BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

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Services, Equipment, and Supplies Requiring Prior Approval

If the service and applicable CPT® or HCPCS code appears below, we require prior approval even if the plan is secondary to another carrier, including Medicare. This list applies to the following health plans. Please note that the IBEW Local 300 and The State of Vermont groups may have benefits and/or requirements that vary from our general
Blue Cross VT List:

- Blue Cross and Blue Shield of Vermont (Blue Cross VT)
  Note: Blue Cross VT also includes Access Blue New England (ABNE), New England Health Plan (NEHP), and The Vermont Health Plan
- IBEW Local 300 (IBEW)
- The State of Vermont ASO (SOV)

ABNE and NEHP members: requirements only apply when members have primary care providers (PCPs) located in Vermont. For members with VT PCPs, the member's Home Plan may manage mental health, pharmacy/mail order prescription drugs, requirements and reviews.

Federal Employee Program (FEP) members have separate prior approval or referral authorization requirements. Please see separate lists for details.

Prior approval requirements and member benefits vary according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates, and member contract language takes precedence over medical policies or the prior approval list when there is a conflict. Please verify member benefits prior to rendering services.

Unless otherwise indicated, the following health plans do not require prior approval for the services within this list:

- The State of Vermont Total Choice Plan (prefix FVT)
- Vermont Blue65 and Vermont Medigap Blue supplement plans (prefix ZIB)

You may use our online prior approval request tool, by logging into your secure account at www.bluecrossvt.org/providers. We supply this list as a quick reference only. Codes appearing on this list may not be all inclusive. AMA and CMS code updates may occur more frequently than policy updates. Please visit our medical policy page for our list of active medical policies.

KEY

- A mid-dot (•) indicates that we require prior approval.
- 'NR' denotes that prior approval is not reviewed. Please verify member benefits prior to rendering services. *An NR notation does not indicate that the service is covered.*

Effective July 01,2024

Table of Contents

Dental Services

Pediatric dental services are provided through CBA Blue, when applicable. See medical policy for pediatric dental services or contact the customer service team for more information.

https://www.bluecrossvt.org/documents/dental-services-pediatric-2023

Durable Medical Equipment, Medical Supplies (including rentals), Orthotics and Prosthetics

Electrical and Ultrasound Stimulation

SOV Total Choice (FVT): Prior approval required, except for bone growth and spinal electrical stimulation (marked with * regardless of purchase price).

Endovascular Stent Grafts

Enteral Formulae and Total Parenteral Nutrition

IBEW: Prior approval required for enteral formulae and total parenteral nutrition when the purchase price meets the dollar threshold indicated in the durable medical equipment section above.

Gender Affirming Services

See medical policy for Gender Affirming Services for more information.

Genetic Testing

Hematopoietic Cell Transplantation

Hospital Beds and Accessories

IBEW: Prior approval required for hospital beds when the purchase price meets the dollar threshold indicated in the durable medical equipment section above.

Hyperbaric Oxygen Therapy

Infertility Treatment and Surgical Correction

Intravascular Ultrasound (IVUS)/Optical Coherence Tomography (OCT)

See medical policy for Use of Intravascular Ultrasound and Optical Coherence Tomography.

Medical Nutrition for Inherited Metabolic Diseases

See medical policy for Medical Food for Inherited Metabolic Disease (IMD) for more information.

Miscellaneous DME, Orthotics and Prosthetics

IBEW: Prior approval required for Miscellaneous DME, Orthotics and Prosthetics when the purchase price meets the dollar threshold indicated in the durable medical equipment section above.

Nasopharyngoscopy

Neurodevelopmental Screening (Pediatric)

See medical policy for Pediatric Neurodevelopmental and Autism Spectrum Disorder (ASD) Screening for more information.

Neurorrhaphy Procedures

Oral Appliances

IBEW: Prior approval required for oral appliances when the purchase price meets the dollar threshold indicated in the durable medical equipment section above.

Orthognathic Surgery

Percutaneous Radiofrequency Ablation of Liver

Polysomnography and Multiple Sleep Latency Testing (MSLT)

See medical policy for Sleep Disorders Diagnosis and Treatment for more information.

Positive Airway Pressure Devices (APAP, BiPAP, CPAP)

IBEW: Prior approval required for positive airway pressure devices when the purchase price meets the dollar threshold indicated in the durable medical equipment section above.

Prescription Drugs (Administered in an Office/Outpatient Setting)

Psychological & Neuropsychological Testing

NEHP/ABNE: Prior approval not reviewed.

Radiation Treatment & High-Dose Electronic Brachytherapy

Radiology (Advanced Imaging)

NEHP/ABNE: Prior approval not reviewed.

Rehabilitation, inpatient

Note: These services require a worksheet in addition to the completed prior approval request form.

Scintimammography Gamma Imaging

Skilled Nursing Facilities, inpatient

Surgery and Related Services

IBEW: Prior approval only required for bariatric surgical procedures. See Attachment IV for additional details.

Temporary Codes (for emerging technologies, services, procedures, and service paradigms, also known as Category III Codes CPT®).

Transcranial Magnetic Stimulation

Transplants

Vermont Blue65 (ZIB): Prior approval may be required for transplant services. Contact customer service for details.

Vestibular Evoked Myogenic Potential Testing (VEMP)

Vision Services and Medical Coverage for Ocular Disease

See medical policy for Vision Services for more information.

Wearable Cardioverter Defibrillators

SOV Total Choice (FVT): Prior approval required for DME (marked with *)

Wheelchairs

IBEW: Prior approval required for wheelchairs and accessories when the purchase price meets the dollar threshold indicated in the durable medical equipment section above.

