T	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee, and ankle, when performed)	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0351T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real-time intraoperative	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real-time or referred	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0353T	Optical coherence tomography of breast, surgical cavity; real-time intraoperative	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0354T	Optical coherence tomography of breast, surgical cavity; interpretation and report, real-time or referred	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0355T	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0356T	Insertion of drug-eluting implant (including punctal dilation and implant removal when performed) into lacrimal canaliculus, each	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0357T	Cryopreservation; immature oocyte(s)	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0358T	Bioelectrical impedance analysis whole body composition assessment, supine position, with interpretation and report	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0375T	Total disc arthroplasty (artificial disc), cervical, three or more levels	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0377T	Anoscopy with directed submucosal injection of bulking agent for fecal incontinence	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0379T	Technical component for assessment of field of vision w/concurrent data analysis & data storage w/patient initiated data transmit to remote surveillance center up to 30 days	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0380T	Computer-aided animation and analysis of time series retinal images for the monitoring of disease progression, unilateral or bilateral, with interpretation and report	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0381T	External heart rate and 3-axis accelerometer data recording up to 14 days to assess changes in heart rate and to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; includes report, scanning analysis with report, re	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0382T	External heart rate and 3-axis accelerometer data recording up to 14 days to assess changes in heart rate and to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; review and interpretation only	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental

RMHP Prior Authorization List**Experimental/Investigational Procedures****Effective October 1, 2017 V5 Revised 10/9/2018 Certain services or items may be specific exclusions of the Member's EOC.**

Code	Procedure Name	Medicare	Medicaid	Commercial, CHP+
0383T	External heart rate and 3-axis accelerometer data recording 15 to 30 days to assess changes in heart rate and to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; includes report, scanning analysis with report, re	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0384T	External heart rate and 3-axis accelerometer data recording 15 to 30 days to assess changes in heart rate and to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; review and interpretation only	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0385T	External heart rate and 3-axis accelerometer data recording more than 30 days to assess changes in heart rate and to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; includes report, scanning analysis with report	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0386T	External heart rate and 3-axis accelerometer data recording more than 30 days to assess changes in heart rate and to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; review and interpretation only	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0388T	Transcatheter removal of permanent leadless pacemaker, ventricular	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0396T	Intra-operative use of kinetic balance sensor for implant stability during knee replacement arthroplasty (List separately in addition to code for primary procedure)	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0397T	Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure)	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0398T	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0399T	Myocardial strain imaging (quantitative assessment of myocardial mechanics using image-based analysis of local myocardial dynamics)	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0400T	Multi-spectral digital skin lesion analysis of clinically atypical cutaneous pigmented lesions for detection of melanomas and high risk melanocytic atypia; one to five lesions	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0401T	Multi-spectral digital skin lesion analysis of clinically atypical cutaneous pigmented lesions for detection of melanomas and high risk melanocytic atypia; six or more lesions	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0403T, 0488T	Preventive behavior change . . . intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0404T	Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental

RMHP Prior Authorization List**Experimental/Investigational Procedures****Effective October 1, 2017 V5 Revised 10/9/2018 Certain services or items may be specific exclusions of the Member's EOC.**

Code	Procedure Name	Medicare	Medicaid	Commercial, CHP+
0405T	Oversight of the care of an extracorporeal liver assist system patient requiring review of status, review of laboratories and other studies, and revision of orders and liver assist care plan (as appropriate), within a calendar month, 30 minutes or more of	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0406T	Nasal endoscopy, surgical, ethmoid sinus, placement of drug eluting implant	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0407T	Nasal endoscopy, surgical, ethmoid sinus, placement of drug eluting implant; with biopsy, polypectomy or debridement	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0408T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0409T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0410T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0411T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0412T	Removal of permanent cardiac contractility modulation system; pulse generator only	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0413T	Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0414T	Removal and replacement of permanent cardiac contractility modulation system pulse generator only	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0415T	Repositioning of previously implanted cardiac contractility modulation transvenous electrode, (atrial or ventricular lead)	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0416T	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0417T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility m	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental

RMHP Prior Authorization List**Experimental/Investigational Procedures****Effective October 1, 2017 V5 Revised 10/9/2018 Certain services or items may be specific exclusions of the Member's EOC.**

