December 19, 2023

Prior Authorization (PA) Program for Certain Hospital Outpatient Department (OPD) Services

Operational Guide

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Purpose

The CY 2020 OPPS/ASC Final Rule (CMS -1717-FC) established a nationwide PA process and requirements for certain hospital OPD services. CMS added additional services to the process through the CY 2021 OPPS/ASC Final Rule (CMS-1736-FC) and the CY 2023 OPPS/ASC Final Rule (CMS-1772-FC). The PA program for certain hospital OPD services ensures that Medicare beneficiaries continue to receive medically necessary care while protecting the Medicare Trust Funds from unnecessary increases in the volume of covered services and improper payments. The prior authorization process does not alter existing medical necessity documentation requirements. The purpose of this Operational Guide is to interpret and clarify the review process for the hospital OPD when rendering certain OPD services for Medicare beneficiaries. This guide will advise hospital OPD providers on the process of submitting documents in support of the final claim.

1- Hospital Outpatient Department (OPD) Services Benefits

For any service or item to be covered by Medicare, it must:

- Be eligible for a defined Medicare benefit category,
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
- Meet all other applicable Medicare statutory and regulatory requirements.

1.1 -Medicare statutory and regulatory requirements

Social Security Act (Title XVIII) Standard References:

- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.
- Title XVIII of Social Security Act, Section 1862(a)(10). No payment may be made under part A or part B for any expenses incurred for items or services where such expenses are for cosmetic surgery or are incurred in connection with, except as required for the prompt repair of accidental injury or improvement of the functioning of a malformed body member.
- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.
- Title XVIII of the Social Security Act, Section 1833(t)(2)(F) states that a method shall be developed for controlling unnecessary increases in the volume of covered OPD services.

Federal Register References:

- 42 CFR 419.8 *et seq* provides the regulatory guidance for this program, which is further explained in this operational guide.
- 42 CFR 411.15(h) Particular services excluded from coverage. Cosmetic surgery and related services.

In order to be covered under Medicare, a service shall be reasonable and necessary. A service to be considered reasonable and necessary when the service is:

- Safe and effective.
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, that meet the requirements of the Clinical Trials NCD are considered reasonable and necessary).
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.

- Furnished in a setting appropriate to the patient's medical needs and condition.
- Ordered and furnished by qualified personnel.
- One that meets, but does not exceed, the patient's medical needs.
- At least as beneficial as an existing and available medically appropriate alternative.

2- Program Overview

This nationwide program will include the hospital OPDs that provide certain OPD services and are enrolled in the Medicare FFS program. The term requester will be used throughout this document to describe the person or entity that submits the prior authorization request (PAR), documentation, and /or claims. The providers will be required to obtain PA before the services are provided to Medicare beneficiaries and before the provider submits claims for payment under Medicare for these services.

The hospital OPD provider will submit the PARs to their local Medicare Administrative Contractor (MAC) jurisdiction. The MAC will review the information submitted and issue the decision (affirmative or non-affirmative) to the provider.

The provider may submit a request for an expedited review of a PAR if delays in receipt of a PA decision could jeopardize the life or health of the beneficiary.

The MAC will deny a claim for a service that requires a PA if the provider has not received a provisional affirmation of coverage unless the provider is exempt. The Centers for Medicare and Medicaid Services (CMS) may elect to exempt a provider from PA upon a provider's demonstration of compliance with Medicare coverage, coding, and payment rules and that this exemption would remain in effect until CMS elects to withdraw the exemption.

The provider may resubmit a PAR with additional supporting information, upon receipt of a non-affirmation, as many times as necessary to achieve an affirmation decision.

Inquiries Regarding the Program:
Hospital OPD providers who have questions about the program review process should contact their local MAC jurisdiction.

Appendix A includes the specific Healthcare Common Procedure Coding System (HCPCS) codes that are included in the OPD PA program.
Note: Codes in Appendix A may be subject to change.

2.1- OPD Services That Require Prior Authorization

CMS added Facet Joint Interventions to the nationwide prior authorization process for hospital OPD services. OPD providers can start submitting PARs on June 15, 2023, for dates of service on or after July 1, 2023. This service category will be in addition to the existing list of services requiring prior authorization, which are blepharoplasty, botulinum toxin injection, rhinoplasty,

panniculectomy, vein ablation, implanted neurostimulators, and cervical fusion with disc removal.

The addition of new services to the Prior Authorization program does not change Medicare benefit or coverage requirements, nor does it create new documentation requirements. The documentation required to be included with a prior authorization request is information that hospital OPDs are regularly required to maintain for Medicare payments.

3 – Prior Authorization Request (PAR)

The PAR must be submitted before the service is provided to the beneficiary and before the claim is submitted for processing. The PAR will not be accepted after the service has been completed. The PAR must include all documentation necessary to show that the service meets applicable Medicare coverage, coding, and payment rules.

3.1-General PAR Documentation

Requesters must include the following data elements in all PARs to avoid potential delays in processing. Your MAC may request additional, optional elements for submission of the PAR.

Initial Submission Documentation:

Beneficiary Information (as written on their Medicare card)
- Beneficiary Name
- Beneficiary Medicare Number (also known as the MBI)
- Beneficiary Date of Birth

Hospital OPD Information
- Name of facility
- PTAN/CCN
- Facility Address
- Facility National Provider Identifier (NPI)

Physician/Practitioner Information
- Physician/Practitioner's Name
- Physician/Practitioner's National Provider Identifier (NPI)
- Physician/Practitioner PTAN
- Physician/Practitioner's Address
- Physician/Practitioner's Fax Number (optional)

Requestor Information
- Requestor Name
- Requestor Phone Number
- Requestor Email Address
- Requestor Fax Number (refer to your MAC jurisdiction)

Other Information
- HCPCS Code(s)
- Diagnosis Code(s)
- Type of Bill
- Units of Service
- Indicate if the request is an initial or subsequent review
- Indicate if the request is expedited and the reason why

Resubmission(s) documentation:

In addition to the required PAR documentation in the Initial Submission section, the resubmission of the PAR should contain an exact match of the beneficiary's first name, last name, date of birth to the previous submission, and the UTN associated with the previous submission.

3.1.1–Sending a PAR

Requesters have the following options for submitting PARs to the A/B MACs:
1) mail,
2) fax,
3) electronic submission of medical documentation (esMD), content type 8.5*, or
4) CMS- approved electronic portal (A/B MAC specific).

* For more information about submissions through esMD, see www.cms.gov/esMD or contact your A/B MAC.