Attachment I – Genetic Testing & Other Pathology Services

Attachment II – Cosmetic and Reconstructive Services

Attachment III – Radiology Services Requiring Prior Approval for the State of Vermont employer group, excluding SOV Total Choice (FVT)

Attachment IV – Surgery

Attachment V – Radiology (Advanced Imaging) - Blue Cross VT/ IBEW, NEHP/ABNE

Procedure or Item	CPT/HCPCS	Blue Cross VT	IBEW	SOV
Out-of-Network Providers and Facilities You may only request prior approval for the following, per medical policy: • There is not a network provider with appropriate training and experience to provide the medically necessary services needed to meet the particular health care needs of a member; or • When a member already temporarily lives, works, or attends school or otherwise already temporarily lives outside of the service area at the time of the request and treatment cannot be delayed. All other out-of-network services are not covered or are subject to the out-of-network or non-preferred benefit in effect at the time of service based on the member's benefit plan. Prior approval requirements remain in effect for all other services on this list. See policy for Out-of-Network Services Claims Processing Policy and Procedure. NEHP: Referral required for services outside the state of Vermont but within New England. For services outside of New England, prior approval is required.	All	•	•	•
Out-of-State Inpatient Care (facilities that are not contracted with Vermont) NEHP: Prior approval required for all inpatient services outside of Vermont.	All Exception: No review required for services when another carrier is primary, unless the service is found elsewhere on this list.	•	•	•

Procedure or Item	CPT/HCPCS	Blue Cross VT	IBEW	SOV
Adoptive Immunotherapy including CAR-T and Gene Therapy Drugs	*when benefits apply* 0537T, 0538T, 0539T, 0540T	•	NR	NR
Ambulance (All Non-Emergency Transport, including transport by land, air, or water) See medical policy for Ambulance and Medical Transport Services for more information.	A0426, A0428, A0430, A0431, A0435, A0436, A0999, S9960, S9961	•	NR	NR
Ambulatory Event Monitoring See medical policy for Ambulatory Event Monitors for more information.	93228, 93229, 93241, 93242, 93243, 93244, 93245, 93246, 93247, 93248	•	NR	•
Anesthesia (Monitored) during gastrointestinal endoscopy, bronchoscopy, or interventional pain procedures. See medical policy for Monitored Anesthesia Care (MAC) for more details	00635, 00731, 00732, 00811, 00812, 00813, 01991, 01992	•	NR	NR

Procedure or Item	CPT/HCPCS	Blue Cross VT	IBEW	SOV
Applied Behavior Analysis (ABA) See medical policy for Applied Behavioral Analysis (ABA) for more details.	*when benefits apply* 0362T, 0373T, 97152, 97153, 97154, 97155, 97156, 97157, 97158	●	NR	●
Artificial Pancreas Device System See medical policy for External Insulin Pumps for more information. SOV Total Choice (FVT): Prior approval required. IBEW: Prior approval required for artificial pancreas device system when the purchase price meets the dollar threshold indicated in the durable medical equipment section below.	S1034, S1035, S1036, S1037	●	●	●
Autism-Spectrum-Disorder-Related Occupational, Physical, and Speech Therapy For additional visits beyond the defined benefit limit. See medical policies for Occupational Therapy, Physical Therapy/Medicine, and Speech Language Pathology/Therapy Services for more details. NEHP/ABNE: Prior approval not reviewed.	*when benefits apply* All	●	●	●
Autonomic Function Testing	95921, 95922, 95923, 95924	●	NR	●
Autologous Chondrocyte Transplantation See medical policy for Autologous Chondrocyte Transplantation for more information. SOV Total Choice (FVT): Prior approval required.	27412, 27416, J7330, S2112	●	NR	●
Biofeedback	*when benefits apply* 90875, 90901, 90912, 90913	NR	NR	●

Procedure or Item	CPT/HCPCS	Blue Cross VT	IBEW	SOV
Blood and Blood Components See medical policy for Blood and Blood Components for more information.	G0460, S0157 S9055	•	NR	•
Breast Pump, Hospital Grade SOV Total Choice (FVT): Prior approval required.	E0604	•	NR	•
Capsule Endoscopy (wireless) See medical policy for Wireless Capsule Endoscopy for more information.	91110, 91112, 91113,	•	NR	NR
Cerebrovascular Arterial Study, Non-Invasive	93895	•	NR	•
Charged Particle Radiotherapy See medical policy for Charged Particle Radiotherapy for Neoplastic Conditions for more information.	61796, 61797, 61798, 61799, 63620, 63621	•	NR	•
Chiropractic Services (after 12 initial visits) See medical policy for Chiropractic Services for more information. NEHP/ABNE: Prior approval not reviewed.	All	•	NR	NR

Procedure or Item	CPT/HCPCS	Blue Cross VT	IBEW	SOV
Cochlear Implants and Implantable Bone Conduction Hearing Aids See medical policy for Cochlear Implants and Implantable Bone Conduction Hearing Aids for more information. IBEW: Prior approval required for cochlear implants and implantable bone conduction hearing aids when the purchase price meets the dollar threshold indicated in the durable medical equipment section below.	69710, 69711, 69714, 69716, 69717, 69719, 69726, 69727, 69728, 69729, 69730, 69930, L8614, L8615, L8616, L8617, L8618, L8619, L8625, L8627, L8628, L8629, L8690, L8691, L8692, L8693, L8694	●	●	NR
Continuous Passive Motion (CPM) Equipment See medical policy for Continuous Passive Motion (CPM) for more information. SOV Total Choice (FVT): Prior approval required. IBEW: Prior approval required for continuous passive motion equipment when the purchase price meets the dollar threshold indicated in the durable medical equipment section below.	E0935, E0936	●	●	●
Cosmetic & Reconstructive Services See medical policy for Cosmetic and Reconstructive Procedures for more information.	*when benefits apply* All See Attachment II; list is not all-inclusive.	●	●	●

