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

BERLIN HQ
445 INDUSTRIAL LANE
BERLIN, VERMONT 05641

P.O. BOX 186
MONTPELIER
VT 05601-0186

800 247 2583
800 922 8778
802 255 4550

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 BCBSVT List:

- Blue Cross and Blue Shield of Vermont (BCBSVT)
  Note: BCBSVT 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, and radiology utilization management 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 Acuity Connect, 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 February 01, 2022

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Rehabilitation, inpatient

Skilled Nursing Facilities, inpatient

Surgery and Related Services

Transcranial Magnetic Stimulation

Transgender Services

Transplants

Vestibular Evoked Myogenic Potential Testing (VEMP)

Vision Services and Medical Coverage for Ocular Disease

Wearable Cardioverter Defibrillators

Wheelchairs

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)

Procedure or Item	CPT/HCPCS	BCBSVT	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 medical policy for Out-of-Network Services for more information. 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.	•	•	•
Adoptive Immunotherapy including CAR-T and Gene Therapy Drugs	*when benefits apply* 0537T, 0538T, 0539T, 0540T, 0544T	•	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 (ZIO® Patch) See medical policy for Ambulatory Event Monitors for more information.	93241, 93242, 93243, 93244, 93245, 93246, 93247, 93248, 0650T	•	NR	•

Procedure or Item	CPT/HCPCS	BCBSVT	IBEW	SOV
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
Applied Behavior Analysis (ABA) See medical policy for Applied Behavioral Analysis (ABA) for more details. NEHP/ABNE: Prior approval not reviewed.	*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.	S1034, S1035, S1036, S1037	•	NR	•
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	•	•	•
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	•
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	•

Procedure or Item	CPT/HCPCS	BCBSVT	IBEW	SOV
Capsule Endoscopy (wireless) See medical policy for Wireless Capsule Endoscopy for more information.	91110, 91112, 91113, 0651T	•	NR	NR
Category III Codes CPT® Codes including, temporary codes for emerging technologies, services, procedures, and service paradigms	0571T, 0572T, 0573T, 0574T, 0575T, 0576T, 0577T, 0578T, 0579T, 0580T, 0584T, 0585T, 0586T	•	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
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, 69930, L8614, L8615, L8616, L8617, L8618, L8619, L8625, L8627, L8628, L8629, L8690, L8691, L8692, L8693, L8694	•	NR	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	•	NR	•
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	BCBSVT	IBEW	SOV
Dental Services for Accidental Injury, Gross Deformity, Head and Neck Cancers, and Congenital/Genetic Disorders See medical policy for Dental Services for Accidental Injury, Gross Deformity, Head and Neck Cancers, and Congenital/Genetic Disorders for more information. 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: • 7 years of age or younger; • 12 years of age or younger with phobias or a mental illness documented by a licensed physician or mental health professional; and • members with severe disabilities that preclude office-based dental care due to safety consideration (examples include, but are not limited to, severe autism, cerebral palsy, hemorrhagic disorders, and severe congestive heart failure). Note: Even with prior approval, benefits are limited. Certain services may not be covered. Pediatric dental services are provided through CBA Blue, when applicable. Contact the customer service team for more information.	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	BCBSVT	IBEW	SOV
Dental Services, Pediatric See medical policy for Dental Services Pediatric (for Qualified Health Plans) for more information. Pediatric dental services are provided through CBA Blue, when applicable. Contact the customer service team for more information.	*When benefits apply* D0364, D0365, D0366, D0367, D0368, D0391, D0393, D2980, D3355, D3356, D3357, D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, D5226, D5410, D5411, D5421, D5422, D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5710, D5711, D5720, D5721, D5750, D5751, D5760, D5761, D5820, D5821, D5863, D5864, D5865, D5866, D6055, D6081, D6101, D6102, D6103, D6210, D6211, D6212, D6214, D6240, D6251, D6252, D6253, D6241, D6242, D6243, D6545, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6980, D6985, D7290, D7291, D7295, D8010, D8020, D8030, D8040, D8050, D8060, D8070, D8080, D8090, D8210, D8220, D8999, D9110, D9999 Other prior approval requirements may apply when services exceed frequency maximums.	•	NR	NR