MACs Contact Information:

J5
WPS GHA
Mailing Address:
WPS GHA
PO Box 7953
Madison, WI 53707-7953
Fax #: 608.327.8516
Website: wpsgha.com
esMD: indicate document/ content type 8.5

J8
WPS GHA
Mailing Address:
WPS GHA
PO Box 7954

Madison, WI 53707-7954
Fax #: 608.327.8517
Website: wpsgha.com
esMD: indicate document/ content type 8.5

J15
CGS
Mailing Address:
CGS Administrators, LLC
J15 Part A Prior Authorization Requests
PO Box 20203
Nashville, TN 37202
FedEx/UPS/Certified Mail (Physical Address):
CGS Administrators, LLC
J15 Part A Prior Authorization Requests
26 Century Blvd., Suite ST610
Nashville, TN 37214-3685
Fax#: 615.782.4486
Customer Service #: 1.866.590.6703
Website: cgsmedicare.com
esMD: indicate document/content type "8.5"

JK
National Government Services (NGS)
Mailing Address:
National Government Services
PO BOX 7108
Indianapolis, IN 46207-7108
Fax#: 317.841.4530
Website: ngsmedicare.com
esMD: indicate document/ content type 8.5

J6
National Government Services (NGS)
Mailing Address:
National Government Services
PO BOX 7108
Indianapolis, IN 46207-7108
Fax#: 317.841.4528
Website: ngsmedicare.com
esMD: indicate document/ content type 8.5

JE

Noridian Healthcare Solutions LLC
Mailing Address:
PO Box 6782
Fargo, ND 58103
Customer Service: 855.609.9960
Fax: 701-277-2903
Website: med.noridianmedicare.com/web/jea
esMD: indicate document/content type "8.5"

JF
Noridian Healthcare Solutions LLC
Mailing Address:
PO Box 6722
Fargo, ND 58103
Customer Service: 877.908.8431
Fax: 701-277-2903
Website: med.noridianmedicare.com/web/jfa
esMD: indicate document/content type "8.5"

JJ
Palmetto GBA
Mailing Address:
Palmetto GBA
Part A – Prior Authorization
PO BOX 100212
Columbia, SC 29202-3212
Fax #: 803.462.7313
Phone Number: 877.567.7271
Website: palmettogba.com/JJA
esMD: indicate document/content type "8.5"

JM
Palmetto GBA
Mailing Address:
Palmetto GBA
Part A – Prior Authorization
PO BOX 100212
Columbia, SC 29202-3212
Fax #: 803.462.7313
Phone Number: 855.696.0705
Website: palmettogba.com/JMA
esMD: indicate document/content type "8.5"

JL
Novitas Solutions
Mailing Address (including the P.O. Box):
Novitas Solutions
JL Prior Authorization Requests
PO BOX 3702
Mechanicsburg, PA 17055
Fax#: 1.833.200.9268
Phone #: 855.340.5975 (Prior Auth Customer Service)
Website: novitas-solutions.com/
esMD: indicate document/content type "8.5"

JH
Novitas Solutions
Mailing Address (including the P.O. Box):
Novitas Solutions
JH Prior Authorization Requests
PO BOX 3702
Mechanicsburg, PA 17055
Fax#: 1.833.200.9268
Phone #: 855.340.5975 (Prior Auth Customer Service)
Website: novitas-solutions.com/
esMD: indicate document/content type "8.5"

JN
First Coast
Mailing Address (including the P.O. Box):
First Coast Services Options, Inc.
JN Prior Authorization
PO Box 3033
Mechanicsburg, PA 17055-1804
Fax#: 1.855.815.3065
Phone # 1.855.340.5975
Website: fcso.com/
esMD: indicate document/content type "8.5"

4- Review of the PAR

The MAC will review the information submitted, and the decision (affirmative or non-affirmative) will be issued to the provider. A provisional affirmation will be issued to the provider if it is decided that applicable Medicare coverage, coding, and payment rules are met. A non-affirmation will be issued to the provider if it is decided that applicable Medicare coverage, coding, and payment rules are not met. A unique tracking number (UTN) will be assigned to each PAR. When the PAR results in a non-affirmative decision, the MAC will provide detailed information about all missing and/or non-compliant information that resulted in the non-affirmative decision.

4.1- Review Decisions and Timeframes

The timeframes for conducting PA of certain hospital OPD services will be dependent upon the service(s) selected and documentation submitted for PAR. There are 3 types of review timeframes:

- **Initial Submission**—the first PAR sent to the contractor for review and decision. The MAC will complete its review of medical records and send an initial decision letter that is either postmarked or faxed within **10 business days** following the receipt of the initial request.
- **Resubmission**—any subsequent resubmissions to correct an error or omission identified during a PA decision. A resubmitted PAR is a request submitted with additional/updated documentation after the initial PAR was non-affirmed. The MAC will postmark or fax notification of the decision of these resubmitted requests to the provider or beneficiary (if specifically requested by the beneficiary) within **10 business days** of receipt of the resubmission request.
- **Expedited**—a PA decision that is performed on an accelerated timeframe based on the MAC determination that delays in review and response could jeopardize the life or health of the beneficiary. If the MAC substantiates the need for an expedited decision, the MAC will make reasonable efforts to communicate a decision within **2 business days** of receipt of the expedited request.

4.1.1- Validation Period for Prior Authorization Decisions

PAR decisions and UTNs for these services are valid for 120 days. The decision date shall be counted as the first day of the 120 days. For example: if the PAR is affirmed on January 1, 2021, the PAR will be valid for dates of service through April 30, 2021. Otherwise, the provider will need to submit a new PAR.

4.1.2 –Resubmission of PAR

The provider should review the detailed decision letter that was provided. A provider may resubmit a PAR an unlimited number of times upon receipt of a non-affirmative decision. The UTN will be assigned with each PA resubmission request.

4.1.3- Rejected PAR

A prior authorization request is rejected when the MAC is unable to process the request due to incomplete or invalid information. The MAC will notify the submitter that their request was rejected and the reason why. Rejected prior authorization requests are not reviewed for medical necessity and are not considered non-affirmations.

When a prior authorization request is rejected, the submitter should review the reason listed in the rejection letter. The submitter may then correct the error and submit the request again using the same submission procedures. When sending the corrections, all original documentation must also be included. If the rejected request was an initial request, the subsequent request should be marked as an initial request.

The following chart includes common rejection reasons and corrective actions:

Rejection Reason	Additional Explanation	OPD's Corrective Action
The request was submitted to the incorrect MAC.	MAC is typically based where the OPD is located.	Submit the request to the correct MAC responsible for processing requests for the state where the OPD is located.
The beneficiary has a Medicare Advantage Plan or Medicaid.	This program applies to Medicare Fee-for-Service beneficiaries.	Contact the individual Medicare Advantage or Medicaid Plan for information on their prior authorization requirements.
The request contains an invalid/missing/deceased Medicare Beneficiary Identifier (MBI), or beneficiary name.	Providers must include certain data elements in a prior authorization request to be processed.	Submit a new request with the corrected information.
The beneficiary already has an affirmed prior authorization on file for the same service(s).	Each UTN is valid for 120 days. Each procedure requires a new prior authorization request regardless of whether the next service falls within 120 days.	Adjust the information on your prior authorization request and submit the request again. Note: If a PAR is for an additional procedure and date of service is within 120 days, please indicate this on the PAR.
Invalid or missing OPD billing information (PTAN, NPI, TOB code).	Only hospital outpatient department services require prior authorization as part of this program. Other facility/provider types, such as physician's offices, critical access	Verify the hospital outpatient department required information and resubmit the prior authorization request.

	hospitals, or ambulatory surgery centers that submit claims other than type of bill 13X, are not required to submit prior authorization requests.	
The PAR for permanent neurostimulator was submitted, but there is an affirmed PAR on file for a trial procedure for the same OPD and physician.	Providers who plan to perform both the trial and permanent implantation procedures using CPT 63650 at the same hospital OPD are only required to submit a PAR for the trial procedure.	To avoid a claim denial, place the Unique Tracking Number (UTN) received for the trial procedure on the claim submitted for the permanent implantation procedure.
The PAR was submitted from an exempt provider.	Exempt providers do not need to submit prior authorization requests.	Render the service and follow your standard billing process.
The PAR was missing a Botulinum toxin administration or drug code.	PAR for Botulinum toxin services must contain both an administration code (64612 or 64615) and a drug code (J0585, J0586, J0587, or J0588)	Verify HCPCS code pairs and resubmit if the procedure codes are 64612 or 64615 and the drug codes are J0585, J0586, J0587, or J0588.
The PAR was submitted with no clinical documentation.	PAR must include medical record documentation to demonstrate compliance with Medicare coverage, coding, and payment rules.	Submit a new request with medical record documentation for review.

