

WV MEDICAID PRIOR AUTHORIZATION CODE LISTING

LABORATORY, IMAGING & RADIOLOGY SERVICES

For Non-MCO enrolled Member benefit verification, CPT/HCPCS code coverage & service limits verification and billing/claims assistance, please contact claims vendor at 888-483-0793

Service Group Code	Service Code	Code Description	ATREZZO Service Type	PRIOR AUTH REQUIRED?	AGE RESTRICTION	PRICED OR NOT PRICED	ADDITIONAL INFORMATION
376 382	70100	RADIOLOGIC EXAMINATION, MANDIBLE; PARTIAL, LESS THAN FOUR VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	Place of service (POS) 12 = HOME
376 382	70110	RADIOLOGIC EXAMINATION, MANDIBLE; COMPLETE, MINIMUM OF FOUR VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
376 382	70140	RADIOLOGIC EXAMINATION, FACIAL BONES; LESS THAN THREE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
376 382	70150	RADIOLOGIC EXAMINATION, FACIAL BONES; COMPLETE, MINIMUM OF THREE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
376 382	70160	RADIOLOGIC EXAMINATION, NASAL BONES, COMPLETE, MINIMUM OF THREE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
376 382	70190	RADIOLOGIC EXAMINATION; OPTIC FORAMINA	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
493	70200	RADIOLOGIC EXAMINATION; OPTIC FORAMINA, ORBITS, COMPLETE, MINIMUM IF 4 VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
376 382	70250	RADIOLOGIC EXAMINATION, SKULL; LESS THAN FOUR VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
376 382	70260	RADIOLOGIC EXAMINATION, SKULL; COMPLETE, MINIMUM OF FOUR VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
494	70328	RADIOLOGIC EXAMINATION, TEMPOROMANDIBULAR JOINT, OPEN AND CLOSED MOUTH; UNILATERAL	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
376 382	70330	RADIOLOGIC EXAMINATION, TEMPOROMANDIBULAR JOINT, OPEN AND CLOSED MOUTH; BILATERAL	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
674	70336	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, TEMPOROMANDIBULAR JOINT(S)	RADIOLOGY	REQUIRED	Age <= 21 years old	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
324	70450	COMPUTED TOMOGRAPHY, HEAD OR BRAIN, WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
324	70460	COMPUTED TOMOGRAPHY, HEAD OR BRAIN WITH CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
324	70470	COMPUTED TOMOGRAPHY, HEAD OR BRAIN WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
331	70480	COMPUTED TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA OR OUTER MIDDLE, OR INNER EAR; WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
331	70481	COMPUTED TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA OR OUTER MIDDLE, OR INNER EAR; WITH CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
331	70482	COMPUTED TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA OR OUTER MIDDLE, OR INNER EAR; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
333	70486	COMPUTED TOMOGRAPHY, MAXILLOFACIAL AREA; WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required

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333	70487	COMPUTED TOMOGRAPHY, MAXILLOFACIAL AREA; WITH CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
333	70488	COMPUTED TOMOGRAPHY, MAXILLOFACIAL AREA; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
330	70490	COMPUTED TOMOGRAPHY, SOFT TISSUE NECK; WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
330	70491	COMPUTED TOMOGRAPHY, SOFT TISSUE NECK; WITH CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
330	70492	COMPUTED TOMOGRAPHY, SOFT TISSUE NECK; WITHOUT CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
338	70496	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, HEAD, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE PROCESSING	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
337	70498	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, NECK, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
357	70540	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, ORBIT, FACE, AND/OR NECK; WITHOUT CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
357	70542	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, ORBIT, FACE, AND/OR NECK; WITH CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
357	70543	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, ORBIT, FACE, AND/OR NECK; WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
344	70544	MAGNETIC RESONANCE ANGIOGRAPHY, HEAD; WITHOUT CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
344	70545	MAGNETIC RESONANCE ANGIOGRAPHY, HEAD; WITH CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
344	70546	MAGNETIC RESONANCE ANGIOGRAPHY, HEAD; WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
345	70547	MAGNETIC RESONANCE ANGIOGRAPHY, NECK; WITHOUT CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
345	70548	MAGNETIC RESONANCE ANGIOGRAPHY, NECK; WITH CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required

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345	70549	MAGNETIC RESONANCE ANGIOGRAPHY, NECK; WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
349	70551	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM); WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
349	70552	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM); WITH CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
349	70553	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM); WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
349	70557	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM AND SKULL BASE), DURING OPEN INTRACRANIAL PROCEDURE (E.G., TO ASSESS FOR RESIDUAL TUMOR OR RESIDUAL VASCULAR MALFORMATION); WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
349	70558	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, BRAIN, (INCLUDING BRAIN STEM AND SKULL BASE), DURING OPEN INTRACRANIAL PROCEDURE (E.G., TO ASSESS FOR RESIDUAL TUMOR OR RESIDUAL VASCULAR MALFORMATION), WITH CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
349	70559	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM AND SKULL BASE), DURING OPEN INTRACRANIAL PROCEDURE (E.G., TO ASSESS FOR RESIDUAL TUMOR OR RESIDUAL VASCULAR MALFORMATION); WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
377 383	71035	RADIOLOGIC EXAMINATION, CHEST, SPECIAL VIEWS (EG, LATERAL DECUBITUS, BUCKY STUDIES)	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
325	71045	RADIOLOGIC EXAMINATION, CHEST; SINGLE VIEW	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
325	71046	RADIOLOGIC EXAMINATION, CHEST; 2 VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
325	71047	RADIOLOGIC EXAMINATION, CHEST; 3 VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
325	71048	RADIOLOGIC EXAMINATION, CHEST; 4 OR MORE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
377 383	71100	RADIOLOGIC EXAMINATION, RIBS, UNILATERAL; TWO VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
377 383	71101	RADIOLOGIC EXAMINATION, RIBS, UNILATERAL; INCLUDING POSTEROANTERIOR CHEST, MINIMUM OF THREE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
377 383	71110	RADIOLOGIC EXAMINATION, RIBS, BILATERAL; THREE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
377 383	71120	RADIOLOGIC EXAMINATION; STERNUM, MINIMUM OF TWO VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	

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377 383	71130	RADIOLOGIC EXAMINATION; STERNOCLAVICULAR JOINT OR JOINTS, MINIMUM OF THREE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
325	71250	COMPUTED TOMOGRAPHY, THORAX; WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
325	71260	COMPUTED TOMOGRAPHY, THORAX, DIAGNOSTIC; WITH CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
325	71270	COMPUTED TOMOGRAPHY, THORAX, DIAGNOSTIC; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
325	71271	COMPUTED TOMOGRAPHY, THORAX, LOW DOSE FOR LUNG CANCER SCREENING, WITHOUT CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required New Code for 2021/ Replacement code for G0297
325	71275	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, CHEST (NONCORONARY), WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
353	71550	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, CHEST (E.G., FOR EVALUATION OF HILAR AND MEDIASTINAL LYMPHADENOPATHY); WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
353	71551	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, CHEST (E.G., FOR EVALUATION OF HILAR AND MEDIASTINAL LYMPHADENOPATHY); WITH CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
353	71552	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, CHEST (E.G., FOR EVALUATION OF HILAR AND MEDIASTINAL LYMPHADENOPATHY); WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
353	71555	MAGNETIC RESONANCE ANGIOGRAPHY, CHEST (EXCLUDING MYOCARDIUM), WITH OR WITHOUT CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
378 384	72020	RADIOLOGIC EXAMINATION, SPINE, SINGLE VIEW, SPECIFY LEVEL	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
378 384	72040	RADIOLOGIC EXAMINATION, SPINE, CERVICAL; TWO OR THREE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
378 384	72050	RADIOLOGIC EXAMINATION, SPINE, CERVICAL; MINIMUM OF FOUR VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
378 384	72052	RADIOLOGIC EXAMINATION, SPINE, CERVICAL; COMPLETE, INCLUDING OBLIQUE AND FLEXION AND/OR EXTENSION STUDIES	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
378 384	72070	RADIOLOGIC EXAMINATION, SPINE; THORACIC, TWO VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
378 384	72072	RADIOLOGIC EXAMINATION, SPINE; THORACIC, THREE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	

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334	72074	RADIOLOGIC EXAMINATION, SPINE; THORACIC, MINIMUM OF 4 VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
378 384	72080	THORACOLUMBAR JUNCTION, MINIMUM OF 2 VIEWS SHOULD INCLUDE EXAMINATION OF THE THORACOLUMBAR JUNCTION	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
378 384	72081	RADIOLOGIC EXAMINATION, SPINE, ENTIRE THORACIC AND LUMBAR, INCLUDING SKULL, CERVICAL AND SACRAL SPINE IF PERFORMED (E.G., SCOLIOSIS EVALUATION); ONE VIEW	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
378 384	72082	RADIOLOGIC EXAMINATION, SPINE, ENTIRE THORACIC AND LUMBAR, INCLUDING SKULL, CERVICAL AND SACRAL SPINE IF PERFORMED (E.G., SCOLIOSIS EVALUATION); 2 OR 3 VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
378 384	72083	RADIOLOGIC EXAMINATION, SPINE, ENTIRE THORACIC AND LUMBAR, INCLUDING SKULL, CERVICAL AND SACRAL SPINE IF PERFORMED (E.G., SCOLIOSIS EVALUATION); 4 OR 5 VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
378 384	72084	RADIOLOGIC EXAMINATION, SPINE, ENTIRE THORACIC AND LUMBAR, INCLUDING SKULL, CERVICAL AND SACRAL SPINE IF PERFORMED (E.G., SCOLIOSIS EVALUATION); MINIMUM OF 6 VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
378 384	72100	RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL; TWO OR THREE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
378 384	72110	RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL; MINIMUM OF FOUR VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
378 384	72114	RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL, COMPLETE, INCLUDING BENDING VIEWS, MINIMUM OF 6 VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
378 384	72120	RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL, BENDING VIEWS ONLY, MINIMUM OF FOUR VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
326	72125	COMPUTED TOMOGRAPHY, CERVICAL SPINE; WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
326	72126	COMPUTED TOMOGRAPHY, CERVICAL SPINE, WITH CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
326	72127	COMPUTED TOMOGRAPHY, CERVICAL SPINE; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
334	72128	COMPUTED TOMOGRAPHY, THORACIC SPINE; WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
334	72129	COMPUTED TOMOGRAPHY, THORACIC SPINE; WITH CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
334	72130	COMPUTED TOMOGRAPHY THORACIC SPINE; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
329	72131	COMPUTED TOMOGRAPHY, LUMBAR SPINE; WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required

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329	72132	COMPUTED TOMOGRAPHY, LUMBAR SPINE; WITH CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
329	72133	COMPUTED TOMOGRAPHY, LUMBAR SPINE; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
352	72141	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, SPINAL CANAL AND CONTENTS, CERVICAL; WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
352	72142	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, SPINAL CANAL AND CONTENTS, CERVICAL; WITH CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
360	72146	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, SPINAL CANAL AND CONTENTS, THORACIC; WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
360	72147	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, SPINAL CANAL AND CONTENTS, THORACIC WITH CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
356	72148	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, SPINAL CANAL AND CONTENTS, LUMBAR, WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
356	72149	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, SPINAL CANAL AND CONTENTS, LUMBAR, WITH CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
352	72156	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, SPINAL CANAL AND CONTENTS, WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES, CERVICAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
360	72157	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, SPINAL CANAL AND CONTENTS, WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES, THORACIC	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
356	72158	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, SPINAL CANAL AND CONTENTS, WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES, LUMBAR	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
378 384	72170	RADIOLOGIC EXAMINATION, PELVIS; ONE OR TWO VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
339	72191	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, PELVIS, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
332	72192	COMPUTED TOMOGRAPHY, PELVIS, WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
332	72193	COMPUTED TOMOGRAPHY, PELVIS, WITH CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
332	72194	COMPUTED TOMOGRAPHY, PELVIS; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required