Code	Procedure Name	Medicare	Medicaid	Commercial, CHP+
0418T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable cardiac contractility modulation system	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0419T	Destruction neurofibromata, extensive, (cutaneous, dermal extending into subcutaneous); face, head and neck, greater than 50 neurofibromata	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0420T	Destruction neurofibromata, extensive, (cutaneous, dermal extending into subcutaneous); trunk and extremities, extensive, greater than 100 neurofibromata	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0421T	Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when p	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0422T	Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0423T	Secretory type II phospholipase A2 (sPLA2-IIA)	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0424T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; complete system (transvenous placement of right or left stimulation lead, sensing lead, implantable pulse generator)	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0425T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; sensing lead only	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0426T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; stimulation lead only	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0427T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; pulse generator only	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0428T	Removal of neurostimulator system for treatment of central sleep apnea; pulse generator only	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0429T	Removal of neurostimulator system for treatment of central sleep apnea; sensing lead only	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0430T	Removal of neurostimulator system for treatment of central sleep apnea; stimulation lead only	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0431T	Removal and replacement of neurostimulator system for treatment of central sleep apnea, pulse generator only	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0432T	Repositioning of neurostimulator system for treatment of central sleep apnea; stimulation lead only	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0433T	Repositioning of neurostimulator system for treatment of central sleep apnea; sensing lead only	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental

RMHP Prior Authorization List**Experimental/Investigational Procedures****Effective October 1, 2017 V5 Revised 10/9/2018 Certain services or items may be specific exclusions of the Member's EOC.**

Code	Procedure Name	Medicare	Medicaid	Commercial, CHP+
0434T	Interrogation device evaluation implanted neurostimulator pulse generator system for central sleep apnea	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0435T	Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; single session	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0436T	Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; during sleep study	Not reasonable and necessary LCD L35094	Not a benefit	Not a Benefit - Experimental
0437T	Implantation of non-biologic or synthetic implant (eg, polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to code for primary procedure)	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0438T	Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0439T	Myocardial contrast perfusion echocardiography; at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to code for primary procedure)	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0443T	Real time spectral analysis of prostate tissue by fluorescence spectroscopy	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0444T	Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0445T	Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training, and removal of existing insert, unilateral or bilateral	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0446T	Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0447T	Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision	Not reasonable and necessary LCD L35094	Not payable	Not a Benefit - Experimental
0448T	Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including system activation	Not reasonable and necessary LCD L35094	Not Payable	Not a Benefit - Experimental
0451T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; complete system (counterpulsation device, vascular graft, implantable vascular hemostatic seal, mechano-electrical skin interface and subcutaneous electrodes)	Not reasonable and necessary LCD L35094	Not Payable	Not a Benefit - Experimental

RMHP Prior Authorization List**Experimental/Investigational Procedures****Effective October 1, 2017 V5 Revised 10/9/2018 Certain services or items may be specific exclusions of the Member's EOC.**

Code	Procedure Name	Medicare	Medicaid	Commercial, CHP+
0452T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; aortic counterpulsation device and vascular hemostatic seal	Not reasonable and necessary LCD L35094	Not Payable	Not a Benefit - Experimental
0453T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; mechano-electrical skin interface	Not reasonable and necessary LCD L35094	Not Payable	Not a Benefit - Experimental
0454T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; subcutaneous electrode	Not reasonable and necessary LCD L35094	Not Payable	Not a Benefit - Experimental
0455T	Removal of permanently implantable aortic counterpulsation ventricular assist system; complete system (aortic counterpulsation device, vascular hemostatic seal, mechano-electrical skin interface and electrodes)	Not reasonable and necessary LCD L35094	Not Payable	Not a Benefit - Experimental
0456T	Removal of permanently implantable aortic counterpulsation ventricular assist system; aortic counterpulsation device and vascular hemostatic seal	Not reasonable and necessary LCD L35094	Not Payable	Not a Benefit - Experimental
0457T	Removal of permanently implantable aortic counterpulsation ventricular assist system; mechano-electrical skin interface	Not reasonable and necessary LCD L35094	Not Payable	Not a Benefit - Experimental
0458T	Removal of permanently implantable aortic counterpulsation ventricular assist system; subcutaneous electrode	Not reasonable and necessary LCD L35094w	Not Payable	Not a Benefit - Experimental
0459T	Relocation of skin pocket with replacement of implanted aortic counterpulsation ventricular assist device, mechano-electrical skin interface and electrodes	Not reasonable and necessary LCD L35094	Not Payable	Not a Benefit - Experimental
0460T	Repositioning of previously implanted aortic counterpulsation ventricular assist device; subcutaneous electrode	Not reasonable and necessary LCD L35094	Not Payable	Not a Benefit - Experimental
0461T	Repositioning of previously implanted aortic counterpulsation ventricular assist device; aortic counterpulsation device	Not reasonable and necessary LCD L35094	Not Payable	Not a Benefit - Experimental
0462T	Programming device evaluation (in person) with iterative adjustment of the implantable mechano-electrical skin interface and/or external driver to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable aortic counterpulsation ventricular assist system, per day	Not reasonable and necessary LCD L35094	Not Payable	Not a Benefit - Experimental
0463T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable aortic counterpulsation ventricular assist system, per day	Not reasonable and necessary LCD L35094	Not Payable	Not a Benefit - Experimental
0464T	Visual evoked potential, testing for glaucoma, with interpretation and report	Not reasonable and necessary LCD L35094	Not Payable	Not a Benefit - Experimental
0465T	Suprachoroidal injection of a pharmacologic agent (does not include supply of medication)	Not reasonable and necessary LCD L35094	Not Payable	Not a Benefit - Experimental

