



Policy: Prior Authorization Code List	Policy Number: UM-22
Department: Utilization Management	Original Issue Date: 12/02/2021
Approver: UM Committee	<input checked="" type="checkbox"/> Date Last Reviewed / Revised [06/11/2025] OR
Dependencies: None	<input type="checkbox"/> Date Last Reviewed / No Revisions [mm/dd/yyyy]
Date Approved: 06/27/2025	OR
	<input type="checkbox"/> New Policy / N/A
	Effective Date: 07/01/2025

PURPOSE

This list provides prior authorization guidance for providers who participate in the Mass Advantage Medicare Advantage HMO Basic, HMO Plus, PPO Premiere, and PPO Extra plans.

- To request prior authorization, please complete and submit the Inpatient Authorization Request or Outpatient Authorization Request Forms and fax to 888-656-7783. You can also contact our Utilization Management team, delegated to Prime Therapeutics Management LLC, by phone at 866-312-8467. Authorization forms can be found on our website: [Provider Forms and Resources - Mass Advantage](#).
- Member eligibility and benefit coverage can be verified by contacting Provider Services or electronically on our secure provider website. You can find contact information for Provider Services [here](#).
- Obtaining a prior authorization is not a guarantee of payment. In addition, while some providers may not be directly responsible for obtaining prior authorization, in some instances as a condition for payment, you may need to make sure that prior authorization has been obtained.
- As a Medicare Advantage plan, Mass Advantage is required to make coverage determinations for services through the Centers for Medicare and Medicaid Services (CMS) National Coverage Determination (NCD) policies and Medicare Administrative Contractors (MACs) Local Coverage Determination (LCD) policies. When cited by CMS, NCDs, LCDs, and Original Medicare guidance in Medicare manuals are utilized for decision making. When CMS citations are unavailable, we will follow a Hierarchy of Evidence for Medical Necessity Decision, including, but not limited to, MCG guidelines.
- New CPT/HCPCS codes approved released quarterly by CMS that are similar to existing services listed below will automatically require prior authorization prior to policy updates.

PROCEDURES

Inpatient Hospitalizations for Acute, Psychiatric, Rehabilitation, and Skilled Nursing Facility Admissions and Partial Hospitalization Program Admissions	
<u>Services</u>	<u>Requirement</u>
<i>Inpatient Acute and Psychiatric Hospitalizations</i>	<ul style="list-style-type: none"> All elective inpatient admissions require prior authorization. Emergent/Urgent admissions require notification of admission within 24 hours of admission.
<i>Long Term Acute Care Hospitalization (LTACH)</i>	All admissions require prior authorization.
<i>Partial Hospitalization Program (PHP)</i>	All admissions require prior authorization.
<i>Skilled Nursing Facility (SNF)</i>	All admissions require prior authorization.
<i>Inpatient Rehabilitation Facility (IRF)</i>	All admissions require prior authorization.
Air Ambulance Services	
<u>Services</u>	<u>Requirement</u>
<i>Air Ambulance (Non-Emergent)</i>	All non-emergent air ambulance services require prior authorization.
Transplants	
<u>Services</u>	<u>Requirements</u>
<i>Transplant Evaluation</i>	99205



<i>Transplant Inpatient Hospitalization</i>	All inpatient transplant admissions require prior authorization.
<i>CAR T-Cell Therapy</i>	38225, 38226, 38227, 38228 Q2041, Q2042, Q2053, Q2054, Q2055, Q2056, Q2057, Q2058
Out of Network Services	
<u>Services</u>	<u>Requirements</u>
<i>HMO Plans (Basic & Plus)</i>	All non-emergent out-of-network services require prior authorization.
<i>PPO Plans (Premiere & Extra)</i>	Advance notification is recommended for members in the following circumstances: <ul style="list-style-type: none"> A network physician or health care professional directs a member to an out-of-network facility, physician, or other health care professional and the member's benefit plan includes benefits for out-of-network services – but there are no available in-network healthcare professionals for the type of specialty services needed. A network physician or health care professional requests in-network cost sharing or benefit level because there aren't in-network health care professionals for the type of specialty services needed.
Outpatient Services	
<u>Services</u>	<u>Requirements</u>
<i>Sleep Apnea Procedures</i>	21685 41512, 41530, 41599, 42145 64582, 64583, 64584 95806, 95807, 95808, 95810, 95811
<i>Cosmetic and Reconstructive Procedures</i>	11960, 11971, 15780, 15781, 15782, 15783, 15788, 15789, 15792, 15793, 15820, 15821, 15822, 15823, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15847, 15876, 15877, 15878, 15879, 17106, 17107, 17108, 17999, 19316, 19318, 19325, 21010, 21050, 21060, 21073, 21089, 21116, 21120, 21121, 21122, 21123, 21141, 21198, 21206, 21230, 21240, 21242, 21243, 21244, 21248, 21255, 21260, 21267, 21299, 21480, 21485, 21490, 28296, 28297, 28298, 28299, 28306, 28308, 28310, 29800, 29804, 55970, 55980 67900, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911, 67914, 67915, 67916, 67917, 67921, 67922, 67923, 67924, 67950 96567, 96900, 96910, 96920, 96921
<i>Implantable Cardiac Defibrillators</i>	33270
<i>Spinal Procedures</i>	20999, 22100, 22101, 22102, 22103, 22220, 22224, 22510, 22511, 22512, 22513, 22514, 22515, 22526, 22527, 22551, 22552, 22554, 22585, 22586, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22633, 22634, 22840, 22842, 22845, 22850, 22852, 22853, 22854, 22855, 22856, 22858, 22859, 22867, 22868, 22869, 22870, 22999, 27279 62287, 62380, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048,