4.2- Expedited Review of a PAR

The requester can submit an expedited review of the PAR if it is determined that a delay could seriously jeopardize the beneficiary's life, health, or ability to regain maximum function. The requester will be notified regarding the acceptance of the PAR for expedited review or if it will convert the request to the standard PA review process. The affirmative or non-affirmative decision will be rendered within the CMS-prescribed expedited review timeframe of 2 business days for requests that are deemed valid for expedited review and provide the decision to the provider via telephone, fax, electronic portal, or other "real-time" communication within the requisite timeframe.

To prevent the claim from denying upon submission, the provider should ***hold their claim and not submit it*** until such time as the UTN is provided. The MAC will follow the normal process to obtain a UTN from CMS shared systems.

A provider may resubmit a request for expedited review.

4.3- Decision Letter(s)

The MAC will send decision letters with the UTN to the requester using the method the PAR was received postmarked within the timeframes described in Section 4.1 of this guide. The MAC will have the option to send a copy of the decision to the requester via fax if a valid fax number was provided, even if the submission was sent via mail. The requester(s) will be notified to hold their claim and not submit it until the UTN is received (in order to avoid a claims payment denial) if the MAC exercises the option to send the PA decision without the UTN.

While the PA process is applicable to hospital OPDs, as specified in CMS-1717-FC, CMS allows the PAR to be sent by the physician/practitioner on behalf of the hospital OPD. Physicians/practitioners who submit the PAR on behalf of the OPD should include their contact information on the PAR cover sheet, in addition to the hospital OPD's contact information. If the physician/ practitioner is not the requester and would like to obtain a copy of the decision letter, they should contact the hospital OPD.

Decision letters sent via electronic submission of medical documentation (esMD) are not available at this time.

A copy of the decision letter will be sent to the beneficiary as well.

5- Exemption(s)

The CMS may elect to exempt a hospital OPD provider from PA upon a provider's demonstration of compliance with Medicare coverage, coding, and payment rules. This exemption would remain in effect until CMS elects to withdraw the exemption. CMS or its contractors would exempt providers that submitted at least 10 requests and achieve a PA provisional affirmation threshold of at least 90 percent during an annual assessment. By achieving this percentage of provisional affirmations, the provider would be demonstrating an understanding of the requirements for submitting accurate claims. Notice of an exemption or withdraw of an exemption will be provided at least 60 days prior to the effective date.

5.1- Exemption Timeline Example

Hospital outpatient departments can expect the following process:

January 1, 2023:

- The exemption cycle begins for providers who met the 90% or greater compliance rate threshold. Exempt providers should not submit PARs.
- PARs received during an exemption period for exempt providers will be rejected.
- Providers who did not meet the compliance rate threshold should continue submitting PARs as usual.

August 1, 2023:

- Exempt providers will receive a postpayment Additional Document Request (ADR) for a 10-claim sample from the period such providers were exempt to determine continued compliance. Providers must have at least 10 claims submitted and paid by June 30 in order to be considered for the exemption. If the exempt providers have less than 10 claims submitted, their exemption status will be withdrawn.
- Providers have 45 days to submit documentation, and MACs will complete their review within 45 days of receipt of the requested documentation.
- Providers who submit additional documentation after the initial 45-day response timeframe will not have their compliance rate changed if the MAC has already finalized their compliance rate and sent a notification to the provider. The MAC will still review late documentation, issue a review determination, and make a claim adjustment, if necessary. Claim denials are subject to the normal appeals process; however, overturned appeals will not change the provider's exemption status.

October 1, 2023- October 31, 2023:

- MACs calculate the affirmation rate of initial PARs for non-exempt providers for all eight service categories combined, and notify those providers with an affirmation rate of 90% or greater.

October 1, 2023- November 30, 2023:

- Hospital OPDs have the option to opt out of the exemption process and continue submitting PARs. Hospital OPDs that choose to opt out of this exemption process must submit an opt-out request to their MAC no later than November 30. Late submissions will be rejected.

November 2, 2023:

- On or after November 2, 2023, providers will receive a Notice of Withdrawal of Exemption if they receive less than a 90% claim approval rate during their exemption cycle.
- Providers who *continue* to demonstrate a 90% or greater claim approval rate based upon the 10-claim review will receive a Notice of Continued Exemption and do not need to submit PARs.

December 18, 2023:

- Providers who did not meet the 90% claim approval rate will no longer be exempt and may start submitting PARs in advance of the January 1 review cycle.

January 1, 2024:

- The exemption cycle begins for providers who met the compliance rate threshold. Exempt providers should not submit PARs.
- PARs received during an exemption period for exempt providers will be rejected.
- Providers who are not exempt must have an associated PAR for any claim submitted on or after this date.

For providers who are not exempt, CMS will continue assessing a provider's compliance through their PAR affirmation rates starting January of each year. For exempt providers, CMS will continue to evaluate their claim approval rate through ADRs sent on August 1 of each year.

6- Program Specifics

6.1 – Implementation of Prior Authorization

The MACs began accepting PARs for hospital OPD services requiring PA on June 17, 2020 and rendered on or after July 1, 2020.

6.2 – Required Documentation

For detailed documentation requirements, the hospital OPD providers should refer to their MAC jurisdiction's Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs), where applicable. To meet coverage criteria, the patient's medical record must contain documentation that fully supports the medical necessity for services[1].

The following hospital OPD services require PA:

(i) Blepharoplasty

(ii) Botulinum toxin injections

(iii) Panniculectomy

(iv) Rhinoplasty

(v) Vein ablation

6.2.1- Blepharoplasty, Blepharoptosis Repair, and Brow Ptosis Repair

General Documentation Requirements for Blepharoplasty, Blepharoptosis Repair, and Brow Ptosis Repair:

- Documented subjective patient complaints which justify functional surgery (vision obstruction, unable to do daily tasks, etc.);
- Documented excessive upper/ lower lid skin;
- Signed clinical notes support a decrease in peripheral vision and/or upper field vision causing the functional deficit (when applicable);
- Signed physician's or non-physician practitioner's documentation of functional impairment and recommendations;
- Supporting pre-op photos (when applicable);
- Visual field studies/exams (when applicable).

6.2.2 - Botulinum Toxin Injections

PA is only required when one of the required Botulinum Toxin codes (J0585, J0586, J0587, or J0588) is used **in conjunction with** one of the required CPT injection codes (64612, injection of chemical for destruction of nerve muscles on one side of face, or 64615, injection of chemical for destruction of facial and neck nerve muscles on both sides of face). Use of these Botulinum Toxin codes in conjunction/paired with procedure codes other than 64612 or 64615 will not require PA under this program.