RMHP Prior Authorization List**Experimental/Investigational Procedures****Effective October 1, 2017 V5 Revised 10/9/2018 Certain services or items may be specific exclusions of the Member's EOC.**

Code	Procedure Name	Medicare	Medicaid	Commercial, CHP+
0466T	Insertion of chest wall respiratory sensor electrode or electrode array, including connection to pulse generator (List separately in addition to code for primary procedure)	Not reasonable and necessary LCD L35094	Not Payable	Not a Benefit - Experimental
0467T	Revision or replacement of chest wall respiratory sensor electrode or electrode array, including connection to existing pulse generator	Not reasonable and necessary LCD L35094	Not Payable	Not a Benefit - Experimental
0468T	Removal of chest wall respiratory sensor electrode or electrode array	Not reasonable and necessary LCD L35094	Not Payable	Not a Benefit - Experimental
0469T	Retinal polarization scan, ocular screening with on-site automated results, bilateral	Not a Benefit - Experimental	Not a Benefit - Experimental	Not a Benefit - Experimental
0470T, 0471T	Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; first lesion or additional lesion	Not a Benefit - Experimental	Not a Benefit - Experimental	Not a Benefit - Experimental
0472T, 0473T	Device evaluation, interrogation, and initial programming of intra-ocular retinal electrode array (eg, retinal prosthesis), in person	Not a Benefit - Experimental	Not a Benefit - Experimental	Not a Benefit - Experimental
0475T, 0476T, 0477T, 0478T	Recording of fetal magnetic cardiac signal using at least 3 channels	Not a Benefit - Experimental	Not a Benefit - Experimental	Not a Benefit - Experimental
34839	Physician planning of a patient-specific fenestrated visceral aortic endograft requiring a minimum of 90 minutes of physician time	Packaged/Bundled	Not payable	Not a Benefit - Experimental
90587	Dengue vaccine, quadrivalent, live, 3 dose schedule, for subcutaneous use	Not a Benefit - Experimental	Not a Benefit - Experimental	Not a Benefit - Experimental
93895	Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral	Not a benefit Status N on MPFS	Not a benefit	Not a Benefit - Experimental
97810, 97811, 97813, 97814	Acupuncture, including as a treatment for behavioral and substance use disorders	Not reasonable and necessary NCD 30.3	Not a benefit	Not a Benefit - Experimental
99500	Home Uterine Activity Monitoring (HUAM)	Invalid code per MPFS	Not a benefit	Not a Benefit - Experimental
A4575	Portable/Topical hyperbaric oxygen chamber	Not a benefit Status N on MPFS	Not a benefit	Not a Benefit - Experimental
A6000	Non-contact wound warming cover/devices or Noncontact Normothermic Wound Therapy (NNWT)	Not a benefit Status N on MPFS	Not a benefit	Not a Benefit - Experimental
C1772	Fully implantable insulin pump. Note: This does not include FDA approved externally worn insulin pumps which are considered medically necessary. Any of these codes with diagnoses E10.10 - E13.9; Z96.41; Z79.4	Not reasonable and necessary. LCD L33794.	Not payable	Not a Benefit - Experimental
C1891	Fully implantable insulin pump. Note: This does not include FDA approved externally worn insulin pumps which are considered medically necessary. Any of these codes with diagnoses E10.10 - E13.9; Z96.41; Z79.4	Not reasonable and necessary. LCD L33794.	Not payable	Not a Benefit - Experimental
C2626	Fully implantable insulin pump. Note: This does not include FDA approved externally worn insulin pumps which are considered medically necessary. Any of these codes with diagnoses E10.10 - E13.9; Z96.41; Z79.4	Not reasonable and necessary. LCD L33794.	Not payable	Not a Benefit - Experimental