Procedure or Item	CPT/HCPCS	BCBSVT	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: • BCBSVT: $500 or more • IBEW: $3,500 or more • SOV (including SOV Total Choice): $250 or more See medical policies on Medical Equipment and Supplies – Durable Medical Equipment (DME) 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 • Home Infusion Therapy • 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, continuous glucose monitoring systems (CGMS) and 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	•	•	•

Procedure or Item	CPT/HCPCS	BCBSVT	IBEW	SOV
Electrical and Ultrasound Stimulation See medical policies for Electrical Bone Growth Stimulation, Electrical Stimulation of the Spine, Gastric Electrical Stimulation, 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, 95970* 95971*, 95972*, 95980, 95981, 95982, A4556, A4557, A4595, C1767, C1778, C1820, C1822, E0720, E0730, E0731, E0745, E0747*, E0748*, E0749*, E0760*, E0766, L8680, L8681, L8682, L8683 L8685, L8686, L8687, L8688, L8689, L8696	●	●	●
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, 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	●
Genetic Testing	See Attachment I	●	NR	●
Home Infusion Therapy See medical policies for Home Infusion Therapy for more information. Note: Infusion drug dispensed may require separate authorization.	All	NR	NR	●

Procedure or Item	CPT/HCPCS	BCBSVT	IBEW	SOV
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	•	NR	•
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, 0058T, J0725, J3355, S0122, S0126, S0128, S4011, S4027, S4037	•	NR	NR
Intensive Outpatient Services (IOP) for mental health and substance use disorder NEHP/ABNE: Prior approval not reviewed.	All (non-emergency, as noted)	•	NR	NR
Intravascular Ultrasound (IVUS)/Optical Coherence Tomography (OCT) See medical policy for Use of Intravascular Ultrasound and Optical Coherence Tomography.	92978, 92979	•	NR	•
Investigational and Experimental Services and Procedures See medical policy for Investigational Services and Procedures for more information.	All	•	NR	•
Ketamine, IV Infusion See medical policy for Ketamine for more information.	J3490	•	NR	NR

Procedure or Item	CPT/HCPCS	BCBSVT	IBEW	SOV
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. 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.	E1399, L0999, L1499, L2006, L2999, L3999, L5999, L7499, L8039, L8499, L8606, L8699	•	NR	•
Nasopharyngoscopy	69705, 69706	•	NR	•
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
Nutritional Counseling See medical policy for Nutritional Counseling for more information. NEHP/ABNE: Prior approval not reviewed.	97802, 97803, 97804, G0270, G0271, S9452, S9470 Exception: No PA required for three or fewer visits, or for the treatment of diabetes regardless of the number of visits.	•	NR	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	•	NR	•

Procedure or Item	CPT/HCPCS	BCBSVT	IBEW	SOV
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 NEHP/ABNE: Prior approval not reviewed.	All (non-emergency, as noted)	•	NR	NR
Percutaneous Radiofrequency Ablation of Liver	47370, 47380, 47382	•	NR	NR
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	•	NR	•
Prescription Drugs BCBSVT/IBEW: Refer to the RX Center for drugs requiring prior approval. SOV: Contact the pharmacy benefits manager for information. NEHP/ABNE: Prior approval not reviewed.	See appropriate lists *For ketamine via IV infusion, see Ketamine section above*	•	•	NR

Procedure or Item	CPT/HCPCS	BCBSVT	IBEW	SOV
Psychological 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 (non-emergency, as noted)	•	NR	NR
Radiation Treatment & High-Dose Electronic Brachytherapy	77424, 77425, 77469, 77520, 77522, 77523, 77525, 0394T, 0395T	•	NR	•
Radiology (Advanced Imaging) BCBSVT/IBEW: See Attachment V for code-specific list with review instructions. SOV: See Attachment III for code-specific list of services. NEHP/ABNE: BCBSVT reviews all prior approval requests for advanced imaging/radiology. Submit requests to the BCBSVT integrated health team directly.	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.	All (non-emergency, as noted)	•	•	•
Rehabilitation, inpatient *Note: These services require a worksheet in addition to the completed prior approval request form.*	All	•	•	•
Skilled Nursing Facilities, inpatient	All	•	•	•
Surgery and Related Services IBEW: Prior approval only required for bariatric surgical procedures. See Attachment IV for additional details.	Refer to Attachment IV	•	•	•
Transcranial Magnetic Stimulation	90867, 90868, 90869	•	NR	•