Procedure or Item	CPT/HCPCS	Blue Cross VT	IBEW	SOV
Dental Services See medical policy for Dental Services for Accidental Injury, Gross Deformity, Head and Neck Cancers, and Congenital/Genetic Disorders for more information. https://www.bluecrossvt.org/documents/dental-services-accidental-injury-2023 We review only the following dental services under the medical benefit: • Treatment for, or in connection with, an accidental injury to jaws, sound natural teeth, mouth or face, provided a continuous course of dental treatment begins within six months of the accident. • Surgery to correct gross deformity resulting from major disease or Surgery (Surgery must take place within six months of the onset of disease or within six months after Surgery, except as otherwise required by law). • Surgery related to head and neck cancer where sound natural teeth may be affected primarily or as a result of the chemotherapy or radiation treatment of that cancer. • Treatment for a congenital or genetic disorder. Treatment for a congenital or genetic disorder, such as but not limited to the absence of one or more teeth, up to the first molar, or abnormal enamel (example lateral peg). Facility and anesthesia charges for members who are: ○ with phobias or mental illness documented by a licensed physician or mental health professional; **OR** ○ with disabilities that preclude office-based dental care due to safety considerations; **OR** ○ who are developmentally unable to safely tolerate office-based dental care Note: Even with prior approval, benefits are limited. Certain services may not be covered. Pediatric dental services are provided through CBA Blue, when applicable. See medical policy for pediatric dental services or contact the customer service team for more information. https://www.bluecrossvt.org/documents/dental-services-pediatric-2023	All Exception: No PA for bone-impacted wisdom teeth *when benefits apply*; No PA for the following: • Lesion excision/destruction (D7286, D7413, D7414, D7415, D7440, D7441); • Lesion excision/biopsy of lips (40490); • Lesion excision/biopsy of mucosa (40810, 40812, 40814, 40816); • Lesion excision/biopsy of vestibule of mouth (40808, 40818, 40820); • Lesion excision/biopsy of tongue (41100, 41105, 41110, 41112, 41113, 41114); • Lesion excision/biopsy of floor of mouth (41108, 41116); • Lesion excision/biopsy of dentoalveolar structures (41800, 41825, 41826, 41827); • Glossectomy (41120, 41130, 41135, 41155); • Frenectomy of uvula (40819); • Biopsy of the uvula (42100, 42104, 42106, 42107); or • Biopsy of salivary glands (42400, 42405).	•	•	•

Procedure or Item	CPT/HCPCS	Blue Cross VT	IBEW	SOV
Durable Medical Equipment, Medical Supplies (including rentals), Orthotics and Prosthetics Prior approval is required when the purchase price is over the following dollar thresholds: • Blue Cross VT: $500 or more • IBEW: $3,500 or more • SOV (including SOV Total Choice): $-500 or more See corporate medical policies on Medical Equipment and Supplies – Durable Medical Equipment (DMEPOS) and Supplies or Medical Equipment and Supplies – Prosthetics and Orthotics, for more information. Additionally, see service-specific medical policies when appropriate. SOV (including SOV Total Choice): Additional coverage applies for the following shoe insert orthotics, and prior approval is required when the purchase price is $500 or more: A5501, A5513, L3000, L3001, L3002, L3003, L3010, L3020, L3030, L3031, L3070, L3080, L3090, L3201, L3202, L3203, L3204, L3206, L3207, L3215, L3216, L3217, L3219, L3221, L3222, L3224, L3225, L3230, L3250, L3251, L3252, L3253 SOV Total Choice (FVT): Prior approval required for durable medical equipment and supplies as indicated within this list. See elsewhere on this list: • Continuous Passive Motion (CPM) Equipment • Electrical and Ultrasound Stimulation • Enteral Formulae and Total Parenteral Nutrition • Hospital Beds and Accessories • Medical Nutrition for Inherited Metabolic Diseases • Miscellaneous DME, Orthotics and Prosthetics • Positive Airway Pressure Devices (APAP, BiPAP, CPAP) • Vision Services and Medical Coverage for Ocular Disease • Wheelchairs	All Exception: No PA required for urinary catheters and supplies, ostomy supplies, oxygen and oxygen-related supplies, insulin pump supplies, certain breast prosthetics for patients with a diagnosis of breast cancer, and cranial/scalp/wig prostheses. Exception: No PA required for the following hand splints: L3702, L3760, L3763, L3764, L3808, L3921 Exception: When benefits apply, hearing Aids do not require PA regardless of purchase price.	•	•	•