RMHP Prior Authorization List**Experimental/Investigational Procedures****Effective October 1, 2017 V5 Revised 10/9/2018 Certain services or items may be specific exclusions of the Member's EOC.**

Code	Procedure Name	Medicare	Medicaid	Commercial, CHP+
C9352	Neuragen nerve guide	Packaged/Bundled	Not a benefit	Not a Benefit - Experimental
C9353	Neurawrap nerve protector	Packaged/Bundled	Not a benefit	Not a Benefit - Experimental
C9354	Veritas Tissue Matrix – C9354	Packaged/Bundled	Not payable	Not a Benefit - Experimental
C9355	NeruoMatrix Collagen Nerve Cuff – C9355	Packaged/Bundled	Not payable	Not a Benefit - Experimental
C9356	TenoGlide Tendon Protector Sheet	Packaged/Bundled	Not a benefit	Not a Benefit - Experimental
C9358	SurgiMend (C9358, C9360)	Packaged/Bundled	Not a benefit	Not a Benefit - Experimental
C9360	SurgiMend (C9358, C9360)	Packaged/Bundled	Not a benefit	Not a Benefit - Experimental
C9361	NeuroMend Nerve Wrap	Packaged/Bundled	Not a benefit	Not a Benefit - Experimental
C9364	Porcine implant, Permacol - C9364	Packaged/Bundled	Not a benefit	Not a Benefit - Experimental
C9745	Nasal endoscopy, surgical; balloon dilation of eustachian tube	Not reasonable and necessary	Not payable	Not a Benefit - Experimental
C9746	Transperineal implantation of permanent adjustable balloon continence device, with cystourethroscopy, when performed and/or fluoroscopy, when performed	Not reasonable and necessary	Not payable	Not a Benefit - Experimental
C9747	Ablation of prostate, transrectal, high intensity focused ultrasound (HIFU), including imaging guidance	Not reasonable and necessary	Not payable	Not a Benefit - Experimental
C9750	Insertion or removal and replacement of intracardiac ischemia monitoring system including imaging supervision and interpretation and peri-operative interrogation and programming; complete system (includes device and electrode)	Not a benefit	Not a benefit	Not a Benefit - Experimental
E0446	Topical oxygen delivery system, NOS, includes all supplies and accessories	Not a benefit Status E on MPFS	Not a benefit	Not a Benefit - Experimental
G0176	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session	Status X on MPFS HCPCs special coverage instructions	No Prior Authorization Required – Manually Priced	Not a Benefit - Experimental
G0276	Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression or placebo-control, in an approved coverage with evidence development clinical trial	Coverage ONLY under clinical trial	Not payable	Not a Benefit - Experimental
G0282	Electrical Stimulation for wound care other than described in G0281	Not a benefit Status N on MPFS	Not a benefit	Not a Benefit - Experimental
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care	Not a benefit Status A on MPFS	Not a benefit	Not a Benefit - Experimental
G0295	Electromagnetic Stimulation to treat urinary incontinence	Not a benefit Status N on MPFS	Not a benefit	Not a Benefit - Experimental
G0295	Magnetic stimulation for treatment of urinary incontinence (e.g., ExMI chair)	Not a benefit Status N on MPFS	Not a benefit	Not a Benefit - Experimental
G0295	Electromagnetic Stimulation to treat chronic wounds/ulcers other than as described in G0329 or for other uses	Not a benefit Status N on MPFS	Not a benefit	Not a Benefit - Experimental
G0295	Radiofrequency stimulation for wound care(e.g., Provant Wound Closure System, MicroVas Vascular Treatment System)	Not a benefit Status N on MPFS	Not a benefit	Not a Benefit - Experimental
G0460	Autologous platelet rich plasma for chronic wounds/ulcers	Coverage ONLY under clinical trial	Not payable	Not a Benefit - Experimental
G9147	Pulsatile IV Insulin Therapy (PIVIT)	Not a benefit Status N on MPFS	Not a benefit	Not a Benefit - Experimental