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358	72195	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, PELVIS, WITHOUT CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
358	72196	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, PELVIS, WITH CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
358	72197	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, PELVIS; WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
343	72198	MAGNETIC RESONANCE ANGIOGRAPHY, PELVIS, WITH OR WITHOUT CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
378 384	72200	RADIOLOGIC EXAMINATION, SACROILIAC JOINTS; LESS THAN THREE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
378 384	72202	RADIOLOGIC EXAMINATION, SACROILIAC JOINTS; THREE OR MORE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
378 384	72220	RADIOLOGIC EXAMINATION, SACRUM AND COCCYX, MINIMUM OF TWO VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
380 386	72503	RADIOLOGIC EXAMINATION, HIP, UNILATERAL, WITH PELVIS WHEN PERFORMED; MINIMUM OF 4 VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
379 385	73000	RADIOLOGIC EXAMINATION; CLAVICLE, COMPLETE	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
379 385	73010	RADIOLOGIC EXAMINATION; SCAPULA, COMPLETE	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
379 385	73020	RADIOLOGIC EXAMINATION, SHOULDER; ONE VIEW	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
379 385	73030	RADIOLOGIC EXAMINATION, SHOULDER; COMPLETE, MINIMUM OF TWO VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
379 385	73060	RADIOLOGIC EXAMINATION; HUMERUS, MINIMUM OF TWO VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
379 385	73070	RADIOLOGIC EXAMINATION, ELBOW; TWO VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
379 385	73080	RADIOLOGIC EXAMINATION, ELBOW; COMPLETE, MINIMUM OF THREE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
379 385	73090	RADIOLOGIC EXAMINATION; FOREARM, TWO VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
379 385	73100	RADIOLOGIC EXAMINATION, WRIST; TWO VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
379 385	73110	RADIOLOGIC EXAMINATION, WRIST; COMPLETE, MINIMUM OF THREE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
379 385	73120	RADIOLOGIC EXAMINATION, HAND; TWO VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
379 385	73130	RADIOLOGIC EXAMINATION, HAND; MINIMUM OF THREE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
379 385	73140	RADIOLOGIC EXAMINATION, FINGER(S), MINIMUM OF TWO VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	

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328	73200	COMPUTED TOMOGRAPHY, UPPER EXTREMITY; WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	
328	73201	COMPUTED TOMOGRAPHY, UPPER EXTREMITY; WITH CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
328	73202	COMPUTED TOMOGRAPHY, UPPER EXTREMITY; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
341	73206	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, UPPER EXTREMITY, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
355	73218	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, UPPER EXTREMITY, OTHER THAN JOINT, WITHOUT CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
355	73219	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, UPPER EXTREMITY, OTHER THAN JOINT, WITH CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
355	73220	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, UPPER EXTREMITY, OTHER THAN JOINT, WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
355	73221	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, ANY JOINT OF UPPER EXTREMITY, WITHOUT CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
355	73222	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, ANY JOINT OF UPPER EXTREMITY, WITH CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
355	73223	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, ANY JOINT OF UPPER EXTREMITY; WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
347	73225	MAGNETIC RESONANCE ANGIOGRAPHY, UPPER EXTREMITY, WITH OR WITHOUT CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
380 386	73501	RADIOLOGIC EXAMINATION, HIP, UNILATERAL, WITH PELVIS WHEN PERFORMED; 1 VIEW	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
380 386	73502	RADIOLOGIC EXAMINATION, HIP, UNILATERAL, WITH PELVIS WHEN PERFORMED; 2-3 VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
380 386	73521	RADIOLOGIC EXAMINATION, HIPS, BILATERAL, WITH PELVIS WHEN PERFORMED; 2 VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
380 386	73522	RADIOLOGIC EXAMINATION, HIPS, BILATERAL, WITH PELVIS WHEN PERFORMED; 3-4 VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
380 386	73523	RADIOLOGIC EXAMINATION, HIPS, BILATERAL, WITH PELVIS WHEN PERFORMED; MINIMUM OF 5 VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
380 386	73551	RADIOLOGIC EXAMINATION, FEMUR; 1 VIEW	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
380 386	73552	RADIOLOGIC EXAMINATION, FEMUR; MINIMUM 2 VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	

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380 386	73560	RADIOLOGIC EXAMINATION, KNEE; ONE OR TWO VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
380 386	73562	RADIOLOGIC EXAMINATION, KNEE; THREE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
380 386	73564	RADIOLOGIC EXAMINATION, KNEE; COMPLETE, FOUR OR MORE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
380 386	73565	RADIOLOGIC EXAMINATION, KNEE; BOTH KNEES, STANDING, ANTEROPOSTERIOR	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
380 386	73590	RADIOLOGIC EXAMINATION; TIBIA AND FIBULA, TWO VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
380 386	73600	RADIOLOGIC EXAMINATION, ANKLE; TWO VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
380 386	73610	RADIOLOGIC EXAMINATION, ANKLE; COMPLETE, MINIMUM OF THREE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
380 386	73620	RADIOLOGIC EXAMINATION, FOOT; TWO VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
380 386	73630	RADIOLOGIC EXAMINATION, FOOT; COMPLETE, MINIMUM OF THREE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
380 386	73650	RADIOLOGIC EXAMINATION; CALCANEUS, MINIMUM OF TWO VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
380 386	73660	RADIOLOGIC EXAMINATION; CALCANEUS, TOE(S), MINIMUM OF TWO VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
327	73700	COMPUTED TOMOGRAPHY, LOWER EXTREMITY, WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
327	73701	COMPUTED TOMOGRAPHY, LOWER EXTREMITY, WITH CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
327	73702	COMPUTED TOMOGRAPHY, LOWER EXTREMITY, WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
340	73706	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, LOWER EXTREMITY, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
354	73718	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, LOWER EXTREMITY OTHER THAN JOINT, WITHOUT CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
354	73719	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, LOWER EXTREMITY OTHER THAN JOINT, WITH CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
354	73720	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, LOWER EXTREMITY OTHER THAN JOINT, WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
354	73721	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, ANY JOINT OF LOWER EXTREMITY, WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required

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354	73722	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, ANY JOINT OF LOWER EXTREMITY, WITH CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
354	73723	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, ANY JOINT OF LOWER EXTREMITY, WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
346	73725	MAGNETIC RESONANCE ANGIOGRAPHY, LOWER EXTREMITY, WITH OR WITHOUT CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
322	74018	RADIOLOGIC EXAMINATION, ABDOMEN; 1 VIEW	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
322	74019	RADIOLOGIC EXAMINATION, ABDOMEN; 2 VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
322	74021	RADIOLOGIC EXAMINATION, ABDOMEN; 3 OR MORE VIEWS	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
381 387	74022	RADIOLOGIC EXAMINATION, COMPLETE ACUTE ABDOMEN SERIES, INCLUDING 2 OR MORE VIEWS OF THE ABDOMEN (E.G., SUPINE, ERECT, DECUBITUS), AND A SINGLE VIEW CHEST	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
322-Adult 323-Pediatric	74150	COMPUTED TOMOGRAPHY, ABDOMEN, WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
322-Adult 323-Pediatric	74160	COMPUTED TOMOGRAPHY, ABDOMEN, WITH CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
322-Adult 323-Pediatric	74170	COMPUTED TOMOGRAPHY, ABDOMEN, WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
322	74174	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, ABDOMEN AND PELVIS, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
336	74175	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, ABDOMEN, WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS, INCLUDING IMAGE POST PROCESSING	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
322-Adult 323-Pediatric	74176	CT, ABDOMEN AND PELVIS, WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	
322-Adult 323-Pediatric	74177	CT, ABDOMEN AND PELVIS, WITH CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	
322-Adult 323-Pediatric	74178	CT ABDOMEN & PELVIS W/O CONTRAST MATERIAL IN ONE OR BOTH BODY REGIONS, FOLLOWED BY CONTRAST MATERIALS AND FURTHER SECTIONS IN ONE OR BOTH BODY REGIONS	RADIOLOGY	REQUIRED	No Restriction	PRICED	
348	74181	MAGNETIC RESONANCE (E.G., PROTON) IMAGING ABDOMEN, WITHOUT CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
348	74182	MAGNETIC RESONANCE (E.G., PROTON) IMAGING ABDOMEN, WITH CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required

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348	74183	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, ABDOMEN, WITHOUT CONTRAST MATERIAL(S); FOLLOWED BY WITH CONTRAST MATERIAL(S) AND FURTHER SEQUENCES	RADIOLOGY	REQUIRED	No Restriction	PRICED	
343	74185	MAGNETIC RESONANCE (E.G., PROTON) IMAGING ABDOMEN, WITH OR WITHOUT CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
388	74261	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, DIAGNOSTIC INCLUDING IMAGE POSTPROCESSING, WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Diagnostic Radiology - Required Inpatient or ER - No Modifier 26 - No
388	74262	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, DIAGNOSTIC INCLUDING IMAGE POSTPROCESSING, WITH CONTRAST MATERIAL(S)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Diagnostic Radiology - Required Inpatient or ER - No Modifier 26 - No
PLEASE USE CPT CODE	74263	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, SCREENING, INCLUDING IMAGE POSTPROCESSING	RADIOLOGY	REQUIRED	No Restriction	PRICED	NEW CODE EFFECTIVE 11/01/2023 Diagnostic Radiology - Required Inpatient or ER - No Modifier 26 - No
673	74712	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, FETAL, INCLUDING PLACENTAL AND MATERNAL PELVIC IMAGING WHEN PERFORMED; SINGLE OR FIRST GESTATION	RADIOLOGY	REQUIRED	No Restriction	PRICED	Diagnostic Radiology - Required Inpatient or ER - Yes Modifier 26 - Yes Modifier TC-Yes
673	74713	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, FETAL, INCLUDING PLACENTAL AND MATERNAL PELVIC IMAGING WHEN PERFORMED; EACH ADDITIONAL GESTATION	RADIOLOGY	REQUIRED	No Restriction	PRICED	Diagnostic Radiology - Required Inpatient or ER - Yes Modifier 26 - Yes Modifier TC-Yes
351	75557	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
351	75559	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL, WITH STRESS IMAGING	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
351	75561	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
351	75563	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES, WITH STRESS IMAGING	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
351	75565	CARDIAC MAGNETIC RESONANCE IMAGING FOR VELOCITY FLOW MAPPING (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Diagnostic Radiology - Required Inpatient or ER - No Modifier 26 - No
351	75572	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL, FOR EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY (INCLUDING 3D IMAGE POSTPROCESSING, ASSESSMENT OF CARDIAC FUNCTION, AND EVALUATION OF VENOUS STRUCTURES, IF PERFORMED)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Diagnostic Radiology - Required Inpatient or ER - No Modifier 26 - No