Procedure or Item	CPT/HCPCS	Blue Cross VT	IBEW	SOV
Electrical and Ultrasound Stimulation See medical policies for Electrical Bone Growth Stimulation, Electrical Stimulation of the Spine, Neuromuscular Electrical Stimulation (NMES), Occipital Nerve Stimulation, or Transcutaneous Electrical Nerve Stimulation (TENS) for more information. IBEW: PA required for electrical bone growth stimulation, neuromuscular electrical stimulation, and transcutaneous electrical nerve stimulation regardless of purchase price. Prior approval required for other electrical and ultrasound stimulation services when the purchase price meets the dollar threshold indicated in the durable medical equipment section above. SOV: No PA required for bone growth and spinal electrical stimulation (marked with * regardless of purchase price). SOV Total Choice (FVT): Prior approval required, except for bone growth and spinal electrical stimulation (marked with * regardless of purchase price).	20974*, 20975*, 20979*, 61885, 61886, 63650*, 63655*, 63661*, 63662*, 63663*, 63664*, 63685*, 63688*, 64553, 64561*, 64566, 64568, 64569, 64570, 64580, 64581*, 64582, 64583, 64584, 64590, 64595, 64596, 64597, 64598. 95970* 95971*, 95972*, 95976, 95977, 95980, 95981, 95982, A4595, C1767, C1778, C1820, C1822, E0720, E0730, E0731, E0735, E0745, E0747*, E0748*, E0749*, E0760*, E0766, L8680, L8681, L8682, L8683, L8684, L8685, L8686, L8687, L8688, L8689, L8696	●	●	●
Endovascular Stent Grafts	34701, 34702, 34703, 34704, 34705, 34706, 34707, 34708	●	NR	●
Enteral Formulae and Total Parenteral Nutrition See medical policies for Enteral Nutrition or Total Parenteral Nutrition for more information. SOV: B4102, B4103, B4104, B4149, B4150, B4152, B4158, B4159, B4160 are eligible without prior approval only when provided through a feeding tube. SOV Total Choice (FVT): Prior approval required, except for B4102, B4103, B4104, B4149, B4150, B4152, B4158, B4159, B4160, which are eligible without prior approval only when provided through a feeding tube. IBEW: Prior approval required for enteral formulae and total parenteral nutrition when the purchase price meets the dollar threshold indicated in the durable medical equipment section above.	B4034, B4035, B4036, B4081, B4082, B4083, B4087, B4088, B4105, B4148, B4153, B4154, B4155, B4157, B4161, B4162, B4164, B4168, B4172, B4176, B4178, B4180, B4185, B4189, B4193, B4197, B4199, B4216, B4220, B4222, B4224, B5000, B5100, B5200, B9002, B9004, B9006, B9998, B9999, E0791, S9340, S9341, S9342, S9343, S9364, S9365, S9366, S9367, S9368	●	NR	●

Procedure or Item	CPT/HCPCS	Blue Cross VT	IBEW	SOV
Gender Affirming Services See medical policy for Gender Affirming Services for more information.	All Exception: No PA required for orchiectomy, hysterectomy, or salpingo-oophorectomy.	●	NR	●
Genetic Testing	See Attachment I	●	NR	●
Hematopoietic Cell Transplantation	38242	●	NR	●
Hospital Beds and Accessories Note: PA required for hospital bed accessories when the purchase price meets the dollar threshold indicated in the durable medical equipment section above. SOV Total Choice (FVT): Prior approval required. IBEW: Prior approval required for hospital beds when the purchase price meets the dollar threshold indicated in the durable medical equipment section above.	All	●	●	●
Hyperbaric Oxygen Therapy	99183, G0277, or revenue code 0413	●	NR	NR
Infertility Treatment and Surgical Correction See medical policies for Infertility Services for more information.	*when benefits apply* 58321, 58322, 58323, 58672, 58673, 58760, 58770, 58970, 58974, 76948, 89250, 89251, 89253, 89254, 89255, 89257, 89258, 89259, 89260, 89261, 89268, 89280, 89281, 89290, 89291, 89337, 89342, 89343, 89352, 89353, 89354, J0725, J3355, S0122, S0126, S0128	●	NR	NR
Intensive Outpatient Services (IOP) for mental health and substance use disorder NOTE: Prior approval will be waived if the rendering provider/facility is contracted with Blue Cross VT.	All (non-emergency, as noted)	●	NR	NR

Procedure or Item	CPT/HCPCS	Blue Cross VT	IBEW	SOV
Intravascular Ultrasound (IVUS)/Optical Coherence Tomography (OCT) See medical policy for Use of Intravascular Ultrasound and Optical Coherence Tomography.	92978, 92979	●	NR	●
Medical Nutrition for Inherited Metabolic Diseases See medical policy for Medical Food for Inherited Metabolic Disease (IMD) for more information.	B9998	●	NR	●
Miscellaneous DME, Orthotics and Prosthetics SOV Total Choice (FVT): Prior approval required. NOTE: *Indicates Custom Knee Brace(s) IBEW: Prior approval required for Miscellaneous DME, Orthotics and Prosthetics when the purchase price meets the dollar threshold indicated in the durable medical equipment section above.	E1800, E1802, E1805, E1810, E1812, E1815, E1820, E1825, E1830, E1840, L0999, L1499, L1810*, L1834*, L1840*, L1844*, L1846*, L1860*, L2006, L2999, L3999, L5999, L7499, L8039, L8499, L8606, L8699	●	●	●
Nasopharyngoscopy	69705, 69706	●	NR	●

Procedure or Item	CPT/HCPCS	Blue Cross VT	IBEW	SOV
Neurodevelopmental Screening (Pediatric) See medical policy for Pediatric Neurodevelopmental and Autism Spectrum Disorder (ASD) Screening for more information.	*when benefits apply* 96110, 96112, 96113 Exception: No PA required for members under the age of three up to five visits.	•	NR	NR
Neurorrhaphy Procedures	64910, 64911, 64912, 64913	•	NR	•
Oral Appliances See medical policies for Oral Appliances for Sleep Apnea or Temporomandibular Joint Dysfunction for more information. SOV Total Choice (FVT): Prior approval required. IBEW: Prior approval required for oral appliances when the purchase price meets the dollar threshold indicated in the durable medical equipment section above.	D7880, E0486, K1027	•	•	•
Orthognathic Surgery	21120, 21121, 21122, 21123, 21125, 21127, 21137, 21138, 21139, 21141, 21142, 21143, 21145, 21146, 21147, 21150, 21151, 21154, 21155, 21159, 21160, 21206, 21208, 21209, 21240, 21242, 21243, 21244, 21245, 21246, 21247, 21248, 21249	•	NR	•
Partial Hospitalization (PHP) for mental health and substance use disorder NOTE: Prior approval will be waived if the rendering provider/facility is contracted with Blue Cross VT.	All (non-emergency, as noted)	•	NR	NR
Percutaneous Radiofrequency Ablation of Liver	47370, 47380, 47382	•	NR	NR