RMHP Prior Authorization List**Experimental/Investigational Procedures****Effective October 1, 2017 V5 Revised 10/9/2018 Certain services or items may be specific exclusions of the Member's EOC.**

Code	Procedure Name	Medicare	Medicaid	Commercial, CHP+
G9147	Chronic Intermittent Intravenous Insulin Therapy (CIIT)	Not a benefit Status N on MPFS	Not a benefit	Not a Benefit - Experimental
H2032	Activity therapy	Non-covered by Medicare Status I on MPFS	No Prior Authorization Required – Manually Priced	Not a Benefit - Experimental
M0076	Platelet-rich plasma injection	Not a benefit Status N on MPFS	Not a benefit	Not a Benefit - Experimental
M0076	Prolotherapy	Not a benefit Status N on MPFS	Not a benefit	Not a Benefit - Experimental
P9020	Treatment for tendonopathies	Not reasonable and necessary NCD 270.3	Not a benefit	Not a Benefit - Experimental
Q4112	Cymetra, injectable, 1cc	Not separately payable LCD 35041	Not a benefit	Not a Benefit - Experimental
Q4113	GRAFTJACKET XPRESS, injectable, 1cc	Not separately payable LCD 35041	Not a benefit	Not a Benefit - Experimental
Q4114	Integra flowable wound matrix, injectable, 1cc	Not separately payable LCD 35041	Not a benefit	Not a Benefit - Experimental
Q4125	Arthroflex, per sq cm – Q4125	Not separately payable LCD 35041	Not a benefit	Not a Benefit - Experimental
Q4130	Strattice	Not separately payable LCD 35041	Not a benefit	Not a Benefit - Experimental
Q4138	BioDfence dryflex, per sq cm	Not separately payable LCD 35041	Not payable	Not a Benefit - Experimental
Q4139	Amnioexcel or Biodexcel, Injectable, 1cc	Not separately payable LCD 35041	Not payable	Not a Benefit - Experimental
Q4142	Xcm biologic tissue matrix, per sq cm	Not separately payable LCD 35041	Not payable	Not a Benefit - Experimental
Q4143	Repriza, per sq cm	Not separately payable LCD 35041	Not payable	Not a Benefit - Experimental
Q4145	Epifix, injectable, 1mg	Not separately payable LCD 35041	Not payable	Not a Benefit - Experimental
Q4149	Excellagen, 0.1 cc	Not separately payable LCD 35041	Not payable	Not a Benefit - Experimental
Q4150	AlloWrap DS or dry, per square centimeter	Not separately payable LCD 35041	Not payable	Not a Benefit - Experimental
Q4155	Neox Flo or Clarix Flo 1 mg	Not separately payable LCD 35041	Not payable	Not a Benefit - Experimental
Q4162	Woundex flow, bioskin flow, 0.5 cc	Not separately payable LCD 35041	Not a benefit	Not a Benefit - Experimental
Q4168	Amnioband, 1 mg	Not separately payable LCD 35041	Not Payable	Not a Benefit - Experimental
Q4169	Artacent wound, per square centimeter	Not separately payable LCD 35041	Not Payable	Not a Benefit - Experimental
Q4170	Cygnus, per square centimeter	Not separately payable LCD 35041	Not Payable	Not a Benefit - Experimental
Q4171	Interfyl, 1 mg	Not separately payable LCD 35041	Not Payable	Not a Benefit - Experimental
Q4173	Palingen or palingen xplus, per square centimeter	Not separately payable LCD 35041	Not Payable	Not a Benefit - Experimental
Q4174	Palingen or promatrix, 0.36 mg per 0.25 cc	Not separately payable LCD 35041	Not Payable	Not a Benefit - Experimental
Q4175	Miroderm, per square centimeter	Not separately payable LCD 35041	Not Payable	Not a Benefit - Experimental
S1030	GlucoWatch Biographer interstitial glucose monitor	Invalid code per MPFS	Not a benefit	Not a Benefit - Experimental
S1031	GlucoWatch Biographer interstitial glucose monitor	Invalid code per MPFS	Not a benefit	Not a Benefit - Experimental

RMHP Prior Authorization List**Experimental/Investigational Procedures****Effective October 1, 2017 V5 Revised 10/9/2018** Certain services or items may be specific exclusions of the Member's EOC.