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351	75573	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL, FOR EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY IN THE SETTING OF CONGENITAL HEART DISEASE (INCLUDING 3D IMAGE POSTPROCESSING, ASSESSMENT OF LEFT VENTRICULAR [LV] CARDIAC FUNCTION, RIGHT VENTRICULAR [RV] STRUCTURE AND FUNCTION AND EVALUATION OF VASCULAR STRUCTURES, IF PERFORMED)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Diagnostic Radiology - Required Inpatient or ER - No Modifier 26 - No
351	75574	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, HEART, CORONARY ARTERIES AND BYPASS GRAFTS (WHEN PRESENT) WITH CONTRAST MATERIAL, INCLUDING 3D IMAGE POSTPROCESSING (INCLUDING EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY, ASSESSMENT OF CARDIAC FUNCTION, AND EVALUATION OF VENOUS STRUCTURES IF PERFORMED)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Diagnostic Radiology - Required Inpatient or ER - No Modifier 26 - No
627	75635	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, ABDOMINAL AORTA AND BILATERAL ILIOFEMORAL LOWER EXTREMITY RUNOFF, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING	RADIOLOGY	REQUIRED	No Restriction	PRICED	
324 330 331	76380	COMPUTED TOMOGRAPHY, LIMITED OR LOCALIZED FOLLOW-UP STUDY	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
350	76391	MAGNETIC RESONANCE (EG, VIBRATION) ELASTOGRAPHY	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
PLEASE USE CPT CODE	76496	UNLISTED FLUOROSCOPIC PROCEDURE	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
335	76497	UNLISTED COMPUTED TOMOGRAPHY PROCEDURE (EG, DIAGNOSTIC, INTERVENTIONAL)	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
342	76498	UNLISTED MAGNETIC RESONANCE PROCEDURE (EG, DIAGNOSTIC, INTERVENTIONAL)	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
PLEASE USE CPT CODE	76499	UNLISTED DIAGNOSTIC RADIOGRAPHIC PROCEDURE	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
630	76942	ULTRASONIC GUIDANCE FOR NEEDLE PLACEMENT (E.G. BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE), IMAGING SUPERVISION AND INTERPRETATION	RADIOLOGY	Required Beyond Service Limits	No Restriction	PRICED	SERVICE LIMIT = 1 PER DAY
PLEASE USE CPT CODE	76999	UNLISTED US PROCEDURE	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
631	77002	FLUOROSCOPIC GUIDANCE FOR NEEDLE PLACEMENT (EG BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE)	RADIOLOGY	Required Beyond Service Limits	No Restriction	PRICED	SERVICE LIMIT = 1 PER DAY
631	77003	FLUOROSCOPIC GUIDANCE AND LOCALIZATION OF NEEDLE OR CATHETER TIP FOR SPINE OR PARASPINOUS DIAGNOSTIC OR THERAPEUTIC INJECTION PROCEDURES (EPIDURAL OR SUBARACHNOID)	RADIOLOGY	Required Beyond Service Limits	No Restriction	PRICED	SERVICE LIMIT = 1 PER DAY

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631	77012	COMPUTED TOMOGRAPHY GUIDANCE FOR NEEDLE PLACEMENT (E.G. BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE); RADIOLOGIC SUPERVISION AND INTERPRETATION	RADIOLOGY	Required Beyond Service Limits	No Restriction	PRICED	SERVICE LIMIT = 1 PER DAY
631	77021	MAGNETIC RESONANCE IMAGING GUIDANCE FOR NEEDLE PLACEMENT (EG, FOR BIOPSY, NEEDLE ASPIRATION, INJECTION, OR PLACEMENT OF LOCALIZATION DEVICE) RADIOLOGICAL SUPERVISION AND INTERPRETATION	RADIOLOGY	Required Beyond Service Limits	No Restriction	PRICED	SERVICE LIMIT = 1 PER DAY
350	77046	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT CONTRAST MATERIAL; UNILATERAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
350	77047	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT CONTRAST MATERIAL; BILATERAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
350	77048	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND WITH CONTRAST MATERIAL(S), INCLUDING COMPUTER-AIDED DETECTION, (CAD REAL-TIME LESION DETECTION, CHARACTERIZATION AND PHARMACOKINETIC ANALYSIS), WHEN PERFORMED; UNILATERAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
350	77049	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND WITH CONTRAST MATERIAL(S), INCLUDING COMPUTER-AIDED DETECTION, (CAD REAL-TIME LESION DETECTION, CHARACTERIZATION AND PHARMACOKINETIC ANALYSIS), WHEN PERFORMED; BILATERAL	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
350	77055	MAMMOGRAPHY; UNILATERAL	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	Must have MQSA certification on file with enrollment
350	77056	MAMMOGRAPHY; BILATERAL	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	Must have MQSA certification on file with enrollment
375	77078	COMPUTED TOMOGRAPHY, BONE MINERAL DENSITY STUDY, 1 OR MORE SITES, AXIAL SKELETON (E.G., HIPS, PELVIS, SPINE)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
375	77080	DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES, AXIAL SKELETON (E.G., HIPS, PELVIS, SPINE)	RADIOLOGY	Required - Beyond Service Limits	No Restriction	PRICED	Limit is one scan every 2 years for codes 77080-77081
375	77081	DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES, APPENDICULAR SKELETON (PERIPHERAL) (E.G., RADIUS, WRIST, HEEL)	RADIOLOGY	Required - Beyond Service Limits	No Restriction	PRICED	Limit is one scan every 2 years for codes 77080-77081
375	77084	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, BONE MARROW BLOOD SUPPLY	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
375	77085	DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES; AXIAL SKELETON (E.G., HIPS, PELVIS, SPINE), INCLUDING VERTEBRAL FRACTURE ASSESSMENT	RADIOLOGY	REQUIRED	No Restriction	PRICED	
375	77086	VERTEBRAL FRACTURE ASSESSMENT VIA DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA)	RADIOLOGY	REQUIRED	No Restriction	PRICED	
631	77385	INTENSITY MODULATED RADIATION TREATMENT DELIVERY (IMRT), INCLUDES GUIDANCE AND TRACKING, WHEN PERFORMED; SIMPLE	RADIOLOGY	REQUIRED	No Restriction	PRICED	
631	77386	INTENSITY MODULATED RADIATION TREATMENT DELIVERY (IMRT), INCLUDES GUIDANCE AND TRACKING, WHEN PERFORMED; COMPLEX	RADIOLOGY	REQUIRED	No Restriction	PRICED	

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PLEASE USE CPT CODE	77299	UNLISTED PROCEDURE, THERAPEUTIC RADIOLOGY CLINICAL TREATMENT PLANNING	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
PLEASE USE CPT CODE	77399	UNLISTED PROCEDURE, MEDICAL RADIATION PHYSICS, DOSIMETRY AND TREATMENT DEVICES, AND SPECIAL SERVICE	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
PLEASE USE CPT CODE	77499	UNLISTED PROCEDURE, RADIATION ONCOLOGY	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
PLEASE USE CPT CODE	77799	UNLISTED PROCEDURE CLINICAL BRACHYTHERAPY	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
535	78071	PARATHYROID PLANAR IMAGING (INCLUDING SUBTRACTION, WHEN PERFORMED); WITH TOMOGRAPHIC (SPECT)	RADIOLOGY	REQUIRED	No Restriction	PRICED	78071 and 78072 with all components are a group- can have all 78071 codes (2 units-1 for each component or 1 unit) or can have all 78072 codes BUT cannot have both.
535	78071 TC	PARATHYROID PLANAR IMAGING (INCLUDING SUBTRACTION, WHEN PERFORMED); WITH TOMOGRAPHIC (SPECT)	RADIOLOGY	REQUIRED	No Restriction	PRICED	78071 and 78072 with all components are a group- can have all 78071 codes (2 units-1 for each component or 1 unit) or can have all 78072 codes BUT cannot have both.
535	78072	PARATHYROID PLANAR IMAGING (INCLUDING SUBTRACTION, WHEN PERFORMED); WITH TOMOGRAPHIC (SPECT), AND CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPHY (CT) FOR ANATOMICAL LOCALIZATION	RADIOLOGY	REQUIRED	No Restriction	PRICED	78071 and 78072 with all components are a group- can have all 78071 codes (2 units-1 for each component or 1 unit) or can have all 78072 codes BUT cannot have both.
535	78072 TC	PARATHYROID PLANAR IMAGING (INCLUDING SUBTRACTION, WHEN PERFORMED); WITH TOMOGRAPHIC (SPECT), AND CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPHY (CT) FOR ANATOMICAL LOCALIZATION	RADIOLOGY	REQUIRED	No Restriction	PRICED	78071 and 78072 with all components are a group- can have all 78071 codes (2 units-1 for each component or 1 unit) or can have all 78072 codes BUT cannot have both.
PLEASE USE CPT CODE	78099	UNLISTED ENDOCRINE PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
PLEASE USE CPT CODE	78199	UNLISTED HEMATOPOIETIC, RETICULOENDOTHELIAL AND LYMPHATIC PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
PLEASE USE CPT CODE	78299	UNLISTED GASTROINTESTINAL PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
PLEASE USE CPT CODE	78399	UNLISTED MUSCULOSKELETAL PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
365	78459	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), METABOLIC EVALUATION STUDY (INCLUDING VENTRICULAR WALL MOTION[S] AND/OR EJECTION FRACTION[S], WHEN PERFORMED), SINGLE STUDY;	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
365	78491	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), PERFUSION STUDY (INCLUDING VENTRICULAR WALL MOTION[S] AND/OR EJECTION FRACTION[S], WHEN PERFORMED); SINGLE STUDY, AT REST OR STRESS (EXERCISE OR PHARMACOLOGIC)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
365	78492	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), PERFUSION STUDY (INCLUDING VENTRICULAR WALL MOTION[S] AND/OR EJECTION FRACTION[S], WHEN PERFORMED); MULTIPLE STUDIES AT REST AND STRESS (EXERCISE OR PHARMACOLOGIC)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
PLEASE USE CPT CODE	78499	UNLISTED CARDIOVASCULAR PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE;	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
PLEASE USE CPT CODE	78599	UNLISTED RESPIRATORY PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024

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364	78608	BRAIN IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), METABOLIC EVALUATION	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
364	78609	BRAIN IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), PERFUSION EVALUATION	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
PLEASE USE CPT CODE	78699	UNLISTED NERVOUS SYSTEM PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
372	78710	KIDNEY IMAGING MORPHOLOGY, TOMOGRAPHIC (SPECT)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
374	78803	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR, INFLAMMATORY PROCESS OR DISTRIBUTION OF RADIOPHARMACEUTICAL AGENT(S) (INCLUDES VASCULAR FLOW AND BLOOD POOL IMAGING, WHEN PERFORMED); TOMOGRAPHIC (SPECT), SINGLE AREA (E.G., HEAD, NECK, CHEST, PELVIS) OR ACQUISITION, SINGLE DAY IMAGING	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
366	78811	POSITRON EMISSION TOMOGRAPHY (PET) IMAGING; LIMITED AREA (E.G., CHEST, HEAD/NECK)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
367	78812	POSITRON EMISSION TOMOGRAPHY (PET) IMAGING; SKULL BASE TO MID-THIGH	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
368	78813	POSITRON EMISSION TOMOGRAPHY (PET) IMAGING; WHOLE BODY	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
366	78814	POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; LIMITED AREA (E.G., CHEST, HEAD/NECK)	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
367	78815	POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; SKULL BASE TO MID-THIGH	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
368	78816	POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; WHOLE BODY	RADIOLOGY	REQUIRED	No Restriction	PRICED	Modifier 26 - No Modifier TC - Required POS other than 23 - Required
889	78830	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR, INFLAMMATORY PROCESS OR DISTRIBUTION OF RADIOPHARMACEUTICAL AGENT(S) (INCLUDES VASCULAR FLOW AND BLOOD POOL IMAGING, WHEN PERFORMED); TOMOGRAPHIC (SPECT) WITH CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPHY (CT) TRANSMISSION SCAN FOR ANATOMICAL REVIEW, LOCALIZATION AND DETERMINATION/DETECTION OF PATHOLOGY, SINGLE AREA (EG, HEAD, NECK, CHEST, PELVIS) OR ACQUISITION, SINGLE DAY IMAGING	RADIOLOGY	REQUIRED	No Restriction	PRICED	***NEW CODE FOR 2020*** Modifier 26 - No Modifier TC - Required POS other than 23 - Required Please use for billing of CPT code 78807