Procedure or Item	CPT/HCPCS	BCBSVT	IBEW	SOV
Transgender Services See medical policy for Transgender Services for more information.	All Exception: No PA required for orchiectomy, hysterectomy, or salpingo-oophorectomy.	•	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	•
Vision Services and Medical Coverage for Ocular Disease See medical policy for Vision Services for more information.	0671T, 65778, 65780, 68841, C9770, 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, K0108, K0898	•	NR	•

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, 0009M,
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, 81221, 81222, 81223, 81224, 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, 81420, 81425, 81426, 81427, 81430, 81431, 81432, 81433, 81434, 81435, 81436, 81437, 81438, 81439, 81440, 81442, 81443, 81445, 81448, 81450, 81455, 81460, 81465, 81470, 81471, 81479, 81490, 81493, 81500, 81503, 81504, 81507, 81519, 81520, 81521, 81522, 81523, 81525, 81529, 81535, 81536, 81538, 81540, 81541, 81542, 81545, 81546, 81551, 81552, 81554, 81595, 81596, 81599, 82077, 88356, S3584

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

Procedure	CPT/HCPCS
Physician Services	G0452
Proprietary Laboratory Analyses	0029U, 0030U, 0032U, 0033U, 0046U, 0049U, 0056U, 0070U, 0071U, 0072U, 0073U, 0074U, 0075U, 0076U, 0093U, 0094U, 0151U, 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, 0245U, 0246U, 0254U, 0265U, 0268U, 0269U, 0270U, 0271U, 0272U, 0273U, 0274U, 0276U, 0277U, 0278U, 0286U, 0287U

Attachment II – Cosmetic and Reconstructive Services

Procedure	CPT/HCPCS
Abdominoplasty	15830, 15847
Bio-Engineered Skin and Soft Tissue Substitutes /Amniotic Membrane/ Amniotic Fluid	C1849, 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, Q4210, Q4211, Q4212, Q4213, Q4214, Q4215, Q4216, Q4217, Q4218, Q4219, Q4220, Q4221, Q4226, Q4227, Q4229, Q4230, Q4231, Q4232, Q4233, Q4234, Q4235, Q4237, Q4238, Q4239, Q4240, Q4241, Q4242, Q4244, Q4245, Q4246, Q4247, Q4248, Q4249, Q4250, Q4254, Q4255, 15777
Blepharoplasty and Repair of Blepharoptosis, including other eyelid procedures	15820, 15821, 15822, 15823, 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, 19301*, 19302*, 19303*, 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
Cryotherapy for Acne	17340
Dermabrasion	15780, 15781, 15782,15783
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
Lateral Canthopexy	21282
Light Therapy for Psoriasis and Vitiligo and Ultraviolet-A Photochemotherapy (PUVA)	96900, 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
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)

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.	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
Positron Emission Tomography (PET) Scans	78459, 78491, 78429, 78430, 78431, 78432, 78433, 78434, 78492, 78608, 78609, 78811, 78812, 78813, 78814, 78815, 78816
Single-Photon Emission Computed Tomography (SPECT/CT)	78803, 78830, 78831, 78832

Attachment IV – Surgery

Procedure	CPT/HCPCS
Ablation, Cryosurgical	50593
Ablation, Irreversible Electroporation (IRE)	0600T, 0601T
Bariatric and Gastric Bypass Surgery BCBSVT: 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
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
Disc Arthroplasty	C9757, 22856, 22858
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
Percutaneous Vertebroplasty and Vertebral Augmentation Services	22510, 22511, 22512, 22513, 22514, 22515, 0200T, 0201T, C1062
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
UPPP/Somnoplasty (palatopharynogoplasty)	42145
Varicose Veins, Venous Insufficiency and Other Vascular Procedures	36465, 36466, 36468, 36470, 36471, 36473, 36474, 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)

AIM Specialty Health reviews many advanced imaging services for BCBSVT members. However, the BCBSVT Utilization Management team also reviews certain advanced imaging services that AIM Specialty Health does not review. Use the grid below to determine who conducts the review for the specific service in question.