[1] The MACs will review all PARs in accordance with the policy in place at the time of the anticipated date of service, including any waivers, flexibilities, and/or revised guidance issued as a result of the COVID-19 Public Health Emergency.

General Documentation Requirements for Botulinum Toxin Injections:

- A covered diagnosis;
- Dosage and frequency of planned injections;
- Specific site(s) injected (refer to your MAC's LCD/LCA);
- Documentation to support the medical necessity when electromyography procedures performed in conjunction with botulinum toxin type A injections to determine the proper injection site(s) (when applicable);
- To support continuous treatment, the documentation should include the clinical effectiveness of two consecutive treatments that preceded the anticipated procedure (refer to your MAC's LCD/LCA);
- Documentation of the management of a chronic migraine diagnosis. A medical record must include a history of migraine and experiencing frequent headaches on most days of the month;
- Documentation of traditional treatments such as medication, physical therapy, and other appropriate methods have been tried and proven unsuccessful (when applicable).

6.2.3- Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy), and related services

General Documentation Requirements for Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy), and related services:

- Stable weight loss with BMI less than 35 be obtained prior to authorization of coverage for panniculectomy surgery (when applicable);
- Description of the pannis and the underlying skin;
- Description of conservative treatment undertaken and its results;
- The medical records document(s) that the panniculus causes chronic intertrigo or candidiasis or tissue necrosis that consistently recurs over three months and is unresponsive to oral or topical medication (when applicable);
- Pre-op photograph (if requested);
- Copies of consultations (when applicable);
- Related Operative report(s) (when applicable);
- Any other pertinent information.

For PARs submitted for CPT 15877, providers should, if applicable, document the main procedure that will be performed on the same day as CPT 15877 in the documentation submitted with the PAR.

6.2.4 - Rhinoplasty, and related services

General Documentation Requirements for Rhinoplasty and related services:

- Medical documentation, with evaluation and management, supporting medical necessity of the service that is to be performed;

- Radiologic imaging if done;
- Photographs that document the nasal deformity (if applicable);
- Documentation supporting unresponsiveness to conservative medical management (if applicable).

6.2.5 - Vein Ablation, and related services

General Documentation Requirements for Vein Ablation and related services:

- Doppler ultrasound;
- Documentation stating the presence or absence of DVT (deep vein thrombosis), aneurysm, and/or tortuosity (when applicable);
- Documented Incompetence of the Valves of the Saphenous, Perforator or Deep venous systems consistent with the patient's symptoms and findings (when applicable);
- Photographs, if the clinical documentation received, is inconclusive;
- Documentation supporting the diagnosis of symptomatic varicose veins (evaluation and complaints), and the failure of an adequate trial of conservative management (before the initial procedure) (refer to your MAC's LCD/LCA).

6.3 – Program Specifics for Additional Hospital OPD Services

6.3.1- Implementation of Prior Authorization

The MACs began accepting PARs for two new services on June 17, 2021, for services rendered on or after July 1, 2021.

6.3.2- Required Documentation

For detailed documentation requirements, the hospital OPD providers should refer to National Coverage Determinations (NCDs) and their MAC jurisdiction's LCDs/LCAs, where applicable. To meet coverage criteria, the patient's medical record must contain documentation that fully supports the medical necessity for services.

The following additional hospital OPD services will require PA:

i. Cervical Fusion with Disc Removal
ii. Implanted Spinal Neurostimulators

6.3.2.1- Cervical Fusion with Disc Removal

General Documentation Requirements for Cervical Fusion with Disc Removal:

- Condition requiring procedure
- Physical examination

- Duration/character/location/radiation of pain
- Activity of daily living (ADL) limitations
- Imaging reports pertinent to performed procedure
- Operative report(s) (when applicable)
- Conservative treatment modalities include but are not limited to*:
    - Physical Therapy
    - Occupational Therapy
    - Injections
    - Medications
    - Assistive device use
    - Activity modification

* When imminent surgery is required, and the medical records are submitted without conservative treatment documentation, supporting documentation must be received in the form of imaging report(s), physical findings correlated to the imaging, and the surgeon's note(s).

6.3.2.2 - Implanted Spinal Neurostimulators[2]

Providers who plan to perform **both** the trial and permanent implantation procedures using CPT 63650 in the hospital OPD will **only** be required to submit a PAR for the trial procedure. To avoid a claim denial, providers must place the Unique Tracking Number (UTN) received for the trial procedure on the claim submitted for the permanent implantation procedure. When the trial is rendered in a setting other than hospital OPD, providers will need to request PA for CPT 63650 as part of the permanent implantation procedure in the hospital OPD.

General Documentation Requirements for trial **or** permanent Implanted Spinal Neurostimulators:

- Indicate if this request is for a trial or permanent placement
- Physician office notes including:
    - Condition requiring procedure
    - Physical examination
    - Treatments tried and failed including but are not limited to:
        - Spine surgery
        - Physical therapy
        - Medications
        - Injections
        - Psychological therapy
- Documentation of **appropriate** psychological evaluation[3]

[2] CPT codes 63685 (Insertion or replacement of spinal neurostimulator pulse generator or receiver) and 63688 (Revision or removal of implanted spinal neurostimulator pulse generator or receiver) were temporarily removed from the list of OPD services that require prior authorization, as finalized in CMS-1736-FC.

[3] See Medicare Learning Network (MLN1986542) booklet and Publication# 100-2, Chapter 15 for more information on psychological evaluations.

- For permanent placement, include all the above documentation, as well as documentation of pain relief with the temporary implanted electrode(s).
    - A successful trial should be associated with at least 50% reduction of target pain or 50% reduction of analgesic medications.

Services associated with devices approved under an Investigational Device Exemption (IDE) study must undergo prior authorization and meet the coverage requirements in NCD 160.7.

6.4 – Program Specifics for an Additional Hospital OPD Service

6.4.1- Implementation of Prior Authorization

The MACs will begin accepting PARs for the new service category on June 15, 2023, for dates of service on or after July 1, 2023.

6.4.2- Required Documentation

For detailed documentation requirements, the hospital OPD providers should refer to their local MAC jurisdiction's LCDs/LCAs, where applicable. To meet coverage criteria, the patient's medical record must contain documentation that fully supports the medical necessity for services.

The following additional hospital OPD service category will require PA: Facet Joint Interventions.

6.4.2.1- Facet Joint Interventions

General Documentation Requirements for Facet Joint Interventions- Intraarticular (IA) Facet Joint Injections, Medial Branch Blocks (MBB), and Radiofrequency Ablations (RFA):

- Moderate to severe chronic neck or low back pain, predominantly axial, that causes functional deficit measured on pain or disability scale, **and**
- Presence of pain for minimum of 3 months with documented failure to respond to conservative management, **and**
- Absence of untreated radiculopathy or neurogenic claudication (except for radiculopathy caused by facet joint synovial cyst), **and**
- Non-facet pathology must be ruled out based on clinical evaluation or radiology studies
- The scales used to assess the measurement of pain and/or disability must be obtained at baseline and documented in the medical record for each assessment (refer to your MAC's LCD/LCA).