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890	78831	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR, INFLAMMATORY PROCESS OR DISTRIBUTION OF RADIOPHARMACEUTICAL AGENT(S) (INCLUDES VASCULAR FLOW AND BLOOD POOL IMAGING, WHEN PERFORMED); TOMOGRAPHIC (SPECT), MINIMUM 2 AREAS (E.G., PELVIS AND KNEES, CHEST AND ABDOMEN) OR SEPARATE ACQUISITIONS (E.G., LUNG VENTILATION AND PERFUSION), SINGLE DAY IMAGING, OR SINGLE AREA OR ACQUISITION OVER 2 OR MORE DAYS	RADIOLOGY	REQUIRED	No Restriction	PRICED	***NEW CODE FOR 2020*** Modifier 26 - No Modifier TC - Required POS other than 23 - Required Please use for billing of CPT code 78807
891	78832	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR, INFLAMMATORY PROCESS OR DISTRIBUTION OF RADIOPHARMACEUTICAL AGENT(S) (INCLUDES VASCULAR FLOW AND BLOOD POOL IMAGING, WHEN PERFORMED); TOMOGRAPHIC (SPECT) WITH CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPHY (CT) TRANSMISSION SCAN FOR ANATOMICAL REVIEW, LOCALIZATION AND DETERMINATION/DETECTION OF PATHOLOGY, MINIMUM 2 AREAS (E.G., PELVIS AND KNEES, CHEST AND ABDOMEN) OR SEPARATE ACQUISITIONS (E.G., LUNG VENTILATION AND PERFUSION), SINGLE DAY IMAGING, OR SINGLE AREA OR ACQUISITION OVER 2 OR MORE DAYS	RADIOLOGY	REQUIRED	No Restriction	PRICED	***NEW CODE FOR 2020*** Modifier 26 - No Modifier TC - Required POS other than 23 - Required Please use for billing of CPT code 78807
892	78835	RADIOPHARMACEUTICAL QUANTIFICATION MEASUREMENT(S) SINGLE AREA (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	RADIOLOGY	REQUIRED	No Restriction	PRICED	***NEW CODE FOR 2020*** Modifier 26 - No Modifier TC - Required POS other than 23 - Required Please use for billing of CPT code 78807
PLEASE USE CPT CODE	78999	UNLISTED PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE-RADIATION THERAPY TREATMENT PLANNING	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
PLEASE USE CPT CODE	79999	RADIOPHARMACEUTICAL THERAPY, UNLISTED PROCEDURE	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
743	80305	DRUG TEST(S), PRESUMPTIVE, ANY NUMBER OF DRUG CLASSES, ANY NUMBER OF DEVICES OR PROCEDURES; CAPABLE OF BEING READ BY DIRECT OPTICAL OBSERVATION ONLY (E.G., UTILIZING IMMUNOASSAY [E.G., DIPSTICKS, CUPS, CARDS, OR CARTRIDGES]), INCLUDES SAMPLE VALIDATION WHEN PERFORMED, PER DATE OF SERVICE	LABORATORY	Required Beyond Service Limits	No Restriction	PRICED	PA required when >24 per year is needed per member treatment plan. May get up to 24 additional units in 180 day authorization period if medically necessary. CALENDER YEAR AUTHORIZATION PERIOD
743	80306	DRUG TEST(S), PRESUMPTIVE, ANY NUMBER OF DRUG CLASSES, ANY NUMBER OF DEVICES OR PROCEDURES; READ BY INSTRUMENT ASSISTED DIRECT OPTICAL OBSERVATION (E.G., UTILIZING IMMUNOASSAY [E.G., DIPSTICKS, CUPS, CARDS, OR CARTRIDGES]), INCLUDES SAMPLE VALIDATION WHEN PERFORMED, PER DATE OF SERVICE	LABORATORY	Required Beyond Service Limits	No Restriction	PRICED	PA required when >24 per year is needed per member treatment plan. May get up to 24 additional units in 180 day authorization period if medically necessary. CALENDER YEAR AUTHORIZATION PERIOD

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743	80307	DRUG TEST(S), PRESUMPTIVE, ANY NUMBER OF DRUG CLASSES, ANY NUMBER OF DEVICES OR PROCEDURES; BY INSTRUMENT CHEMISTRY ANALYZERS (EG, UTILIZING IMMUNOASSAY [E.G., EIA, ELISA, EMIT, FPJA, IA, KIMS, RIA]), CHROMATOGRAPHY (E.G., GC, HPLC), AND MASS SPECTROMETRY EITHER WITH OR WITHOUT CHROMATOGRAPHY, (E.G., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) INCLUDES SAMPLE VALIDATION WHEN PERFORMED, PER DATE OF SERVICE	LABORATORY	Required Beyond Service Limits	No Restriction	PRICED	PA required when >24 per year is needed per member treatment plan. May get up to 24 additional units in 180 day authorization period if medically necessary. CALENDER YEAR AUTHORIZATION PERIOD
700	81105	HUMAN PLATELET ANTIGEN 1 GENOTYPING (HPA-1), ITGB3 (INTEGRIN, BETA 3 [PLATELET GLYCOPROTEIN IIIA], ANTIGEN CD61 [GPIIIA]) (E.G., NEONATAL ALLOIMMUNE THROMBOCYTOPENIA [NAIT], POST-TRANSFUSION PURPURA), GENE ANALYSIS, COMMON VARIANT, HPA-1A/B (L33P)	GENETIC TESTING	Required Beyond Service Limits	No Restriction	PRICED	
701	81106	HUMAN PLATELET ANTIGEN 2 GENOTYPING (HPA-2), GP1BA (GLYCOPROTEIN IB [PLATELET], ALPHA POLYPEPTIDE [GPIBA]) (E.G., NEONATAL ALLOIMMUNE THROMBOCYTOPENIA [NAIT], POST-TRANSFUSION PURPURA), GENE ANALYSIS, COMMON VARIANT, HPA-2A/B (T145M)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
702	81107	HUMAN PLATELET ANTIGEN 3 GENOTYPING (HPA-3), ITGA2B (INTEGRIN, ALPHA 2B [PLATELET GLYCOPROTEIN IIB OF IIB/IIIA COMPLEX], ANTIGEN CD41 [GPIIB]) (E.G., NEONATAL ALLOIMMUNE THROMBOCYTOPENIA [NAIT], POST-TRANSFUSION PURPURA), GENE ANALYSIS, COMMON VARIANT, HPA-3A/B (I843S)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
703	81108	HUMAN PLATELET ANTIGEN 4 GENOTYPING (HPA-4), ITGB3 (INTEGRIN, BETA 3 [PLATELET GLYCOPROTEIN IIIA], ANTIGEN CD61 [GPIIIA]) (E.G., NEONATAL ALLOIMMUNE THROMBOCYTOPENIA [NAIT], POST-TRANSFUSION PURPURA), GENE ANALYSIS, COMMON VARIANT, HPA-4A/B (R143Q)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
704	81109	HUMAN PLATELET ANTIGEN 5 GENOTYPING (HPA-5), ITGA2 (INTEGRIN, ALPHA 2 [CD49B, ALPHA 2 SUBUNIT OF VLA-2 RECEPTOR] [GPIA]) (E.G., NEONATAL ALLOIMMUNE THROMBOCYTOPENIA [NAIT], POST-TRANSFUSION PURPURA), GENE ANALYSIS, COMMON VARIANT (E.G., HPA-5A/B (K505E))	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
705	81110	HUMAN PLATELET ANTIGEN 6 GENOTYPING (HPA-6W), ITGB3 (INTEGRIN, BETA 3 [PLATELET GLYCOPROTEIN IIIA, ANTIGEN CD61] [GPIIIA]) (E.G., NEONATAL ALLOIMMUNE THROMBOCYTOPENIA [NAIT], POST-TRANSFUSION PURPURA), GENE ANALYSIS, COMMON VARIANT, HPA-6A/B (R489Q)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
706	81111	HUMAN PLATELET ANTIGEN 9 GENOTYPING (HPA-9W), ITGA2B (INTEGRIN, ALPHA 2B [PLATELET GLYCOPROTEIN IIB OF IIB/IIIA COMPLEX, ANTIGEN CD41] [GPIIB]) (E.G., NEONATAL ALLOIMMUNE THROMBOCYTOPENIA [NAIT], POST-TRANSFUSION PURPURA), GENE ANALYSIS, COMMON VARIANT, HPA-9A/B (V837M)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
707	81112	HUMAN PLATELET ANTIGEN 15 GENOTYPING (HPA-15), CD109 (CD109 MOLECULE) (E.G., NEONATAL ALLOIMMUNE THROMBOCYTOPENIA [NAIT], POST-TRANSFUSION PURPURA), GENE ANALYSIS, COMMON VARIANT, HPA-15A/B (S682Y)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	