NEHP/ABNE: BCBSVT reviews all prior approval requests for advanced imaging/radiology. Submit requests to the BCBSVT integrated health team directly.

Please note that members of the State of Vermont groups have their own radiology lists for prior approval requirements. Please see the applicable lists for those members.

Imaging Type and Review Notes	**CPT/HCPCS Codes**
Cardiac Blood Pool Imaging The ordering physician must submit the request through AIM Specialty Health by phone (800) 701-0080 or at aimspecialtyhealth.com	78472, 78473, 78481, 78483, 78494
Computed Tomographic Scan (CT) The ordering physician must submit the request through AIM Specialty Health by phone (800) 701-0080 or at aimspecialtyhealth.com	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 The ordering physician must submit the request through AIM Specialty Health by phone (800) 701-0080 or at aimspecialtyhealth.com	70496, 70498, 71275, 72191, 73206, 73706, 74174, 74175, 75574, 75635
Coronary Fractional Flow Reserve (FFR) The ordering physician must submit the request through AIM Specialty Health by phone (800) 701-0080 or at aimspecialtyhealth.com	0501T, 0502T, 0503T, 0504T
Magnetic Resonance Angiography (MRA) The ordering physician must submit the request through AIM Specialty Health by phone (800) 701-0080 or at aimspecialtyhealth.com	70544, 70545, 70546, 70547, 70548, 70549, 71555, 72159, 72198, 73225, 73725, 74185
Magnetic Resonance Imaging (MRI) The ordering physician must submit the request through AIM Specialty Health by phone (800) 701-0080 or at aimspecialtyhealth.com	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
Magnetic Resonance Spectroscopy (MRS) The ordering physician must submit the request through AIM Specialty Health by phone (800) 701-0080 or at aimspecialtyhealth.com	76390

Attachment V – Radiology (Advanced Imaging) (continued)

Imaging Type and Reviewer	CPT/HCPCS Codes
Myocardial Imaging The ordering physician must submit the request through AIM Specialty Health by phone (800) 701-0080 or at aimspecialtyhealth.com	78466, 78468, 78469
Positron Emission Tomography (PET) The ordering physician must submit the request through AIM Specialty Health by phone (800) 701-0080 or at aimspecialtyhealth.com	78459,78491,78492, 78429, 78430, 78431, 78432, 78433, 78434, 78608, 78609
Single-Photon Emission Computerized Tomography (SPECT) Submit the request to the BCBSVT Utilization Management team. See www.bcbsvt.com/priorapproval for instructions. See medical policy for Single Photon Emission Computed Tomography (SPECT/CT) Imaging for the Evaluation of Spine for more information.	78803, 78830, 78831, 78832
Single-Photon Emission Computerized Tomography (SPECT) Myocardial Perfusion The ordering physician must submit the request through AIM Specialty Health by phone (800) 701-0080 or at aimspecialtyhealth.com	78451, 78452, 78453, 78454
Transesophageal Echocardiography (TEE) The ordering physician must submit the request through AIM Specialty Health by phone (800) 701-0080 or at aimspecialtyhealth.com	93312, 93313, 93314, 93315, 93316, 93317
Transthoracic [Resting] Echocardiography (TTE) The ordering physician must submit the request through AIM Specialty Health by phone (800) 701-0080 or at aimspecialtyhealth.com	93303, 93304, 93306, 93307, 93308
Other Imaging The ordering physician must submit the request through AIM Specialty Health by phone (800) 701-0080 or at aimspecialtyhealth.com	78811, 78812, 78813, 78814, 78815, 78816