Diagnostic Facet Joint Procedures (IA or MBB):

- Indicate if this request is for an initial or second diagnostic procedure
- For the first diagnostic facet joint procedure, documentation must support the criteria outlined in general documentation requirements for facet joint interventions
- Diagnostic procedures should be performed with the intent that if successful, RFA would be considered the primary treatment goal at the diagnosed level(s)
- For the second diagnostic facet joint procedure(s), documentation must support the following:
    - Documentation must support the requirements for the first diagnostic procedure at the same level, **and**
    - After the first diagnostic procedure, there must be at least 80% of pain relief, **and**
    - The second diagnostic procedure may only be performed a minimum of 2 weeks after the initial diagnostic procedure. Exception to the two-weeks duration may be considered on an individual basis and must be clearly documented in the medical record

Frequency limitation for IA/MBB: For each covered spinal region, no more than four (4) diagnostic joint sessions will be considered medically reasonable and necessary per rolling 12 months, in recognition that the pain generator cannot always be identified with the initial and confirmatory diagnostic procedure.

Therapeutic Facet Joint Procedures (IA):

- Indicate if this request is for an initial or subsequent therapeutic procedure
- Documentation of two (2) diagnostic facet joint procedures with each providing at least 80% of pain relief, **and**
- Subsequent therapeutic facet joint procedures at the same anatomic site with at least 50% pain relief for at least 3 months from the prior therapeutic procedure or at least 50% improvement in the ability to perform previously painful movements and ADLs, compared to baseline measurement using the same scale, **and**
- Documentation of why the beneficiary is not a candidate for radiofrequency ablation (RFA)

Frequency limitation: For each covered spinal region no more than four (4) therapeutic facet joint injection (IA) sessions will be reimbursed per rolling 12 months.

Facet Joint Denervation (RFA):

- Indicate if this request is for an initial or subsequent facet joint denervation procedure
- For the initial thermal RFA, documentation must support at least two (2) diagnostic MBBs with each one providing at least 80% of pain relief, **and**
- Subsequent thermal facet joint RFA at the same anatomic site with at least 50% of pain improvement for at least six (6) months or at least 50% improvement in the ability to perform previously painful movements and ADLs, compared to baseline measurement using the same scale

Frequency limitation: For each covered spinal region no more than two (2) radiofrequency sessions will be reimbursed per rolling 12 months.

7 – Decisions

7.1 - Provisional Affirmation PA Decision

A provisional affirmation PA decision is a preliminary finding that a future claim submitted to Medicare for the service (s) likely meets Medicare's coverage, coding, and payment requirements. The provisional affirmation PA decision is valid for 120 days from the date decision was made.

7.2 - Non-Affirmation PA Decision

A non-affirmation PA decision is a preliminary finding that if a future claim is submitted to Medicare for the requested service does not likely meet Medicare's coverage, coding, and payment requirements.

The MAC will provide the PAR requester notification of what required documentation is missing or noncompliant with Medicare requirements via fax, mail, or the MAC provider portal (when available). The decision letter for an incomplete PAR will be detailed and postmarked within the applicable timeframes described in Section 4.1 as it pertains to each hospital's OPD service.

7.3 - Provisional Partial Affirmation PA Decision

A provisional partial affirmation PA decision means that one or more service(s) on the PAR received a provisional affirmation decision and one or more service(s) received a non-affirmation decision.

The MAC will follow the same process for any service(s) within the PA request that is given a provisional affirmation decision as is described in § 7.1 and for any service(s) that are given a non-affirmation decision as is described in § 7.2.

7.4 - Resubmitting PAR

The requestor may resubmit another complete PAR with all documentation required and whatever modifications are needed, as noted in the detailed decision letter. Unlimited resubmissions are permitted. The requestor is encouraged to include the original non-affirmed UTN on the resubmitted PAR.

8 - Claim Submission

8.1 – Affirmed PA Decision on File

Cases where a PAR was submitted, and a provisional affirmation PA decision was granted, including any service(s) that was part of a partially affirmed decision.

- The submission of the prior authorized claim is to have the 14 bytes UTN that is located on the decision letter. For submission of electronic claims, the UTN must be in positions 1 through 18. When the claim enters the Fiscal Intermediary Shared System (FISS), the UTN will move to positions 19 through 32, and zeros will autofill the first field. For providers submitting electronic claims, the Medicare Treatment Authorization field must contain blanks or valid Medicare data in the first 14 bytes of the treatment authorization field at the loop 2300 REF02 (REF01=G1) segment for the ASC X12 837 claim.

- For all other submissions, the provider must TAB to the second field of the treatment authorization field (positions 19–32) and key the UTN. If information is entered into the first field (positions 1 through 18), it will come into FISS as zeros. If the Treatment Authorization Code is entered into the first field, FISS changes the Treatment Authorization code to zeros, and the claim will not be accepted. If the UTN is entered into the first Treatment Authorization field, FISS will change the UTN to all zeros. The claim is accepted into FISS with the zeros and without the UTN. The claim will process without the UTN but will edit for the OPD UTN.

- Should be submitted to the applicable MAC for adjudication.

Note: If all Medicare coverage, coding, and payment requirements are met, the claim will likely be paid.

- Claims receiving a provisional affirmation may be denied based on either of the following:

- Technical requirements that can only be evaluated after the claim has been submitted for formal processing; or

- Information was not available at the time of a PAR.

- We note claims for which there is a provisional affirmation PA decision will be afforded some protection from future audits, both pre- and postpayment; however, review contractors may audit claims if potential fraud, inappropriate utilization, or changes in billing patterns are identified.

8.2 – Non-Affirmed PA Decision on File

Cases where a PAR was submitted, and a non-affirmed PA decision was granted, including any non-affirmed service(s) that was part of a partially affirmed decision.

- The submission of the prior authorized claim is to have the 14-byte UTN that is located on the decision letter. For submission of electronic claims, the UTN must be in positions 1 through 18. When the claim enters the Fiscal Intermediary Shared System (FISS), the UTN will move to positions 19 through 32, and zeros will autofill the first field. For providers submitting electronic claims, the Medicare Treatment Authorization field must contain blanks or valid Medicare data in the first 14 bytes of the treatment authorization field at the loop 2300 REF02 (REF01=G1) segment for the ASC X12 837 claim.

- For all other submissions, the provider must TAB to the second field of the treatment authorization field (positions 19–32) and key the UTN. If information is entered into the first field (positions 1 through 18), it will come into FISS as zeros. If the Treatment Authorization Code is entered into the first field, FISS changes the Treatment Authorization code to zeros, and the claim will not be accepted. If the UTN is entered into the first Treatment Authorization field, FISS will change the UTN to all zeros. The claim is accepted into FISS with the zeros and without the UTN. The claim will process without the UTN but will edit for the OPD UTN.

- Should be submitted to the applicable MAC for adjudication.

  - If the claim is submitted to the MAC for payment with a non-affirmative PA decision, it will be denied.

  - All appeal rights are then available.

  - This claim could then be submitted to secondary insurance, if applicable.

8.3- Claims Submitted without a PA Decision on File

- As described in 42 CFR §419.82, if a service requires PA under this program, submitting a PAR is a **condition of payment**.

- Claims for HCPCS code subject to required PA submitted without a PA determination and a corresponding UTN will be automatically denied.

8.4 – Denials for Related Services

Claims related to or associated with services that require PA as a condition of payment will not be paid if the service requiring PA is not also paid. These related services include, but are not limited to, services such as anesthesiology services, physician services, and/or facility services. Only associated services performed in the OPD setting will be affected.

Depending on the timing of claim submission for any related services, claims may be automatically denied or denied on a postpayment basis.