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708	81120	IDH1 (ISOCITRATE DEHYDROGENASE 1 [NADP+], SOLUBLE) (EG, GLIOMA), COMMON VARIANTS (E.G., R132H, R132C)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
709	81121	IDH2 (ISOCITRATE DEHYDROGENASE 2 [NADP+], MITOCHONDRIAL) (EG, GLIOMA), COMMON VARIANTS (E.G., R140W, R172M)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
537	81161	DMD (DYSTROPHIN) (E.G., DUCHENNE/BECKER MUSCULAR DYSTROPHY) DELETION ANALYSIS, AND DUPLICATION ANALYSIS, IF PERFORMED	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
675	81162	BRCA1(BRCA1, DNA REPAIR ASSOCIATED), BRCA2 (BRCA2 DNA REPAIR ASSOCIATED) (E.G., HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS AND FULL DUPLICATION/DELETION ANALYSIS (I.E., DETECTION OF LARGE GENE ARRANGEMENTS)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	Do not report 81162 in conjunction with 81163, 81164, 81165, 81166, 81167, 81216, 81217, 81432
751	81163	BRCA1(BRCA1, DNA REPAIR ASSOCIATED), BRCA2 (BRCA2 DNA REPAIR ASSOCIATED) (E.G., HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	Do not report 81163 in conjunction with 81162, 81164, 81165, 81166, 81167, 81216, 81217, 81432
752	81164	BRCA1, BRCA2 (BREAST CANCER 1 AND 2) (E.G., HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL DUPLICATION/DELETION ANALYSIS (I.E., DETECTION OF LARGE GENE REARRANGEMENTS)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	Do not report 81164 in conjunction with 81162, 81163, 81165, 81166, 81167, 81216, 81217, 81432
753	81165	BRCA1 (BRCA1, DNA REPAIR ASSOCIATED) (E.G., HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	Do not report 81165 in conjunction with 81162, 81643, 81164, 81166, 81167, 81216, 81217, 81432
754	81166	BRCA1 (BRCA1, DNA REPAIR ASSOCIATED) (E.G., HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL DUPLICATION/DELETION ANALYSIS (I.E., DETECTION OF LARGE GENE REARRANGEMENTS)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	Do not report 81166 in conjunction with 81162, 81643, 81164, 81165, 81167, 81216, 81217, 81432
755	81167	BRCA2 (BRCA2, DNA REPAIR ASSOCIATED) (E.G., HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL DUPLICATION/DELETION ANALYSIS (I.E., DETECTION OF LARGE GENE REARRANGEMENTS)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	Do not report 81167 in conjunction with 81162, 81643, 81164, 81165, 81166, 81216, 81217, 81432)
676	81170	ABL1 (ABL PROTO-ONCOGENE 1, NON-RECEPTOR TYROSINE KINASE) (E.G., ACQUIRED IMATINIB TYROSINE KINASE INHIBITOR RESISTANCE), GENE ANALYSIS, VARIANTS IN THE KINASE DOMAIN	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
756	81171	AFF2 (ALF TRANSCRIPTION ELONGATION FACTOR 2 [FMR2]) (E.G., FRAGILE X INTELLECTUAL DISABILITY 2 [FRAXE]) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (E.G., EXPANDED) ALLELES	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
757	81172	AFF2 (ALF TRANSCRIPTION ELONGATION FACTOR 2 [FMR2]) (E.G., FRAGILE X INTELLECTUAL DISABILITY 2 [FRAXE]) GENE ANALYSIS; CHARACTERIZATION OF ALLELES (E.G., EXPANDED SIZE AND METHYLATION STATUS)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
758	81173	AR (ANDROGEN RECEPTOR) (E.G., SPINAL AND BULBAR MUSCULAR ATROPHY, KENNEDY DISEASE, X CHROMOSOME INACTIVATION) GENE ANALYSIS; FULL GENE SEQUENCE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
759	81174	AR (ANDROGEN RECEPTOR) (E.G., SPINAL AND BULBAR MUSCULAR ATROPHY, KENNEDY DISEASE, X CHROMOSOME INACTIVATION) GENE ANALYSIS; KNOWN FAMILIAL VARIANT	GENETIC TESTING	REQUIRED	No Restriction	PRICED	

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710	81175	ASXL1 (ADDITIONAL SEX COMBS LIKE 1, TRANSCRIPTIONAL REGULATOR) (E.G., MYELODYSPLASTIC SYNDROME, MYELOPROLIFERATIVE NEOPLASMS, CHRONIC MYELOMONOCYTIC LEUKEMIA), GENE ANALYSIS; FULL GENE SEQUENCE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
711	81176	ASXL1 (ADDITIONAL SEX COMBS LIKE 1, TRANSCRIPTIONAL REGULATOR) (E.G., MYELODYSPLASTIC SYNDROME, MYELOPROLIFERATIVE NEOPLASMS, CHRONIC MYELOMONOCYTIC LEUKEMIA), GENE ANALYSIS; TARGETED SEQUENCE ANALYSIS (EG, EXON 12)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
760	81177	ATN1 (ATROPHIN 1) (EG, DENTATORUBRAL-PALLIDOLUYSIAN ATROPHY) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (E.G., EXPANDED) ALLELES	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
761	81178	ATXN1 (ATAXIN 1) (E.G., SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (E.G., EXPANDED) ALLELES	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
762	81179	ATXN2 (ATAXIN 2) (E.G., SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (E.G., EXPANDED) ALLELES	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
763	81180	ATXN3 (ATAXIN 3) (E.G., SPINOCEREBELLAR ATAXIA, MACHADO-JOSEPH DISEASE) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
764	81181	ATXN7 (ATAXIN 7) (E.G., SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (E.G., EXPANDED) ALLELES	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
765	81182	ATXN8OS (ATXN8 OPPOSITE STRAND [NON-PROTEIN CODING]) (E.G., SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (E.G., EXPANDED) ALLELES	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
766	81183	ATXN10 (ATAXIN 10) (E.G., SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (E.G., EXPANDED) ALLELES	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
767	81184	CACNA1A (CALCIUM VOLTAGE-GATED CHANNEL SUBUNIT ALPHA1 A) (E.G., SPINOCEREBELLAR ATAXIA) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (E.G., EXPANDED) ALLELES	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
768	81185	CACNA1A (CALCIUM VOLTAGE-GATED CHANNEL SUBUNIT ALPHA1 A) (E.G., SPINOCEREBELLAR ATAXIA) GENE ANALYSIS; FULL GENE SEQUENCE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
769	81186	CACNA1A (CALCIUM VOLTAGE-GATED CHANNEL SUBUNIT ALPHA1 A) (E.G., SPINOCEREBELLAR ATAXIA) GENE ANALYSIS; KNOWN FAMILIAL VARIANT	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
770	81187	CNBP (CCHC-TYPE ZINC FINGER NUCLEIC ACID BINDING PROTEIN) (E.G., MYOTONIC DYSTROPHY TYPE 2) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (E.G., EXPANDED) ALLELES	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
771	81188	CSTB (CYSTATIN B) (E.G., UNVERRICHT-LUNDBORG DISEASE) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (E.G., EXPANDED) ALLELES	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
772	81189	CSTB (CYSTATIN B) (E.G., UNVERRICHT-LUNDBORG DISEASE) GENE ANALYSIS; FULL GENE SEQUENCE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
773	81190	CSTB (CYSTATIN B) (E.G., UNVERRICHT-LUNDBORG DISEASE) GENE ANALYSIS; KNOWN FAMILIAL VARIANT(S)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	

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538	81201	APC (ADENOMATOUS POLYPOSIS COLI) (E.G., FAMILIAL ADENOMATOSIS POLYPOSIS [FAP], ATTENUATED FAP) GENE ANALYSIS; FULL GENE SEQUENCE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
539	81202	APC (ADENOMATOUS POLYPOSIS COLI) (E.G., FAMILIAL ADENOMATOSIS POLYPOSIS [FAP], ATTENUATED FAP) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
540	81203	APC (ADENOMATOUS POLYPOSIS COLI) (E.G., FAMILIAL ADENOMATOSIS POLYPOSIS [FAP], ATTENUATED FAP) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
774	81204	AR (ANDROGEN RECEPTOR) (E.G., SPINAL AND BULBAR MUSCULAR ATROPHY, KENNEDY DISEASE, X CHROMOSOME INACTIVATION) GENE ANALYSIS; CHARACTERIZATION OF ALLELES (E.G., EXPANDED SIZE OR METHYLATION STATUS)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
541	81205	BCKDHB (BRANCHED-CHAIN KETO ACID DEHYDROGENASE E1, BETA POLYPEPTIDE) (EG, MAPLE SYRUP URINE DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, R183P, G278S, E422X)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
542	81209	BLM (BLOOM SYNDROME, RECQ HELICASE-LIKE) (EG, BLOOM SYNDROME) GENE ANALYSIS, 2281DEL6INS7 VARIANT	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
542	81210	BRAF (V-RAF MURINE SARCOMA VIRAL ONCOGENE HOMOLOG B1) (E.G. COLON CANCER), GENE ANALYSIS, V600E VARIANT	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
609	81212	BRCA1(BRCA1, DNA REPAIR ASSOCIATED), BRCA2 (BRCA2 DNA REPAIR ASSOCIATED) (E.G., HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; 185 DELAG, 5385INSC, 6174DEIT VARIANTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
609	81215	BRCA1(BRCA1, DNA REPAIR ASSOCIATED), (E.G., HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; KNOWN FAMILIAL VARIANT	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
609	81216	BRCA2 (BRCA2 DNA REPAIR ASSOCIATED) (E.G., HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
609	81217	BRCA2 (BRCA2 DNA REPAIR ASSOCIATED) (E.G., HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; KNOWN FAMILIAL VARIANT	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
677	81218	CEBPA (CCAAT/ENHANCER BINDING PROTEIN [C/EBP], ALPHA) (E.G., ACUTE MYELOID LEUKEMIA), GENE ANALYSIS, FULL GENE SEQUENCE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
544	81221	CFTR (CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR) (EG, CYSTIC FIBROSIS) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
545	81222	CFTR (CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR) (EG, CYSTIC FIBROSIS) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
546	81223	CFTR (CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR) (EG, CYSTIC FIBROSIS) GENE ANALYSIS; FULL GENE SEQUENCE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	81225	CYP2C19 (CYTOCHROME P450, FAMILY 2, SUBFAMILY C, POLYPEPTIDE 19) (E.G., DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (E.G., *2, *3, *4, *8, *17)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	

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PLEASE USE CPT CODE	81226	CYP2D6 (CYTOCHROME P450, FAMILY 2, SUBFAMILY D, POLYPEPTIDE 6) (E.G., DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (E.G., *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	81227	CYP2C9 (CYTOCHROME P450, FAMILY 2, SUBFAMILY C, POLYPEPTIDE 9) (E.G., DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (E.G., *2, *3, *5, *6)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	81228	CYTOGENOMIC (GENOME-WIDE) ANALYSIS FOR CONSTITUTIONAL CHROMOSOMAL ABNORMALITIES; INTERROGATION OF GENOMIC REGIONS FOR COPY NUMBER VARIANTS, COMPARATIVE GENOMIC HYBRIDIZATION [CGH] MICROARRAY ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	81229	CYTOGENOMIC (GENOME-WIDE) ANALYSIS FOR CONSTITUTIONAL CHROMOSOMAL ABNORMALITIES; INTERROGATION OF GENOMIC REGIONS FOR COPY NUMBER AND SINGLE NUCLEOTIDE POLYMORPHISM (SNP) VARIANTS, COMPARATIVE GENOMIC HYBRIDIZATION (CGH) MICROARRAY ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	81230	CYP3A4 (CYTOCHROME P450 FAMILY 3 SUBFAMILY A MEMBER 4) (EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANT(S) (EG, *2, *22)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	81231	CYP3A5 (CYTOCHROME P450 FAMILY 3 SUBFAMILY A MEMBER 5) (EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *2, *3, *4, *5, *6, *7)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
775	81233	BTK (BRUTON'S TYROSINE KINASE) (E.G., CHRONIC LYMPHOCYTIC LEUKEMIA) GENE ANALYSIS, COMMON VARIANTS (E.G., C481S, C481R, C481F)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
776	81234	DMPK (DM1 PROTEIN KINASE) (E.G., MYOTONIC DYSTROPHY TYPE 1) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (EXPANDED) ALLELES	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
547	81235	EGFR (EPIDERMAL GROWTH FACTOR RECEPTOR) (E.G., NON-SMALL CELL LUNG CANCER) GENE ANALYSIS, COMMON VARIANTS (E.G., EXON 19 LREA DELETION, L858R, T790M, G719A, G719S, L861Q)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
777	81236	EZH2 (ENHANCER OF ZESTE 2 POLYCOMB REPRESSIVE COMPLEX 2 SUBUNIT) (E.G., MYELODYSPLASTIC SYNDROME, MYELOPROLIFERATIVE NEOPLASMS) GENE ANALYSIS, FULL GENE SEQUENCE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
712	81238	F9 (COAGULATION FACTOR IX) (E.G., HEMOPHILIA B), FULL GENE SEQUENCE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
778	81239	DMPK (DM1 PROTEIN KINASE) (E.G., MYOTONIC DYSTROPHY TYPE 1) GENE ANALYSIS; CHARACTERIZATION OF ALLELES (E.G., EXPANDED SIZE)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
548	81240	F2 (PROTHROMBIN, COAGULATION FACTOR II) (EG, HEREDITARY HYPERCOAGULABILITY) GENE ANALYSIS, 20210G>A VARIANT	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
549	81241	F5 (COAGULATION FACTOR V) (EG, HEREDITARY HYPERCOAGULABILITY) GENE ANALYSIS, LEIDEN VARIANT	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME

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550	81242	FMR1 (FRAGILE X MESSENGER RIBONUCLEOPROTEIN 1) (E.G., FRAGILE X SYNDROME, X-LINKED INTELLECTUAL DISABILITY [XLID]) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (E.G., EXPANDED) ALLELES	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
551	81243	FMR1 (FRAGILE X MESSENGER RIBONUCLEOPROTEIN 1) (E.G., FRAGILE X SYNDROME, X-LINKED INTELLECTUAL DISABILITY [XLID]) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (E.G., EXPANDED) ALLELES	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
552	81244	FMR1 (FRAGILE X MESSENGER RIBONUCLEOPROTEIN 1) (E.G., FRAGILE X SYNDROME, X-LINKED INTELLECTUAL DISABILITY [XLID]) GENE ANALYSIS; CHARACTERIZATION OF ALLELES (E.G., EXPANDED SIZE AND PROMOTER METHYLATION STATUS)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
553	81245	FLT3 (FMS-RELATED TYROSINE KINASE 3) (E.G. ACUTE MYELOID LEUKEMIA), GENE ANALYSIS, INTERNAL TANDEM DUPLICATION (ITD) VARIANTS (I.E., EXONS 14, 15	GENETIC TESTING	REQUIRED	No Restriction	PRICED	Justification must include to differentiate CML from AML. Requires order from hematology/oncology and with a diagnosis of myelogenous leukemia.
652	81246	FLT3 (FMS-RELATED TYROSINE KINASE 3) (EG, ACUTE MYELOID LEUKEMIA), GENE ANALYSIS; TYROSINE KINASE DOMAIN (TKD) VARIANTS (E.G., D835, I836)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
713	81247	G6PD (GLUCOSE-6-PHOSPHATE DEHYDROGENASE) (E.G., HEMOLYTIC ANEMIA, JAUNDICE), GENE ANALYSIS; COMMON VARIANT(S) (E.G., A, A-)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
714	81248	G6PD (GLUCOSE-6-PHOSPHATE DEHYDROGENASE) (E.G., HEMOLYTIC ANEMIA, JAUNDICE), GENE ANALYSIS; KNOWN FAMILIAL VARIANT(S)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
715	81249	G6PD (GLUCOSE-6-PHOSPHATE DEHYDROGENASE) (E.G., HEMOLYTIC ANEMIA, JAUNDICE), GENE ANALYSIS; FULL GENE SEQUENCE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
554	81252	GJB2 (GAP JUNCTION PROTEIN, BETA 2, 26KDA, CONNEXIN 26) (E.G., NONSYNDROMIC HEARING LOSS) GENE ANALYSIS; FULL GENE SEQUENCE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
555	81253	GJB2 (GAP JUNCTION PROTEIN, BETA 2, 26KDA; CONNEXIN 26) (E.G., NONSYNDROMIC HEARING LOSS) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
556	81254	GJB6 (GAP JUNCTION PROTEIN, BETA 6, 30KDA, CONNEXIN 30) (E.G., NONSYNDROMIC HEARING LOSS) GENE ANALYSIS, COMMON VARIANTS (E.G., 309KB [DEL(GJB6-D13S1830)] AND 232KB [DEL(GJB6-D13S1854)])	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
557	81255	HEXA (HEXOSAMINIDASE A [ALPHA POLYPEPTIDE]) (EG, TAY-SACHS DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, 1278INSTATC, 1421+1G>C, G269S)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
558	81256	HFE (HEMOCHROMATOSIS) (EG, HEREDITARY HEMOCHROMATOSIS) GENE ANALYSIS, COMMON VARIANTS (EG, C282Y, H63D)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
559	81257	HBA1/HBA2 (ALPHA GLOBIN 1 AND ALPHA GLOBIN 2) (EG, ALPHA THALASSEMIA, HB BART HYDROPS FETALIS SYNDROME, HBH DISEASE), GENE ANALYSIS, FOR COMMON DELETIONS OR VARIANT (EG, SOUTHEAST ASIAN, THAI, FILIPINO, MEDITERRANEAN, ALPHA3.7, ALPHA4.2, ALPHA20.5, AND CONSTANT SPRING)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME

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716	81258	HBA1/HBA2 (ALPHA GLOBIN 1 AND ALPHA GLOBIN 2) (E.G., ALPHA THALASSEMIA, HB BART HYDROPS FETALIS SYNDROME, HBH DISEASE), GENE ANALYSIS; KNOWN FAMILIAL VARIANT	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
717	81259	HBA1/HBA2 (ALPHA GLOBIN 1 AND ALPHA GLOBIN 2) (E.G., ALPHA THALASSEMIA, HB BART HYDROPS FETALIS SYNDROME, HBH DISEASE), GENE ANALYSIS; FULL GENE SEQUENCE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
560	81261	IGH@ (IMMUNOGLOBULIN HEAVY CHAIN LOCUS) (EG, LEUKEMIAS AND LYMPHOMAS, B-CELL), GENE REARRANGEMENT ANALYSIS TO DETECT ABNORMAL CLONAL POPULATION(S); AMPLIFIED METHODOLOGY (EG, POLYMERASE CHAIN REACTION)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
561	81262	IGH@ (IMMUNOGLOBULIN HEAVY CHAIN LOCUS) (EG, LEUKEMIAS AND LYMPHOMAS, B-CELL), GENE REARRANGEMENT ANALYSIS TO DETECT ABNORMAL CLONAL POPULATION(S); DIRECT PROBE METHODOLOGY (EG, SOUTHERN BLOT)	GENETIC TESTING	Required - Beyond Service Limits	No Restriction	PRICED	
562	81263	IGH@ (IMMUNOGLOBULIN HEAVY CHAIN LOCUS) (EG, LEUKEMIA AND LYMPHOMA, B-CELL), VARIABLE REGION SOMATIC MUTATION ANALYSIS	GENETIC TESTING	Required - Beyond Service Limits	No Restriction	PRICED	
563	81264	IGK@ (IMMUNOGLOBULIN KAPPA LIGHT CHAIN LOCUS) (EG, LEUKEMIA AND LYMPHOMA, B-CELL), GENE REARRANGEMENT ANALYSIS, EVALUATION TO DETECT ABNORMAL CLONAL POPULATION(S)	GENETIC TESTING	Required - Beyond Service Limits	No Restriction	PRICED	
564	81265	COMPARATIVE ANALYSIS USING SHORT TANDEM REPEAT (STR) MARKERS; PATIENT AND COMPARATIVE SPECIMEN (EG, PRE-TRANSPLANT RECIPIENT AND DONOR GERMLINE TESTING, POST-TRANSPLANT NON-HEMATOPOIETIC RECIPIENT GERMLINE [EG, BUCCAL SWAB OR OTHER GERMLINE TISSUE SAMPLE] AND DONOR TESTING, TWIN ZYGOSITY TESTING, OR MATERNAL CELL CONTAMINATION OF FETAL CELLS)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
565	81266	COMPARATIVE ANALYSIS USING SHORT TANDEM REPEAT (STR) MARKERS; EACH ADDITIONAL SPECIMEN (EG, ADDITIONAL CORD BLOOD DONOR, ADDITIONAL FETAL SAMPLES FROM DIFFERENT CULTURES, OR ADDITIONAL ZYGOSITY IN MULTIPLE BIRTH PREGNANCIES) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
566	81267	CHIMERISM (ENGRAFTMENT) ANALYSIS, POST TRANSPLANTATION SPECIMEN (EG, HEMATOPOIETIC STEM CELL), INCLUDES COMPARISON TO PREVIOUSLY PERFORMED BASELINE ANALYSES; WITHOUT CELL SELECTION	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
567	81268	CHIMERISM (ENGRAFTMENT) ANALYSIS, POST TRANSPLANTATION SPECIMEN (EG, HEMATOPOIETIC STEM CELL), INCLUDES COMPARISON TO PREVIOUSLY PERFORMED BASELINE ANALYSES; WITH CELL SELECTION (EG, CD3, CD33), EACH CELL TYPE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
718	81269	HBA1/HBA2 (ALPHA GLOBIN 1 AND ALPHA GLOBIN 2) (E.G., ALPHA THALASSEMIA, HB BART HYDROPS FETALIS SYNDROME, HBH DISEASE), GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
568	81270	JAK2 (JANUS KINASE 2) (EG, MYELOPROLIFERATIVE DISORDER) GENE ANALYSIS, P.VAL617PHE (V617F) VARIANT	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME

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779	81271	HTT (HUNTINGTIN) (E.G., HUNTINGTON DISEASE) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (E.G., EXPANDED) ALLELES	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
689	81272	KIT (V-KIT HARDY-ZUKERMAN 4 FELINE SARCOMA VIRAL ONCOGENE HOMOLOG) (E.G., GASTROINTESTINAL STROMAL TUMOR [GIST], ACUTE MYELOID LEUKEMIA, MELANOMA), GENE ANALYSIS, TARGETED SEQUENCE ANALYSIS (E.G., EXONS 8, 11, 13, 17, 18)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
780	81274	HTT (HUNTINGTIN) (E.G., HUNTINGTON DISEASE) GENE ANALYSIS; CHARACTERIZATION OF ALLELES (E.G., EXPANDED SIZE)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
690	81275	KRAS (KIRSTEN RAT SARCOMA VIRAL ONCOGENE HOMOLOG) (E.G., CARCINOMA GENE ANALYSIS; VARIANTS IN EXON 2 (E.G., CODONS 12 & 13)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
691	81276	KRAS (KIRSTEN RAT SARCOMA VIRAL ONCOGENE HOMOLOG) (E.G., CARCINOMA GENE ANALYSIS; ADDITIONAL VARIANTS(S) (E.G., CODON 61, CODON 146)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
941	81278	IGH@/BCL2 (T(14;18)) (E.G., FOLLICULAR LYMPHOMA) TRANSLOCATION ANALYSIS, MAJOR BREAKPOINT REGION (MBR) AND MINOR CLUSTER REGION (MCR) BREAKPOINTS, QUALITATIVE OR QUANTITATIVE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
942	81279	JAK2 (JANUS KINASE 2) (E.G., MYELOPROLIFERATIVE DISORDER) TARGETED SEQUENCE ANALYSIS (E.G., EXONS 12 AND 13)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
781	81284	FXN (FRATAXIN) (E.G., FRIEDREICH ATAXIA) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (EXPANDED) ALLELES	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
782	81285	FXN (FRATAXIN) (E.G., FRIEDREICH ATAXIA) GENE ANALYSIS; CHARACTERIZATION OF ALLELES (E.G., EXPANDED SIZE)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
783	81286	FXN (FRATAXIN) (E.G., FRIEDREICH ATAXIA) GENE ANALYSIS; FULL GENE SEQUENCE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
784	81289	FXN (FRATAXIN) (E.G., FRIEDREICH ATAXIA) GENE ANALYSIS; KNOWN FAMILIAL VARIANT(S)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
570	81290	MCOLN1 (MUCOLIPIN 1) (EG, MUCOLIPIDOSIS, TYPE IV) GENE ANALYSIS, COMMON VARIANTS (EG, IVS3-2A>G, DEL6.4KB)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
571	81291	MTHFR (5,10-METHYLENETETRAHYDROFOLATE REDUCTASE) (EG, HEREDITARY HYPERCOAGULABILITY) GENE ANALYSIS, COMMON VARIANTS (EG, 677T, 1298C)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
609	81292	MLH1 (MUTL HOMOLOG 1, COLON CANCER, NONPOLYPOSIS TYPE 2) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
609	81293	MLH1 (MUTL HOMOLOG 1, COLON CANCER, NONPOLYPOSIS TYPE 2) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
609	81294	MLH1 (MUTL HOMOLOG 1, COLON CANCER, NONPOLYPOSIS TYPE 2) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
609	81295	MSH2 (MUTS HOMOLOG 2, COLON CANCER, NONPOLYPOSIS TYPE 1) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME

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609	81296	MSH2 (MUTS HOMOLOG 2, COLON CANCER, NONPOLYPOSIS TYPE 1) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
609	81297	MSH2 (MUTS HOMOLOG 2, COLON CANCER, NONPOLYPOSIS TYPE 1) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
572	81298	MSH6 (MUTS HOMOLOG 6 [E. COLI]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
573	81299	MSH6 (MUTS HOMOLOG 6 [E. COLI]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
574	81300	MSH6 (MUTS HOMOLOG 6 [E. COLI]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
575	81301	MICROSATELLITE INSTABILITY ANALYSIS (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) OF MARKERS FOR MISMATCH REPAIR DEFICIENCY (EG, BAT25, BAT26), INCLUDES COMPARISON OF NEOPLASTIC AND NORMAL TISSUE, IF PERFORMED	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
785	81305	MYD88 (MYELOID DIFFERENTIATION PRIMARY RESPONSE 88) (E.G., WALDENSTROM'S MACROGLOBULINEMIA, LYMPHOPLASMACYTIC LEUKEMIA) GENE ANALYSIS, P.LEU265PRO (L265P) VARIANT	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
893	81307	PALB2 (PARTNER AND LOCALIZER OF BRCA2) (E.G., BREAST AND PANCREATIC CANCER) GENE ANALYSIS; FULL GENE SEQUENCE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
894	81308	PALB2 (PARTNER AND LOCALIZER OF BRCA2) (E.G., BREAST AND PANCREATIC CANCER) GENE ANALYSIS; KNOWN FAMILIAL VARIANT	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
895	81309	PIK3CA (PHOSPHATIDYLINOSITOL-4, 5-BIPHOSPHATE 3-KINASE, CATALYTIC SUBUNIT ALPHA) (E.G., COLORECTAL AND BREAST CANCER) GENE ANALYSIS, TARGETED SEQUENCE ANALYSIS (E.G., EXONS 7, 9, 20)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
576	81310	NPM1 (NUCLEOPHOSMIN) (EG, ACUTE MYELOID LEUKEMIA) GENE ANALYSIS, EXON 12 VARIANTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
786	81312	PABPN1 (POLY[A] BINDING PROTEIN NUCLEAR 1) (E.G., OCULOPHARYNGEAL MUSCULAR DYSTROPHY) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (E.G., EXPANDED) ALLELES	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
678	81314	PDGFRA (PLATELET-DERIVED GROWTH FACTOR RECEPTOR, ALPHA POLYPEPTIDE) (E.G., GASTROINTESTINAL STROMAL TUMOR [GIST]), GENE ANALYSIS, TARGETED SEQUENCE ANALYSIS (E.G., EXONS 12, 18)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
577	81315	PML/RARALPHA, (T(15;17)), (PROMYELOCYTIC LEUKEMIA/RETINOIC ACID RECEPTOR ALPHA) (EG, PROMYELOCYTIC LEUKEMIA) TRANSLOCATION ANALYSIS; COMMON BREAKPOINTS (EG, INTRON 3 AND INTRON 6), QUALITATIVE OR QUANTITATIVE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
609	81316	PML/RARALPHA, (T(15;17)), (PROMYELOCYTIC LEUKEMIA/RETINOIC ACID RECEPTOR ALPHA) (EG, PROMYELOCYTIC LEUKEMIA) TRANSLOCATION ANALYSIS; SINGLE BREAKPOINT (EG, INTRON 3, INTRON 6 OR EXON 6), QUALITATIVE OR QUANTITATIVE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	

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609	81317	PMS2 (POSTMEIOTIC SEGREGATION INCREASED 2 [S. CEREVISIAE]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
609	81318	PMS2 (POSTMEIOTIC SEGREGATION INCREASED 2 [S. CEREVISIAE]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
609	81319	PMS2 (POSTMEIOTIC SEGREGATION INCREASED 2 [S. CEREVISIAE]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
578	81321	PTEN (PHOSPHATASE AND TENSIN HOMOLOG) (E.G., COWDEN SYNDROME, PTEN HAMARTOMA TUMOR SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
579	81322	PTEN (PHOSPHATASE AND TENSIN HOMOLOG) (E.G., COWDEN SYNDROME, PTEN HAMARTOMA TUMOR SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANT	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
580	81323	PTEN (PHOSPHATASE AND TENSIN HOMOLOG) (E.G., COWDEN SYNDROME, PTEN HAMARTOMA TUMOR SYNDROME) GENE ANALYSIS;	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
581	81324	PMP22 (PERIPHERAL MYELIN PROTEIN 22) (E.G., CHARCOT-MARIE-TOOTH, HEREDITARY NEUROPATHY WITH LIABILITY TO PRESSURE PALSIES) GENE ANALYSIS; DUPLICATION/DELETION ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
582	81325	PMP22 (PERIPHERAL MYELIN PROTEIN 22) (E.G., CHARCOT-MARIE-TOOTH, HEREDITARY NEUROPATHY WITH LIABILITY TO PRESSURE PALSIES) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
583	81326	PMP22 (PERIPHERAL MYELIN PROTEIN 22) (E.G., CHARCOT-MARIE-TOOTH, HEREDITARY NEUROPATHY WITH LIABILITY TO PRESSURE PALSIES) GENE ANALYSIS; KNOWN FAMILIAL VARIANT	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
787	81329	SMN1 (SURVIVAL OF MOTOR NEURON 1, TELOMERIC) (E.G., SPINAL MUSCULAR ATROPHY) GENE ANALYSIS; DOSAGE/DELETION ANALYSIS (E.G., CARRIER TESTING), INCLUDES SMN2 (SURVIVAL OF MOTOR NEURON 2, CENTROMERIC) ANALYSIS, IF PERFORMED	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
584	81331	SNRPN/UBE3A (SMALL NUCLEAR RIBONUCLEOPROTEIN POLYPEPTIDE N AND UBIQUITIN PROTEIN LIGASE E3A) (EG, PRADER-WILLI SYNDROME AND/OR ANGELMAN SYNDROME), METHYLATION ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
585	81332	SERPINA1 (SERPIN PEPTIDASE INHIBITOR, CLADE A, ALPHA-1 ANTIPROTEINASE, ANTITRYPSIN, MEMBER 1) (EG, ALPHA-1-ANTITRYPSIN DEFICIENCY), GENE ANALYSIS, COMMON VARIANTS (EG, *S AND *Z)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
788	81333	TGFB1 (TRANSFORMING GROWTH FACTOR BETA-INDUCED) (E.G., CORNEAL DYSTROPHY) GENE ANALYSIS, COMMON VARIANTS (E.G., R124H, R124C, R124L, R555W, R555Q)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
719	81334	RUNX1 (RUNT RELATED TRANSCRIPTION FACTOR 1) (E.G., ACUTE MYELOID LEUKEMIA, FAMILIAL PLATELET DISORDER WITH ASSOCIATED MYELOID MALIGNANCY), GENE ANALYSIS, TARGETED SEQUENCE ANALYSIS (E.G., EXONS 3-8)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	81335	TPMT (THIOPURINE S-METHYLTRANSFERASE) (EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *2, *3)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	

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789	81336	SMN1 (SURVIVAL OF MOTOR NEURON 1, TELOMERIC) (E.G., SPINAL MUSCULAR ATROPHY) GENE ANALYSIS; FULL GENE SEQUENCE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
790	81337	SMN1 (SURVIVAL OF MOTOR NEURON 1, TELOMERIC) (E.G., SPINAL MUSCULAR ATROPHY) GENE ANALYSIS; KNOWN FAMILIAL SEQUENCE VARIANT(S)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
943	81338	MPL (MPL PROTO-ONCOGENE, THROMBOPOIETIN RECEPTOR) (E.G., MYELOPROLIFERATIVE DISORDER) GENE ANALYSIS; COMMON VARIANTS (E.G., W515A, W515K, W515L, W515R)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
944	81339	MPL (MPL PROTO-ONCOGENE, THROMBOPOIETIN RECEPTOR) (E.G., MYELOPROLIFERATIVE DISORDER) GENE ANALYSIS; SEQUENCE ANALYSIS, EXON 10	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
791	81343	PPP2R2B (PROTEIN PHOSPHATASE 2 REGULATORY SUBUNIT BBETA) (E.G., SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
792	81344	TBP (TATA BOX BINDING PROTEIN) (E.G., SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (E.G., EXPANDED) ALLELES	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	81349	CYTOGENOMIC (GENOME-WIDE) ANALYSIS FOR CONSTITUTIONAL CHROMOSOMAL ABNORMALITIES; INTERROGATION OF GENOMIC REGIONS FOR COPY NUMBER AND LOSS-OF-HETEROZYGOSITY VARIANTS, LOW-PASS SEQUENCING ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
945	81351	TP53 (TUMOR PROTEIN 53) (E.G., LI-FRAUMENI SYNDROME) GENE ANALYSIS; FULL GENE SEQUENCE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
946	81353	TP53 (TUMOR PROTEIN 53) (E.G., LI-FRAUMENI SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANT	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
947	81357	U2AF1 (U2 SMALL NUCLEAR RNA AUXILIARY FACTOR 1) (E.G., MYELODYSPLASTIC SYNDROME, ACUTE MYELOID LEUKEMIA) GENE ANALYSIS, COMMON VARIANTS (E.G., S34F, S34Y, Q157R, Q157P)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
720	81361	HBB (HEMOGLOBIN, SUBUNIT BETA) (E.G., SICKLE CELL ANEMIA, BETA THALASSEMIA, HEMOGLOBINOPATHY); COMMON VARIANT(S) (E.G., HBS, HBC, HBE)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
721	81362	HBB (HEMOGLOBIN, SUBUNIT BETA) (E.G., SICKLE CELL ANEMIA, BETA THALASSEMIA, HEMOGLOBINOPATHY); KNOWN FAMILIAL VARIANT(S)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
722	81363	HBB (HEMOGLOBIN, SUBUNIT BETA) (E.G., SICKLE CELL ANEMIA, BETA THALASSEMIA, HEMOGLOBINOPATHY); DUPLICATION/DELETION VARIANT(S)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
723	81364	HBB (HEMOGLOBIN, SUBUNIT BETA) (E.G., SICKLE CELL ANEMIA, BETA THALASSEMIA, HEMOGLOBINOPATHY); FULL GENE SEQUENCE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
586	81370	HLA CLASS I AND II TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); HLA-A, -B, -C, -DRB1/3/4/5, AND -DQB1	GENETIC TESTING	Required - Beyond Service Limits	No Restriction	PRICED	
587	81371	HLA CLASS I AND II TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); HLA-A, -B, AND -DRB1/3/4/5 (EG, VERIFICATION TYPING)	GENETIC TESTING	Required - Beyond Service Limits	No Restriction	PRICED	