Procedure or Item	CPT/HCPCS	Blue Cross VT	IBEW	SOV
Polysomnography and Multiple Sleep Latency Testing (MSLT) See medical policy for Sleep Disorders Diagnosis and Treatment for more information.	95782, 95783, 95805, 95807, 95808, 95810, 95811	•	NR	NR
Positive Airway Pressure Devices (APAP, BiPAP, CPAP) See medical policy for Sleep Disorders Diagnosis and Treatment for more information. SOV Total Choice (FVT): Prior approval required. IBEW: Prior approval required for positive airway pressure devices when the purchase price meets the dollar threshold indicated in the durable medical equipment section above.	E0470, E0471, E0472, E0601	•	•	•
Prescription Drugs (Administered in an Office/Outpatient Setting) Blue Cross VT/IBEW: Refer to the RX Center for drugs requiring prior approval.	See appropriate lists	•	•	NR
Psychological & Neuropsychological Testing See medical policy for Neuropsychological and Psychological Testing for more information. *Note: These services require a worksheet in addition to the completed prior approval request form.* NEHP/ABNE: Prior approval not reviewed.	96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139 (non-emergency, as noted)	•	NR	NR
Radiation Treatment & High-Dose Electronic Brachytherapy	77424, 77425, 77469, 77520, 77522, 77523, 77525, 0394T, 0395T	•	NR	•

Procedure or Item	CPT/HCPCS	Blue Cross VT	IBEW	SOV
Radiology (Advanced Imaging) Blue Cross VT/IBEW, NEHP/ABNE: See Attachment V for code-specific list of services. NOTE: Prior Approval is waived if MRI services are provided by: • VT Open MRI [NPI:1083904114] • NH Open MRI [NPI:1437364965]. SOV: See Attachment III for code-specific list of services.	All	•	•	•
Residential Treatment Centers (RTC) for mental health and substance use disorder SOV Total Choice (FVT): Prior approval required. NEHP/ABNE: Prior approval not reviewed. NOTE: Prior approval will be waived if the rendering provider/facility is contracted with Blue Cross VT.	All (non-emergency, as noted)	•	•	•
Rehabilitation, inpatient *Note: These services require a worksheet in addition to the completed prior approval request form.*	All	•	•	•
Scintimammography Gamma Imaging	78195, 78800, 78801, 78802, 78804, S8080	•	NR	•
Skilled Nursing Facilities, inpatient	All	•	•	•

Procedure or Item	CPT/HCPCS	Blue Cross VT	IBEW	SOV
Surgery and Related Services IBEW: Prior approval only required for bariatric surgical procedures. See Attachment IV for additional details.	Refer to Attachment IV	●	●	●
Temporary Codes (for emerging technologies, services, procedures, and service paradigms, also known as Category III Codes CPT®).	0544T, 0571T, 0572T, 0573T, 0574T, 0575T, 0576T, 0577T, 0578T, 0579T, 0580T, 0584T, 0585T, 0586T, 0600T, 0601T, 0095T, 0098T, 0784T, 0785T, 0786T, 0787T, 0788T, 0789T, 0816T, 0817T, 0818T, 0819T, 0823T, 0824T, 0825T, 0826T	●	NR	●
Transcranial Magnetic Stimulation	90867, 90868, 90869	●	NR	●
Transplants SOV Total Choice (FVT): Prior approval required for transplant services, excluding cornea and kidney. Vermont Blue65 (ZIB): Prior approval may be required for transplant services. Contact customer service for details.	All Exception: No PA required for cornea or kidney transplant services.	●	NR	●
Vestibular Evoked Myogenic Potential Testing (VEMP)	92517, 92518, 92519	●	NR	●

Procedure or Item	CPT/HCPCS	Blue Cross VT	IBEW	SOV
Vision Services and Medical Coverage for Ocular Disease See medical policy for Vision Services for more information.	0671T, 0810T, 65778, 65780, 68841, 92229, V2627, V2531 Exception: No PA required for frames or lenses, including tinting, with a diagnosis of aphakia or keratoconus regardless of purchase price of the DME.	●	NR	●
Wearable Cardioverter Defibrillators SOV Total Choice (FVT): Prior approval required for DME (marked with *)	*E0617, K0606*, K0607*, K0608*, K0609*, 93745, 93292	●	NR	●
Wheelchairs Note: PA required for wheelchairs and accessories when the purchase price meets the dollar threshold indicated in the durable medical equipment section above. SOV Total Choice (FVT): Prior approval required for wheelchairs and accessories when the purchase price meets the dollar threshold indicated in the durable medical equipment section above. IBEW: Prior approval required for wheelchairs and accessories when the purchase price meets the dollar threshold indicated in the durable medical equipment section above.	E1229, E1239, K0898	●	●	●

Attachment I – Genetic Testing & Other Pathology Services

See medical policies for Assays of Genetic Expression in Tumor Tissue as a Technique to Determine Prognosis in Patients with Breast Cancer, Cytochrome P450 Genotype-Guided Treatment Strategy.