8.4.1 –Associated Services Codes

CMS intends to deny services that are associated with OPD services (blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, vein ablation, cervical fusion with disc removal, and implanted spinal neurostimulators) that require PA as a condition of payment and have received non-affirmation decisions and/or have denied claims. The codes for these associated services are listed in the table located in Appendix B (OPD PA Part B Associated Codes List). This list is subject to change in the future.

9 – Special Claim Considerations

9.1 – Advanced Beneficiary Notice (ABN)

If the hospital OPD receives a non-affirmed PA decision because the service was determined to be not medically reasonable and necessary, the provider should issue an ABN in advance of performing the service if it is expected that payment will be denied. The provider should submit the claim with the GA modifier appended to it. The Contractor will determine the validity of the ABN in accordance with standard ABN policies. (See IOM 100-04, Chapter 30)

If an applicable claim is submitted without a PA decision and is flagged as having an ABN, it will be stopped for additional documentation to be requested, and a review of the ABN will be performed (to determine the validity of the ABN) following standard claim review guidelines and timelines.

The provider should issue ABN and submit the claim with a GX modifier if it is expected that Medicare would deny payment for a service under the statutory exclusion for purely cosmetic services. Under those circumstances, ABN is voluntary and is not required to bill the patient for the service that is denied under the cosmetic services exclusion. However, CMS encourages providers to issue an ABN in this situation to inform the beneficiary of the likelihood of financial liability.

9.2 – Claims Exclusions

The following claim types are excluded from the PA program described in this operational guide unless otherwise specified:

- Veterans Affairs
- Indian Health Services
- Medicare Advantage
- Part A and Part B Demonstration
- Medicare Advantage sub-category IME only claims
- Part A/B rebilling
- Claims for Emergency Department services when the claim is submitted with an ET modifier or 045x revenue code. (This does not exclude these claims from regular medical review.)

10 – Secondary Insurance

This section pertains to the instances where the beneficiary has more than one insurance. In these instances, Medicare must be either the first or the secondary insurance company.

10.1 – Medicare is Primary Insurance

In cases where Medicare is primary, and another insurance company is secondary:

The contractors will suspend claims to request documentation and conduct a review of the Advanced Beneficiary Notice (ABN) when there is no PAR and the claim is submitted with the GA modifier appended.

The Contractor will determine the validity of the ABN in accordance with standard ABN policies. (See IOM 100-04, Chapter 30, Section 40).

Providers who choose to use the PA process to obtain a claim denial should follow the below process:

- The requester may submit the **PAR** with complete documentation as appropriate. If all relevant Medicare coverage requirements are **not** met for the service, then a non-affirmative PA decision will be sent to the provider and beneficiary, advising that Medicare will not pay for the item.

- After receiving a non-affirmative decision for the PAR, if the associated **claim** is submitted by the provider to the MAC for payment, it will be denied.

- The provider or beneficiary may forward the denied claim to his/her secondary insurance payer as appropriate to determine payment for the service.

In cases where a beneficiary is dually eligible for Medicaid and Medicare, a non-affirmed PA decision is sufficient for meeting states' obligation to pursue other coverage before considering Medicaid coverage. The provider may need to submit the claim to Medicare first and obtain a denial before submitting the claim to Medicaid for payment[4].

10.2 – Another Insurance Company is Primary

Cases where another insurance company is primary and Medicare is secondary:

- The requester submits the PAR with complete documentation as appropriate. If all relevant Medicare coverage requirements **are** met for the item(s), then a provisional affirmative PA decision will be sent to the provider and to the beneficiary, if specifically requested by the beneficiary, advising them that Medicare **will** pay for the service.

[4] https://www.medicaid.gov/federal-policy-guidance/downloads/cib011317.pdf

- The provider submits a claim to the other insurance company.
- If the other insurance company denies the claim, the provider or beneficiary can submit a claim to the MAC for payment (listing the unique tracking number on the claim).

11- Claim Appeals

Claims subject to PA requirements under the hospital OPD program follow all current appeals procedures. A PAR that is non-affirmed is not an initial determination on a claim for payment for services provided and, therefore, would not be appealable; however, the provider has an unlimited number of opportunities to resubmit a PAR, provided the claim has not yet been submitted and denied.

A non-affirmation PA decision does not prevent the provider from submitting a claim. Submission of such a claim and resulting denial by the MAC would constitute an initial payment determination, which makes the appeal rights available.

For further information, please consult the Medicare Claims Processing Manual publication, Chapter 29, Appeals of Claims Decision.

12- Suspension of PA process

CMS may suspend the OPD services PA process requirements generally or for a particular service(s) at any time by issuing a notification on the CMS website.

Appendix A

Final List of Outpatient Department Services That Require Prior Authorization

The following is the list of codes associated with the list of hospital outpatient department services contained in 42 CFR 419.83(a)(1) and (2).	
The following service categories comprise the list of hospital outpatient department services requiring prior authorization beginning for service dates on or after *July 1, 2020*: (i) Blepharoplasty (ii) Botulinum toxin injections (iii) Panniculectomy (iv) Rhinoplasty (v) Vein ablation	
Code	(i) Blepharoplasty, Blepharoptosis Repair, and Brow Ptosis Repair[1]
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)
Code	(ii) Botulinum Toxin Injection
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)
64615	Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)
J0585	Injection, onabotulinumtoxina, 1 unit
J0586	Injection, abobotulinumtoxina, 5 units
J0587	Injection, rimabotulinumtoxinb, 100 units
J0588	Injection, incobotulinumtoxin a, 1 unit
Code	(iii) Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy), and related services

[1] CPT 67911 (Correction of lid retraction) was removed on January 7, 2022.

15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication)
15877	Suction assisted lipectomy; trunk
Code	(iv) Rhinoplasty, and related services[2]
20912	Cartilage graft; nasal septum
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
Code	(v) Vein Ablation, and related services
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites

[2] CPT 21235 (Obtaining ear cartilage for grafting) was removed on June 10, 2020.

36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites
The following service categories comprise the list of hospital outpatient department services requiring prior authorization beginning for service dates on or after July 1, 2021: (i) Cervical Fusion with Disc Removal (ii) Implanted Spinal Neurostimulators	
Code	Cervical Fusion with Disc Removal
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace
Code	(ii) Implanted Spinal Neurostimulators[3]
63650	Percutaneous implantation of neurostimulator electrode array, epidural
The following service category comprise the list of hospital outpatient department services requiring prior authorization beginning for service dates on or after July 1, 2023: Facet Joint Interventions.	
Code	Facet Joint Interventions
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s)
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral;

	single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint

[3]CPT codes 63685 (Insertion or replacement of spinal neurostimulator pulse generator or receiver) and 63688 (Revision or removal of implanted spinal neurostimulator pulse generator or receiver) were temporarily removed from the list of OPD services that require prior authorization, as finalized in CMS-1736-FC.