Code	Procedure Name	Medicare	Medicaid	Commercial, CHP+
S2107	Adoptive Immunotherapy	Invalid code per MPFS	Not a benefit	Not a Benefit - Experimental
S2300	Thermal capsulorrhaphy for all joints:	Invalid code per MPFS	Not a benefit	Not a Benefit - Experimental
S3650	Saliva tests: Hormone levels for menopause and aging (e.g., cortisol, DHEA, estradiol, estrone, progesterone, testosterone)	Invalid code per MPFS	Not a benefit	Not a Benefit - Experimental
S3905	Automated point-of-care nerve conduction studies	Invalid code per MPFS	Not payable	Not a Benefit - Experimental
S8948	Low level laser therapy for treatment of pain syndromes (e.g., carpal tunnel)	Invalid code per MPFS	Not a benefit	Not a Benefit - Experimental
S9024	Ultrasound for evaluation of paranasal sinuses	Invalid code per MPFS	Not a benefit	Not a Benefit - Experimental
S9055	Procuren (platelet-derived growth factor) or other growth factor preparation to promote wound healing; SafeBlood; Autologous Blood-Derived or Platelet-Derived Growth Factors	Invalid code per MPFS	Not a benefit	Not a Benefit - Experimental
S9056	Coma Stimulation	Invalid code per MPFS	Not a benefit	Not a Benefit - Experimental
S9090	Vertebral Axial Decompression (Vax-D®, DRX9000TM, and TruTrac401 Traction)	Invalid code per MPFS	Not a benefit	Not a Benefit - Experimental

Procedures determined by RMHP to be experimental that are reported with an unlisted code
Acoustic cardiography, including automated analysis of combined acoustic and electrical intervals;
Allergy testing: Cytotoxic food testing
Allergy testing: Hair analysis for allergy
Allergy testing: Passive transfer or PK (Prausnitz-Kustner)
Allergy testing: Provocative Food Test (neutralizing dose immunotherapy or NDIT)
Allergy testing: Rebuck Skin Window Test
Allergy testing: Rinkel Method
Antiprothrombin (phospholipid cofactor) antibody, each 1g class
Aquapheresis (e.g. Aquadex FlexFlow) for congestive heart failure (Dx 6A550Z3)
ATP Assay
Autologous cell therapy with myocytes, hematopoietic stem cells
Avaulta Plus
BioDfactor
Brachytherapy of the femoral popliteal arterial system
Breast duct endoscopy
Cancer Chemosensitivity Assay
Cautery-Assisted Palatal Stiffening (CAPSO)
CellSearch™
Cellular Therapy
Cervicography
Chemical Aversion Therapy
Chemosensitivity Assay Testing
Circulating Tumor Cell (CTC) detection
Clinical Ecology
Clonogenic Assay
Clonogenic Chemosensitivity
Cognitive Evoked Potential Testing (e.g., P300 test)
Conjunctival incision with posterior extrac scleral placement of pharmacological agent (Retaane® ; Anecortave Acetate Depot Suspension
Cont Meas Wheeze Rate Bronchodil Sleep 3-24 Hrs
Cormatrix
Cuffpatch
Cytoprint Assay
DiSC
Discectomy with anular repair
Duct lavage of mammary ducts; Cytoc and HALO NAF collection systems
Ductoscopy
Electrothermal coagulation of knee, wrist, ankle and elbow joints
Embolization, ovarian and internal iliac vein for pelvic congestion syndrome
Enzyme-potentiated desensitization
Evicel fibrin sealant
Fecal (stool) analysis for diagnosis of intestinal dysbiosis
Fetal mesencephalic transplantation for treatment of Parkinson's Disease
Fiberoptic analysis of colorectal polyps (SpectraScience™ Optical Biopsy™ System