Procedure	CPT/HCPCS
Cytogenetic Studies	88230, 88233, 88235, 88237, 88239, 88240, 88241, 88245, 88248, 88249, 88261, 88262, 88263, 88264, 88267, 88269, 88271, 88272, 88273, 88274, 88275, 88280, 88283, 88285, 88289, 88291, 88299
Diseases and Other Medical Conditions	0002M, 0003M, 0006M, 0007M
Gene Sequencing and Other Genetic Testing	S3800, S3840, S3841, S3842, S3844, S3845, S3846, S3849, S3850, S3852, S3853, S3854, S3861, S3865, S3866, S3870,
Hematology and Coagulation	84999, 85999
Pathology and Laboratory /Molecular Pathology	81105, 81106, 81107, 81108, 81109, 81110, 81111, 81112, 81120, 81121, 81161, 81162, 81163, 81164, 81165, 81166, 81167, 81168, 81170, 81171, 81172, 81173, 81174, 81175, 81176, 81177, 81178, 81179, 81180, 81181, 81182, 81183, 81184, 81185, 81186, 81187, 81188, 81189, 81190, 81191, 81192, 81193, 81194, 81200, 81201, 81202, 81203, 81204, 81205, 81206, 81207, 81208, 81209, 81210, 81212, 81215, 81216, 81217, 81218, 81219, 81225, 81226, 81227, 81228, 81229, 81230, 81231, 81232, 81233, 81234, 81235, 81236, 81237, 81238, 81239, 81240, 81241, 81242, 81243, 81244, 81245, 81246, 81247, 81248, 81249, 81250, 81251, 81252, 81253, 81254, 81255, 81256, 81257, 81258, 81259, 81260, 81261, 81262, 81263, 81264, 81265, 81266, 81269, 81270, 81271, 81272, 81273, 81274, 81275, 81276, 81278, 81279, 81283, 81284, 81285, 81286, 81287, 81288, 81289, 81290, 81291, 81292, 81293, 81294, 81295, 81296, 81297, 81298, 81299, 81300, 81301, 81302, 81303, 81304, 81305, 81306, 81307, 81308, 81309, 81310, 81311, 81312, 81313, 81314, 81315, 81316, 81317, 81318, 81319, 81320, 81321, 81322, 81323, 81324, 81325, 81326, 81328, 81330, 81331, 81332, 81333, 81334, 81335, 81336, 81337, 81338, 81339, 81340, 81341, 81342, 81343, 81344, 81345, 81346, 81347, 81348, 81349, 81350, 81351, 81352, 81353, 81355, 81357, 81360, 81361, 81362, 81363, 81364, 81400, 81401, 81402, 81403, 81404, 81405, 81406, 81407, 81408, 81410, 81411, 81412, 81413, 81414, 81415, 81416, 81417, 81419, 81425, 81426, 81427, 81430, 81431, 81432, 81433, 81434, 81435, 81436, 81437, 81438, 81439, 81440, 81442, 81443, 81445, 81448, 81450, 81455, 81457, 81458, 81459, 81460, 81462, 81463, 81464, 81465, 81470, 81471, 81479, 81490, 81493, 81500, 81503, 81504, 81518, 81519, 81520, 81521, 81522, 81523, 81525, 81529, 81535, 81536, 81538, 81540, 81541, 81542, 81546, 81551, 81552, 81554, 81595, 81596, 81599, 82239, 82397, 82542, 82652, 82710, 82715, 82725, 83520, 83698, 83986, 84311, 87328, 87329, 87336, 88356, 89160, 89240

Attachment I – Genetic Testing & Other Pathology Services (continued)

Procedure	CPT/HCPCS
Physician Services	G0452
Proprietary Laboratory Analyses	0026U, 0029U, 0030U, 0031U, 0032U, 0033U, 0129U, 0037U, 0046U, 0049U, 0070U, 0071U, 0072U, 0073U, 0074U, 0075U, 0076U, 0093U, 0094U, 0107U, 0154U, 0155U, 0156U, 0157U, 0158U, 0159U, 0160U, 0161U, 0162U, 0172U, 0173U, 0175U, 0177U, 0212U, 0213U, 0214U, 0215U, 0230U, 0231U, 0232U, 0233U, 0234U, 0235U, 0236U, 0237U, 0238U, 0239U, 0242U, 0245U, 0246U, 0254U, 0265U, 0268U, 0269U, 0270U, 0271U, 0272U, 0273U, 0274U, 0276U, 0277U, 0278U, 0286U, 0287U, 0326U, 0388U, 0396U, 0409U, 0425U, 0426U, 0428U, 0448U, 0454U, 0459U, 0471U, 0473U.