	63052, 63053, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63265, 63266, 63267, 63268, 0095T, 0098T, 0164T, 0165T, 0202T, 0219T, 0220T, 0221T, 0222T, 0274T, 0275T, 0656T, 0657T, C1821, C2614, C9757
<i>Vein Procedures</i>	36465, 36466, 36468, 36470, 36471, 36473, 36474, 36475, 36476, 36478, 36479, 36482, 36483, 37500, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766, 37780, 37785, 0524T
<i>Bariatric Surgery/Gastric Restrictive Procedures</i>	43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43775, 43845, 43846, 43847, 43838, 43886, 43887, 43888
<i>Urologic Surgery</i>	0935T, 0941T, 0942T, 0943T, 51721, 55881, 55882
<i>Hysterectomy</i>	58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554
<i>Neurostimulators</i>	0908T, 0909T, 63661, 63662, 63663, 63664, A4593, A4594
<i>Other Implanted Stimulators</i>	61880, 64553, 64561, 64569, 64570, 64575, 64581, 64585, 64595, 64999, E0736
<i>Other Stimulation Techniques</i>	0906T, 0907T
<i>Bone Growth Stimulators</i>	E0747, E0748, E0749, E0760
<i>Orthopedic Implants</i>	0946T
<i>Cochlear Implants</i>	69714, 69930, 69949
Outpatient Diagnostic Procedures and Tests	
<u>Services</u>	<u>Requirements</u>
<i>Genetic Testing</i>	All services require prior authorization.
<i>Molecular Pathology</i>	All services require prior authorization.
<i>Heart Catheterization</i>	93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93462, 93463, 93464
<i>CTA Coronary Arteries</i>	75574
<i>Cardiac Resynchronization Therapy</i>	33221, 33224, 33225, 33231
<i>Percutaneous Transluminal Angiography (PTA)</i>	37220, 37221, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231
Medicare Part B Drugs	
<u>Services</u>	<u>Requirements</u>
<i>Part B Drugs</i>	J0129, J0174, J0175, J0177, J0178, J0185, J0585, J0586, J0587, J0588, J0589, J0596, J0597, J0598, J0881, J0885, J0897, J1303, J1306, J1326, J1453, J1459, J1561, J1569, J1602, J1745, J1952, J2350, J2353, J2357, J2469, J2506, J2777, J2778, J2781, J3111, J3247, J3262, J3357, J3358, J3380, J3489, J3490, J3590, J7171, J7172, J7356, J9022, J9024, J9041, J9054, J9144, J9145 (IV), J9173, J9174, J9217, J9228, J9264, J9271, J9276, J9289, J9299, J9305, J9312, J9332, J9355, J9382, Q5098, Q5099, Q5100, Q5103, Q5106, Q5107, Q5108, Q5111, Q5112, Q5113, Q5114, Q5115, Q5116, Q5117, Q5118, Q5119, Q5128, Q5153
Durable Medical Equipment	
<u>Services</u>	<u>Requirements</u>



<i>Durable Medical Equipment</i>	Requires authorization for any billed purchase or rental with a Medicare allowable amount of \$1000 or greater.
Prosthetics/Orthotics	
<u>Services</u>	<u>Requirements</u>
<i>Prosthetics</i>	Requires authorization for any billed purchase or rental with a Medicare allowable amount of \$1000 or greater.
<i>Orthotics</i>	Requires authorization for any billed purchase or rental with a Medicare allowable amount of \$1000 or greater.

VERSION AND REVIEW HISTORY

Version #	Action (Original Issue, Reviewed, Revised)	Description of Changes	Business Lead Name/Title	Approving Committee Or Business Lead Area Approver	Committee or Business Lead Approval Date
v1	Original Issue	Policy origination	MWhitley/Executive Director of Health Plan Operations	UM Committee	10/01/2023
v2	Revised	Revision, codes added or removed after quarterly review.	MHeath/UM Manager	UM Committee	04/01/2024
v3	Revised	Revision, codes added or removed after quarterly review.	MHeath/UM Manager	UM Committee	07/01/2024
v4	Revised	Revision, codes added or removed after quarterly review.	MHeath/Director, Utilization Management	UM Committee	09/25/2024
v5	Revised	Revision, codes added or removed after quarterly review.	MHeath/Director, Utilization Management	UM Committee	12/31/2024
v6	Revised	Revision, codes added or removed after quarterly review.	MHeath/Director, Utilization Management	UM Committee	04/04/2025
v7	Revised	Revision, codes added or removed after quarterly review.	MHeath/Director, Utilization Management	UM Committee	06/27/2025