Functional Intracellular Analysis (FIATM) by SpectraCell Labs
Gastric electrical stimulation/gastric pacemaker for treatment of obesity
GORE Bio-A Fistula Plug
GORE Bio-A Tissue Reinforcement
GORE® PRECLUDE® Vessel Guard
Holo-transcobalamin (serum) as a marker of Vitamin B12 status
Home monitoring of hemoglobin (e.g., HemoCue B-Hemoglobin Photometer)
Idiopathic environmental intolerance
Immunologic treatment for miscarriage: Paternal and fetal antigen immunotherapy for recurrent fetal loss, if identified
Implantation intracardiac pressure monitor, e.g. CardioMEMS
Indirect, non-invasive measurement of left ventricular filling pressure (e.g., VeriCor device) in the outpatient setting
Inert gas rebreathing as a measurement of cardiac output (e.g., Innocur)
Insulin potentiation therapy
Intermittent measurement of wheeze rate for bronchodilator or bronchial-challenge diagnostic evaluation(s), with interpretation and report
Intraluminal gastric bubble (e.g., Garren-Edwards, etc.)
Ketamine Infusions
Labral reconstruction of hip - allograft
Laparoscopic bipolar coagulation to treat uterine fibroids
Laser Discectomy; lumbar and cervical discs
Laser treatment of acne
LiquidGen
Magnetic bio-stimulation therapy
MedX Lumbar and Cervical Extension Machine
Mesenchymal Stem Cell Therapy (e.g., Osteocel, Osteocel Plus)
Microwave thermotherapy for breast cancer (Microfocus™ APA1000, Celsion)
Minimally Invasive Lumbar Decompression (MILD)
MTT Assay
Multiple chemical sensitivity (MCS)
Multivariate analysis of patient-specific findings with quantifiable computer probability assessment, including report
NC-STAT
Nonclonogenic Cytotoxic Drug Resistance Assay (EDR)
OrthAD Collamend APT
Osteopathic cranial manipulation
OvaCheck, OvaSure, OVA1
Pancreatic islet cell transplantation
Parietex
Paternal and fetal antigen immunotherapy for recurrent fetal loss
Pelvicol
PTFE felt
Radiofrequency ablation of Adrenal cancer
Radiofrequency ablation of Breast cancer
Radiofrequency ablation of Breast fibroadenoma
Radiofrequency ablation of Head and neck cancer

RMHP Prior Authorization List**Experimental/Investigational Procedures****Effective October 1, 2017 V5 Revised 10/9/2018 Certain services or items may be specific exclusions of the Member's EOC.**

Radiofrequency ablation of Lymphoma
Radiofrequency ablation of Ovarian Cancer
Radiofrequency ablation of Pelvic/abdominal metastatic cancer of unspecified origin
Radiofrequency microablation or lesioning for plantar fasciitis
Radiofrequency transvaginal and transurethral radiofrequency for treatment of urinary incontinence
Radiofrequency treatment of fecal incontinence
Rapid Anesthesia Assisted Detoxification (RAAD)
Rhinophototherapy, intranasal application of ultraviolet and visible light, bilateral
Sarapin
Sexual Conversion Therapy (Reparative Therapy)
Skin advanced glycation endproducts (AGE) measurement by multi-wavelength fluorescent spectroscopy
SpectraCell Labs Functional Intracellular Analysis (FIATM) test
Speculoscopy; PapSure Test
Suprachoroidal delivery of pharmacologic agent
Sural nerve graft with radical prostatectomy
Sympathetic stimulation devices for home use (Dynatron)
Thoracoscopic laser ablation for treatment of emphysema
Three-dimensional (3-D) ultrasound for routine obstetrics
Thymidine Incorporated Assay
TissueMend
Transciliary fistulization (transciliary filtration or Singh filtration) for glaucoma
Transmyocardial transcatheter closure of ventricular septal defect, with implant; with or without cardiopulmonary bypass
Transoral incisionless fundoplication procedure (EsophyX System)
Treatment for Sick Building Syndrome
Tumor Stem Cell Assay
Ultrarapid Detoxification
Upper airway stimulation for obstructive sleep apnea
Vestibular Autorotation Test (VAT)
Whole body DEXA for body composition studies
Wilderness Therapy