Attachment II – Cosmetic and Reconstructive Services

Procedure	CPT/HCPCS
Abdominoplasty	15830, 15847
Bio-Engineered Skin and Soft Tissue Substitutes /Amniotic Membrane/ Amniotic Fluid	A2011, A2012, Q4100, Q4101, Q4102, Q4105, Q4106, Q4107, Q4108, Q4114, Q4116, Q4122, Q4128, Q4132, Q4133, Q4137, Q4138, Q4139, Q4140, Q4145, Q4148, Q4150, Q4151, Q4153, Q4154, Q4155, Q4156, Q4157, Q4159, Q4160, Q4162, Q4163, Q4168, Q4169, Q4170, Q4171, Q4173, Q4174, Q4175, Q4176, Q4177, Q4178, Q4180, Q4181, Q4183, Q4184, Q4185, Q4186, Q4187, Q4188, Q4189, Q4190, Q4191, Q4192, Q4194, Q4195, Q4197, Q4198, Q4201, Q4204, Q4205, Q4206, Q4208, Q4209, Q4211, Q4212, Q4213, Q4214, Q4215, Q4216, Q4217, Q4218, Q4219, Q4220, Q4221, Q4224, Q4225, Q4226, Q4227, Q4229, Q4230, Q4231, Q4232, Q4233, Q4234, Q4235, Q4237, Q4238, Q4239, Q4240, Q4241, Q4242, Q4245, Q4246, Q4247, Q4248, Q4249, Q4250, Q4254, Q4255, Q4256, Q4257, Q4258, 15777
Blepharoplasty and Repair of Blepharoptosis, including other eyelid procedures	15820, 15821, 15822, 15823,15824, 15826, 67900, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911
Breast Repair and Reconstruction *Except for patients with a diagnosis of breast cancer where prior approval is not required for certain reconstructive procedures.	11920*, 11921*, 11922*, 15769, 15771, 15772, 15773, 15774, 15777, 19316*, 19318*, 19325, 19328, 19330, 19340*, 19342*, 19350*, 19355, 19357*, 19361*, 19364*, ,19367*, 19368*, 19369*, 19370, 19371, 19380*, 19396*, 21601, 21602, 21603, C1789*, L8020*, L8030*, L8031*, L8032*, L8033*, L8039, L8499, L8699, Q4122, S2066*, S2067*, S2068*
Collagen Injections	11950, 11951, 11952, 11954, 11960, L8603, L8605
Cryotherapy for Acne	17340
Dermatologic Application of Photodynamic Therapy	96567, 96573, 96574
Genitalia Procedures (Vaginoplasty, Clitoroplasty, Labiaplasty, Phalloplasty, Scrotoplasty, Vulvectomy, Vulvoplasty)	55175, 55180, 56620, 56625, 56630, 56631, 56632, 56633, 56805, 57335
Laser Treatment	96920, 96921, 96922, 97037
Lateral Canthopexy	21282
Light Therapy for Psoriasis and Vitiligo and Ultraviolet-A Photochemotherapy (PUVA)	96900, 96904, 96910, 96912, 96913
Lipectomy/Panniculectomy	15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15847, 15876, 15877, 15878
Malar Augmentation, prosthetic material	21270
Mastectomy for Gynecomastia	19300
Otoplasty and Reconstruction of external auditory canal	69300, 69310, 69320, 69399
Pectus Excavatum/Pectus Carinatum Repair	21740, 21742, 21743

Attachment II – Cosmetic and Reconstructive Services (continued)

Procedure	CPT/HCPCS
Rhinoplasty/Septorhinoplasty	30120, 30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, 30630
Rhytidectomy	15824, 15825, 15826, 15828, 15829
Tattooing of Skin *Except for patients with a diagnosis of breast cancer where prior approval is not required for certain reconstructive procedures	11920*, 11921*, 11922*
Testicular Prosthesis Insertion	54660

Attachment III – Radiology Services Requiring Prior Approval for the State of Vermont employer group, excluding SOV Total Choice (FVT)

Carelon Medical Benefits Management reviews advanced imaging radiology services for The State of Vermont employer group (excluding SOV Total Choice members with a prefix of FVT). Prior approval requests are submitted through Carelon either by phone (800) 701-0080 or on-line at https://www.providerportal.com.

Please note members with Blue Cross VT (including IBEW), NEHP/ABNE have a separate prior approval list for advanced imaging radiology services, located in Attachment V.

Procedure	CPT/HCPCS
Computed Tomography (CT) Bone Density Study	77078
CT Colonography	74261, 74262, 74263
CT Scans Note: CT guided procedures do not require prior approval.	70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 71250, 71260, 71270, 71271, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72192, 72193, 72194, 73200, 73201, 73202, 73700, 73701, 73702, 74150, 74160, 74170, 74176, 74177, 74178, 75571, 75572, 75573, 77078,
Magnetic Resonance Imaging (MRI) Note: MRI guided procedures do not require prior approval. NOTE: Prior Approval is waived if MRI services are provided by: • VT Open MRI [NPI:1083904114] • NH Open MRI [NPI:1437364965]	70336, 70540, 70542, 70543, 70551, 70552, 70553, 70554, 70555, 71550, 71551, 71552, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72195, 72196, 72197, 73218, 73219, 73220, 73221, 73222, 73223, 73718, 73719, 73720, 73721, 73722, 73723, 74181, 74182, 74183, 74712, 74713, 75557, 75559, 75561, 75563, 75565, 76390, 76391, 77046, 77047, 77048, 77049, 77084, 0648T, 0649T
Positron Emission Tomography (PET) Scans	78459, 78491, 78429, 78430, 78431, 78432, 78433, 78434, 78492, 78608, 78609, 78811, 78812, 78813, 78814, 78815, 78816
Radiotracers	A9515, A9552, A9580, A9586, A9587, A9588, A9591, A9592, A9593, A9594, A9595, A9596, A9597, A9598, A9601, A9602, A9800, Q9982, Q9983
Single-Photon Emission Computed Tomography (SPECT/CT)	78803, 78830, 78831, 78832