Appendix B

OPD PA Part B Associated Codes List

Blepharoplasty, Blepharoptosis Repair, and Brow Ptosis Repair

HCPCS Codes	HCPCS Description
00103	Anesthesia for reconstructive procedures of eyelid (eg, blepharoplasty, ptosis surgery)
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
21282	Lateral canthopexy
67830	Correction of trichiasis; incision of lid margin
67840	Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure
67875	Temporary closure of eyelids by suture (eg, Frost suture)
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)
67917	Repair of ectropion; extensive (eg, tarsal strip operations)
67921	Repair of entropion; suture
67924	Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)
67950	Canthoplasty (reconstruction of canthus)
67966	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin
67973	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, lower, 1 stage or first stage

HCPCS Codes	HCPCS Description
88300	Level I - Surgical pathology, gross examination only
88302	Level II - Surgical pathology, gross and microscopic examination: Appendix, incidental; Fallopian tube, sterilization; Fingers/toes, amputation, traumatic; Foreskin, newborn; Hernia sac, any location; Hydrocele sac; Nerve; Skin, plastic repair; Sympathetic ganglion; Testis, castration; Vaginal mucosa, incidental; Vas deferens, sterilization
88304	Level III - Surgical pathology, gross and microscopic examination: Abortion, induced; Abscess; Aneurysm - arterial/ventricular; Anus, tag; Appendix, other than incidental; Artery, atheromatous plaque; Bartholin's gland cyst; Bone fragment(s), other than pathologic fracture; Bursa/synovial cyst; Carpal tunnel tissue; Cartilage, shavings; Cholesteatoma; Colon, colostomy stoma; Conjunctiva - biopsy/pterygium; Cornea; Diverticulum - esophagus/small intestine; Dupuytren's contracture tissue; Femoral head, other than fracture; Fissure/fistula; Foreskin, other than newborn; Gallbladder; Ganglion cyst; Hematoma; Hemorrhoids; Hydatid of Morgagni; Intervertebral disc; Joint, loose body; Meniscus; Mucocele, salivary; Neuroma - Morton's/traumatic; Pilonidal cyst/sinus; Polyps, inflammatory - nasal/sinusoidal; Skin - cyst/tag/debridement; Soft tissue, debridement; Soft tissue, lipoma; Spermatocele; Tendon/tendon sheath; Testicular appendage; Thrombus or embolus; Tonsil and/or adenoids; Varicocele; Vas deferens, other than sterilization; Vein, varicosity;
88331	Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen

Botulinum Toxin Injections

HCPCS Codes	HCPCS Description
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles
31573	Laryngoscopy, flexible; with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral
31575	Laryngoscopy, flexible; diagnostic
64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)
64405	Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch
64611	Chemodenervation of parotid and submandibular salivary glands, bilateral
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)
64615	Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)
64616	Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)
64617	Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

HCPCS Codes	HCPCS Description
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits
92285	External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)
95874	Needle electromyography for guidance in conjunction with chemodenervation
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
J0585	Injection, onabotulinumtoxina, 1 unit
J0586	Injection, abobotulinumtoxina, 5 units
J0587	Injection, rimabotulinumtoxinb, 100 units
J0588	Injection, incobotulinumtoxin a, 1 unit

Panniculectomy

HCPCS Codes	HCPCS Description
00802	Anesthesia for procedures on lower anterior abdominal wall; panniculectomy
11406	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm
13101	Repair, complex, trunk; 2.6 cm to 7.5 cm
13102	Repair, complex, trunk; each additional 5 cm or less
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof
15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk)
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication)
15877	Suction assisted lipectomy; trunk
31571	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope or telescope
33286	Removal, subcutaneous cardiac rhythm monitor
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated
49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated
64488	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)
88300	Level I - Surgical pathology, gross examination only
88302	Level II - Surgical pathology, gross and microscopic examination: Appendix, incidental; Fallopian tube, sterilization; Fingers/toes, amputation, traumatic;

HCPCS Codes	HCPCS Description
	Foreskin, newborn; Hernia sac, any location; Hydrocele sac; Nerve; Skin, plastic repair; Sympathetic ganglion; Testis, castration; Vaginal mucosa, incidental; Vas deferens, sterilization
88304	Level III - Surgical pathology, gross and microscopic examination: Abortion, induced; Abscess; Aneurysm - arterial/ventricular; Anus, tag; Appendix, other than incidental; Artery, atheromatous plaque; Bartholin's gland cyst; Bone fragment(s), other than pathologic fracture; Bursa/synovial cyst; Carpal tunnel tissue; Cartilage, shavings; Cholesteatoma; Colon, colostomy stoma; Conjunctiva - biopsy/pterygium; Cornea; Diverticulum - esophagus/small intestine; Dupuytren's contracture tissue; Femoral head, other than fracture; Fissure/fistula; Foreskin, other than newborn; Gallbladder; Ganglion cyst; Hematoma; Hemorrhoids; Hydatid of Morgagni; Intervertebral disc; Joint, loose body; Meniscus; Mucocele, salivary; Neuroma - Morton's/traumatic; Pilonidal cyst/sinus; Polyps, inflammatory - nasal/sinusoidal; Skin - cyst/tag/debridement; Soft tissue, debridement; Soft tissue, lipoma; Spermatocele; Tendon/tendon sheath; Testicular appendage; Thrombus or embolus; Tonsil and/or adenoids; Varicocele; Vas deferens, other than sterilization; Vein, varicosity
88312	Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)

Rhinoplasty

HCPCS Codes	HCPCS Description
00160	Anesthesia for procedures on nose and accessory sinuses; not otherwise specified
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm
13133	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
15730	Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)
15733	Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)
20912	Cartilage graft; nasal septum
21016	Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; 2 cm or greater
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)

HCPCS Codes	HCPCS Description
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
21282	Lateral canthopexy
30120	Excision or surgical planing of skin of nose for rhinophyma
30140	Submucous resection inferior turbinate, partial or complete, any method
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
31253	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed
31259	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus
31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus
31276	Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed
61782	Stereotactic computer-assisted (navigational) procedure; cranial, extradural
88300	Level I - Surgical pathology, gross examination only
88302	Level II - Surgical pathology, gross and microscopic examination: Appendix, incidental; Fallopian tube, sterilization; Fingers/toes, amputation, traumatic; Foreskin, newborn; Hernia sac, any location; Hydrocele sac; Nerve; Skin, plastic repair; Sympathetic ganglion; Testis, castration; Vaginal mucosa, incidental; Vas deferens, sterilization;
88304	Level III - Surgical pathology, gross and microscopic examination: Abortion, induced; Abscess; Aneurysm - arterial/ventricular; Anus, tag; Appendix, other than incidental; Artery, atheromatous plaque; Bartholin's gland cyst; Bone fragment(s), other than pathologic fracture; Bursa/synovial cyst; Carpal tunnel tissue; Cartilage, shavings; Cholesteatoma; Colon, colostomy stoma; Conjunctiva - biopsy/pterygium; Cornea; Diverticulum - esophagus/small intestine; Dupuytren's contracture tissue; Femoral head, other than fracture; Fissure/fistula; Foreskin, other than newborn; Gallbladder; Ganglion cyst; Hematoma; Hemorrhoids; Hydatid of Morgagni; Intervertebral disc; Joint, loose body; Meniscus; Mucocele, salivary; Neuroma - Morton's/traumatic; Pilonidal cyst/sinus; Polyps, inflammatory - nasal/sinusoidal; Skin - cyst/tag/debridement; Soft tissue, debridement; Soft tissue,

HCPCS Codes	HCPCS Description
	lipoma; Spermatocele; Tendon/tendon sheath; Testicular appendage; Thrombus or embolus; Tonsil and/or adenoids; Varicocele; Vas deferens, other than sterilization; Vein, varicosity;
88331	Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen

Vein Ablation

HCPCS Codes	HCPCS Description
01930	Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); not otherwise specified
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites
37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions
37766	Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions
37799	Unlisted procedure, vascular surgery
88304	Level III - Surgical pathology, gross and microscopic examination: Abortion, induced; Abscess; Aneurysm - arterial/ventricular; Anus, tag; Appendix, other than incidental; Artery, atheromatous plaque; Bartholin's gland cyst; Bone fragment(s), other than pathologic fracture; Bursa/synovial cyst; Carpal tunnel tissue; Cartilage, shavings; Cholesteatoma; Colon, colostomy stoma; Conjunctiva - biopsy/pterygium;

HCPCS Codes	HCPCS Description
	Cornea; Diverticulum - esophagus/small intestine; Dupuytren's contracture tissue; Femoral head, other than fracture; Fissure/fistula; Foreskin, other than newborn; Gallbladder; Ganglion cyst; Hematoma; Hemorrhoids; Hydatid of Morgagni; Intervertebral disc; Joint, loose body; Meniscus; Mucocele, salivary; Neuroma - Morton's/traumatic; Pilonidal cyst/sinus; Polyps, inflammatory - nasal/sinusoidal; Skin - cyst/tag/debridement; Soft tissue, debridement; Soft tissue, lipoma; Spermatocele; Tendon/tendon sheath; Testicular appendage; Thrombus or embolus; Tonsil and/or adenoids; Varicocele; Vas deferens, other than sterilization; Vein, varicosity;
93922	Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study

Cervical Fusion with Disc Removal

HCPCS Codes	HCPCS Description
00600	Anesthesia for procedures on cervical spine and cord; not otherwise specified
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only
20931	Allograft, structural, for spine surgery only
20936	Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from same incision
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision)
20939	Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace
22830	Exploration of spinal fusion
22845	Anterior instrumentation; 2 to 3 vertebral segments
22846	Anterior instrumentation; 4 to 7 vertebral segments
22849	Reinsertion of spinal fixation device
22853	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace

HCPCS Codes	HCPCS Description
22854	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect
22855	Removal of anterior instrumentation
36620	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous
63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
63082	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment
72020	Radiologic examination, spine, single view, specify level
72040	Radiologic examination, spine, cervical; 2 or 3 views
72050	Radiologic examination, spine, cervical; 4 or 5 views
72125	Computed tomography, cervical spine; without contrast material
76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting
88300	Level I - Surgical pathology, gross examination only
95861	Needle electromyography; 2 extremities with or without related paraspinal areas
95865	Needle electromyography; larynx
95868	Needle electromyography; cranial nerve supplied muscles, bilateral
95870	Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs
95937	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method
95938	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs
95939	Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs

Implanted Spinal Neurostimulators

HCPCS Codes	HCPCS Description
00620	Anesthesia for procedures on thoracic spine and cord, not otherwise specified
00630	Anesthesia for procedures in lumbar region; not otherwise specified
01992	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); prone position

HCPCS Codes	HCPCS Description
61624	Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver
69990	Microsurgical techniques, requiring use of operating microscope
72020	Radiologic examination, spine, single view, specify level
72070	Radiologic examination, spine; thoracic, 2 views
72074	Radiologic examination, spine; thoracic, minimum of 4 views
72080	Radiologic examination, spine; thoracolumbar junction, minimum of 2 views
72100	Radiologic examination, spine, lumbosacral; 2 or 3 views
75705	Angiography, spinal, selective, radiological supervision and interpretation
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)
95861	Needle electromyography; 2 extremities with or without related paraspinal areas
95870	Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters
95926	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs
95937	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method
95938	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs
95939	Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming
95971	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional

HCPCS Codes	HCPCS Description
95972	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug
99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older
99153	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intraservice time

Facet Joint Interventions

HCPCS Codes	HCPCS Description
01937	Anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord; cervical or thoracic
01938	Anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral
01939	Anesthesia for percutaneous image-guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic
01940	Anesthesia for percutaneous image-guided destruction procedures by neurolytic agent on the spine or spinal cord; lumbar or sacral
01992	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); prone position
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)

HCPCS Codes	HCPCS Description
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)
72020	Radiologic examination, spine, single view, specify level
99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older
00300	Anesthesia for all procedures on the integumentary system, muscles and nerves of head, neck, and posterior trunk, not otherwise specified
00600	Anesthesia for procedures on cervical spine and cord; not otherwise specified
00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)
01941	Anesthesia for percutaneous image-guided neuromodulation or intravertebral procedures (eg, kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic
01942	Anesthesia for percutaneous image-guided neuromodulation or intravertebral procedures (eg, kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral
01991	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); other than the prone position
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance
62322	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)

HCPCS Codes	HCPCS Description
62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
72040	Radiologic examination, spine, cervical; 2 or 3 views
72080	Radiologic examination, spine; thoracolumbar junction, minimum of 2 views
72100	Radiologic examination, spine, lumbosacral; 2 or 3 views
72110	Radiologic examination, spine, lumbosacral; minimum of 4 views
72114	Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation
77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)
88305	Level IV - Surgical pathology, gross and microscopic examination: Abortion - spontaneous/missed; Artery, biopsy; Bone marrow, biopsy; Bone exostosis; Brain/meninges, other than for tumor resection; Breast, biopsy, not requiring microscopic evaluation of surgical margins; Breast, reduction mammoplasty; Bronchus, biopsy; Cell block, any source; Cervix, biopsy; Colon, biopsy; Duodenum, biopsy; Endocervix, curettings/biopsy; Endometrium, curettings/biopsy; Esophagus, biopsy; Extremity, amputation, traumatic; Fallopian tube, biopsy; Fallopian tube, ectopic pregnancy; Femoral head, fracture; Fingers/toes, amputation, non-traumatic; Gingiva/oral mucosa, biopsy; Heart valve; Joint, resection; Kidney, biopsy; Larynx, biopsy; Leiomyoma(s), uterine myomectomy - without uterus; Lip, biopsy/wedge resection; Lung, transbronchial biopsy; Lymph node, biopsy; Muscle, biopsy; Nasal mucosa, biopsy; Nasopharynx/oropharynx, biopsy; Nerve, biopsy; Odontogenic/dental cyst; Omentum, biopsy; Ovary with or without tube, non-neoplastic; Ovary, biopsy/wedge resection; Parathyroid gland; Peritoneum, biopsy; Pituitary tumor; Placenta, other than third trimester; Pleura/pericardium - biopsy/tissue; Polyp, cervical/endometrial; Polyp, colorectal; Polyp, stomach/small intestine; Prostate, needle biopsy; Prostate, TUR; Salivary gland, biopsy; Sinus, paranasal biopsy; Skin, other than cyst/tag/debridement/plastic repair; Small intestine, biopsy; Soft tissue, other than tumor/mass/lipoma/debridement; Spleen; Stomach, biopsy; Synovium; Testis, other than tumor/biopsy/castration; Thyroglossal duct/brachial cleft cyst; Tongue, biopsy; Tonsil, biopsy; Trachea, biopsy; Ureter, biopsy; Urethra, biopsy; Urinary bladder, biopsy; Uterus, with or without tubes and ovaries, for prolapse; Vagina, biopsy; Vulva/labia, biopsy