Attachment IV – Surgery

Procedure	CPT/HCPCS
Ablation	50593,58674
Bariatric and Gastric Bypass Surgery Blue Cross VT: Some members may not require prior approval but may be limited to services at Blue Distinction Centers. Please contact the customer service team for assistance determining prior approval requirements. IBEW: Members must use Blue Distinction Centers and require prior approval.	43644, 43645, 43770, 43771, 43772, 43773, 43775, 43842, 43843, 43845, 43846, 43847,43848, 43886, 43887, 43888
Bronchoscopy with Placement of Fiducial Markers **See Anesthesia (Monitored) during gastrointestinal endoscopy, bronchoscopy, or interventional pain procedures section above for guidance on related anesthesia services.**	31626
Bulking Agents	51715
Cardiovascular Surgery including Transcatheter Aortic Valve Replacement (TAVR/TAVI) and Ventricular Assist Device (VAD)	33267, 33268, 33269, 33361, 33362, 33363, 33364, 33365, 33366, 33367, 33368, 33369, 33418, 33419, 33990, 33991, 33992, 33993, 93355, C1605
Disc Arthroplasty	C9757, 22856, 22858, 22861, 22864
Endovascular Occlusion of Ovarian and Internal Iliac Vein	36012, 37241
Esophagoscopy/Esophagogastroduodenoscopy **See Anesthesia (Monitored) during gastrointestinal endoscopy, bronchoscopy, or interventional pain procedures section above for guidance on related anesthesia services.**	43201, 43210, 43212, 43257
Facet Joint Denervation	64632, 64640
Interbody/ Interspinous Devices	22840
Lumbar Spinal Fusion	22533, 22558, 22585, 22586, 22612, 22614, 22630, 22632, 22633, 22634, 22840, 63052, 63053
Meniscal Transplantation	29868
Minimally Invasive Treatments for Benign Prostatic Hyperplasia	52441, 52442, 53854, C9739, C9740
Neck (Soft Tissues) and Thorax	21685
Percutaneous Vertebroplasty and Vertebral Augmentation Services	22510, 22511, 22512, 22513, 22514, 22515, 0200T, 0201T, C1062, C7504, C7505, C7507, C7508
Percutaneous transcatheter closure of the left atrial appendage	33340

Radioembolization for Primary and Metastatic Tumors of the Liver	S2095
Sacroiliac Joint Pain Treatment	27279, 27280, 27299, 64451, G0259
Trigger/Tender Point Injection	76940
UPPP/Somnoplasty (palatopharynogoplasty)	42145
Varicose Veins, Venous Insufficiency and Other Vascular Procedures	36465, 36466, 36468, 36470, 36471, 36475, 36476, 36478, 36479, 36482, 36483, 37243, 37500, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766, 37780, 37785, 37799 S2202

Attachment V – Radiology (Advanced Imaging) - Blue Cross VT/ IBEW, NEHP/ABNE

Carelon Medical Benefits Management reviews advanced imaging radiology services for Blue Cross VT/ IBEW, NEHP/ABNE. Prior approval requests are submitted through Carelon either by phone (800) 701-0080 or on-line at https://www.providerportal.com.

Please note members with State of Vermont employer group have a separate prior approval list for advanced imaging radiology services, located in Attachment III.

Imaging Type and Review Notes	**CPT/HCPCS Codes**
Cardiac Blood Pool Imaging	78472, 78473, 78481, 78483, 78494
Computed Tomographic Scan (CT)	70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 71250, 71260, 71270, 71271, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72192, 72193, 72194, 73200, 73201, 73202, 73700, 73701, 73702, 74150, 74160, 74170, 74176, 74177, 74178, 74261, 74262, 74263, 75571, 75572, 75573, 77078
Computed Tomographic Scan (CTA) – Angiography	70496, 70498, 71275, 72191, 73206, 73706, 74174, 74175, 75574, 75635
Coronary Fractional Flow Reserve (FFR)	75580
Magnetic Resonance Angiography (MRA)	70544, 70545, 70546, 70547, 70548, 70549, 71555, 72159, 72198, 73225, 73725, 74185
Magnetic Resonance Imaging (MRI) NOTE: Prior Approval is waived if MRI services are provided by: • VT Open MRI [NPI:1083904114] • NH Open MRI [NPI:1437364965]	70336, 70540, 70542, 70543, 70551, 70552, 70553, 70554, 70555, 71550, 71551, 71552, 72141, 72142, 72156, 72146, 72147, 72157, 72148, 72149, 72158, 72195, 72196, 72197, 73218, 73219, 73220, 73221, 73222, 73223, 73718, 73719, 73720, 73721, 73722, 73723, 74181, 74182, 74183, 76391, 74712, 74713, 75557, 75559, 75561, 75563, 75565, 77046, 77047, 77048, 77049, 77084, 0648T, 0649T
Magnetic Resonance Spectroscopy (MRS)	76390

Attachment V – Radiology (Advanced Imaging) (continued)

Imaging Type and Reviewer	CPT/HCPCS Codes
Myocardial Imaging	78466, 78468, 78469
Positron Emission Tomography (PET)	78459,78491,78492, 78429, 78430, 78431, 78432, 78433, 78434, 78608, 78609
Radiotracers	A9515, A9552, A9580, A9586, A9587, A9588, A9591, A9592, A9583, A9594, A9595, A9596, A9597, A9598, A9601, A9602, A9800, Q9982, Q9983
Single-Photon Emission Computerized Tomography (SPECT)	78803, 78830, 78831, 78832
Single-Photon Emission Computerized Tomography (SPECT) Myocardial Perfusion	78451, 78452, 78453, 78454
Stress Echography (SE)	93350, 93351
Transesophageal Echocardiography (TEE)	93312, 93313, 93314, 93315, 93316, 93317
Transthoracic [Resting] Echocardiography (TTE)	93303, 93304, 93306, 93307, 93308

Other Imaging	78811, 78812, 78813, 78814, 78815, 78816