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588	81372	HLA CLASS I TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); COMPLETE (IE, HLA-A, -B, AND -C)	GENETIC TESTING	Required - Beyond Service Limits	No Restriction	PRICED	
589	81373	HLA CLASS I TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); ONE LOCUS (EG, HLA-A, -B, OR -C), EACH	GENETIC TESTING	Required - Beyond Service Limits	No Restriction	PRICED	
590	81374	HLA CLASS I TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); ONE ANTIGEN EQUIVALENT (EG, B*27), EACH	GENETIC TESTING	Required - Beyond Service Limits	No Restriction	PRICED	
591	81375	HLA CLASS II TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); HLA-DRB1/3/4/5 AND -DQB1	GENETIC TESTING	Required - Beyond Service Limits	No Restriction	PRICED	
592	81376	HLA CLASS II TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); ONE LOCUS (EG, HLA-DRB1/3/4/5, -DQB1, -DQA1, -DPB1, OR -DPA1), EACH	GENETIC TESTING	Required - Beyond Service Limits	No Restriction	PRICED	
593	81377	HLA CLASS II TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); ONE ANTIGEN EQUIVALENT, EACH	GENETIC TESTING	Required - Beyond Service Limits	No Restriction	PRICED	
594	81378	HLA CLASS I AND II TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS), HLA-A, -B, -C, AND -DRB1	GENETIC TESTING	Required - Beyond Service Limits	No Restriction	PRICED	
595	81379	HLA CLASS I TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); COMPLETE (IE, HLA-A, -B, AND -C)	GENETIC TESTING	Required - Beyond Service Limits	No Restriction	PRICED	
596	81380	HLA CLASS I TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); ONE LOCUS (EG, HLA-A, -B, OR -C), EACH	GENETIC TESTING	Required - Beyond Service Limits	No Restriction	PRICED	
597	81381	HLA CLASS I TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); ONE ALLELE OR ALLELE GROUP (EG, B*57:01P), EACH	GENETIC TESTING	Required - Beyond Service Limits	No Restriction	PRICED	
599	81382	HLA CLASS II TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); ONE LOCUS (EG, HLA-DRB1, -DRB3, -DRB4, -DRB5, -DQB1, -DQA1, -DPB1, OR -DPA1), EACH	GENETIC TESTING	Required - Beyond Service Limits	No Restriction	PRICED	
598	81383	HLA CLASS II TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); ONE ALLELE OR ALLELE GROUP (EG, HLA-DQB1*06:02P), EACH	GENETIC TESTING	Required - Beyond Service Limits	No Restriction	PRICED	
735	81400	MOLECULAR PATHOLOGY PROCEDURE-LEVEL 1 (E.G. IDENTIFICATION OF SINGLE GERMLINE VARIANT (E.G. SNP) BY TECHNIQUES SUCH AS RESTRICTION ENZYME DIGESTION OR MELT CURVE ANALYSIS)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
736	81401	MOLECULAR PATHOLOGY PROCEDURE-LEVEL 2 (E.G., 2-10 SNPS, 1 METHYLATED VARIANT, OR 1 SOMATIC VARIANT (TYPICALLY USING NONSEQUENCING TARGET VARIANT ANALYSIS), OR DETECTION OF A DYNAMIC MUTATION DISORDER/TRIPLET REPEAT)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	

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737	81402	MOLECULAR PATHOLOGY PROCEDURE-LEVEL 3 (E.G. >10 SNP'S, 2-10 METHYLATED VARIANTS, OR 2-10 SOMATIC VARIANTS (TYPICALLY USING NON-SEQUENCING TARGET VARIANT ANALYSIS) IMMUNOGLOBIN AND T-CELL RECEPTOR GENE REARRANGEMENTS, DUPLICATION/DELETION VARIANTS OF 1 EXON, LOSS OF HETEROZYGOSITY (LOH), UNIPARENTAL DISOMY(UPD))	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
738	81403	MOLECULAR PATHOLOGY PROCEDURE-LEVEL 4 (E.G., ANALYSIS OF SINGLE EXON BY DNA SEQUENCE ANALYSIS, ANALYSIS OF >10 AMPLICONS USING MULTIPLEX PCR IN 2 OR MORE INDEPENDENT REACTIONS, MUTATION SCANNING OR DUPLICATION/DELETION VARIANTS OF 2-5 EXONS)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
740	81405	MOLECULAR PATHOLOGY PROCEDURE-LEVEL 6 (E.G., ANALYSIS OF 6-10 EXONS BY DNA SEQUENCE ANALYSIS, MUTATION SCANNING OR DUPLICATION/DELETION VARIANTS OF 11-25 EXONS, REGIONALLY TARGETED CYTOGENOMIC ARRAY ANALYSIS)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
741	81406	MOLECULAR PATHOLOGY PROCEDURE-LEVEL 7 (E.G., ANALYSIS OF 11-25 EXONS BY DNA SEQUENCE ANALYSIS, MUTATION SCANNING OR DUPLICATION/DELETION VARIANTS OF 25-50 EXONS, CYTOGENOMIC ARRAY ANALYSIS FOR NEOPLASIA)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
742	81407	MOLECULAR PATHOLOGY PROCEDURE-LEVEL 8(E.G., ANALYSIS OF 26-50 EXONS BY DNA SEQUENCE ANALYSIS, MUTATION SCANNING OR DUPLICATION/DELETION VARIANTS OF >50 EXONS, SEQUENCE ANALYSIS OF MULTIPLE GENES ON ONE PLATFORM)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
654	81410	AORTIC DYSFUNCTION OR DILATION (E.G., MARFAN SYNDROME, LOEYS DIETZ SYNDROME, EHLER DANLOS SYNDROME TYPE IV, ATRIAL TORTUOSITY SYNDROME); GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 9 GENES, INCLUDING FBN1, TGFB1, TGFB2, COL3A1, MYH11, ACTA2, SLC2410, AMA01 AND MYLK	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
679	81411	AORTIC DYSFUNCTION OR DILATION (E.G., MARFAN SYNDROME, LOEYS DIETZ SYNDROME, EHLER DANLOS SYNDROME TYPE IV, ATRIAL TORTUOSITY SYNDROME); GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAT 9 GENES, INCLUDING FBN1, TGFB1, TGFB2, COL3A1, MYH11, ACTA2, SLC2410, AMA01 AND MYLK. DUPLICATION/DELETION ANALYSIS PANEL, MUST INCLUDE ANALYSIS FOR TGFB1, TGFB2, MYH11, AND COL3A1	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
680	81412	ASHKENAZI JEWISH ASSOCIATED DISORDERS (E.G., BLOOM SYNDROME, CANAVAN DISEASE, CYSTIC FIBROSIS, FAMILIAL DYSAUTONOMIA, FANCONI ANEMIA GROUP C, GAUCHER DISEASE, TAY-SACHS DISEASE), GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 9 GENES, INCLUDING ASPA, BLM, CFTR, FANCC, GA, HEXA, IKBKAP, MCOLN1, AND SMPD1	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	81415	EXOME (E.G., UNEXPLAINED CONSTITUTIONAL OR HERITABLE DISORDER OR SYNDROME); SEQUENCE ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	

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PLEASE USE CPT CODE	81416	EXOME (E.G., UNEXPLAINED CONSTITUTIONAL OR HERITABLE DISORDER OR SYNDROME); SEQUENCE ANALYSIS, EACH COMPARATOR EXOME (E.G., PARENTS, SIBLINGS) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE). THIS CODE IS USED IN THE CONTEXT OF WHOLE EXOME SEQUENCING (WES) WHEN COMPARING THE PATIENT'S EXOME TO THAT OF A RELATIVE, SUCH AS A PARENT OR SIBLING, TO HELP DIAGNOSE GENETIC DISORDERS.	GENETIC TESTING	REQUIRED	No Restriction	PRICED	NEW CODE EFFECTIVE 09/01/2025
PLEASE USE CPT CODE	81418	DRUG METABOLISM (E.G., PHARMACOGENOMICS) GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE TESTING OF AT LEAST 6 GENES, INCLUDING CYP2C19, CYP2D6, AND CYP2D6 DUPLICATION/DELETION ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
688	81420	FETAL CHROMOSOMAL ANEUPLOIDY (TRISOMY 21, MONOSOMY X) GENOMIC SEQUENCE ANALYSIS PANEL, CIRCULATING CELL-FREE FETAL DNA IN MATERNAL BLOOD, MUST INCLUDE ANALYSIS OF CHROMOSOMES 13, 18, AND 21	GENETIC TESTING	REQUIRED	No Restriction	PRICED	Note: Prior authorization requirement removed for dates of service from 05/01/2025 forward.
681	81432	HEREDITARY BREAST CANCER-RELATED DISORDERS (E.G., HEREDITARY BREAST CANCER, HEREDITARY OVARIAN CANCER, HEREDITARY ENDOMETRIAL CANCER, HEREDITARY PANCREATIC CANCER, HEREDITARY PROSTATE CANCER), GENOMIC SEQUENCE ANALYSIS PANEL, 5 OR MORE GENES, INTERROGATION FOR SEQUENCE VARIANTS AND COPY NUMBER VARIANTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
683	81434	HEREDITARY RETINAL DISORDERS (E.G., RETINITIS PIGMENTOSA, LEBER CONGENITAL AMAUROSIS, CONE-ROD DYSTROPHY), GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 15 GENES, INCLUDING ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31, PRPH2, RDH12, RHO, RP1, RP2, RPE65, RPGR, AND USH2A	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
655	81435	HEREDITARY COLON CANCER-RELATED DISORDERS (E.G., LYNCH SYNDROME, PTEN HAMARTOMA SYNDROME, COWDEN SYNDROME, FAMILIAL ADENOMATOSIS POLYPOSIS), GENOMIC SEQUENCE ANALYSIS PANEL, 5 OR MORE GENES, INTERROGATION FOR SEQUENCE VARIANTS AND COPY NUMBER VARIANTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
684	81437	HEREDITARY NEUROENDOCRINE TUMOR-RELATED DISORDERS (E.G., MEDULLARY THYROID CARCINOMA, PARATHYROID CARCINOMA, MALIGNANT PHEOCHROMOCYTOMA OR PARAGANGLIOMA), GENOMIC SEQUENCE ANALYSIS PANEL, 5 OR MORE GENES, INTERROGATION FOR SEQUENCE VARIANTS AND COPY NUMBER VARIANTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	

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PLEASE USE CPT CODE	81441	INHERITED BONE MARROW FAILURE SYNDROMES (IBMFS) (E.G., FANCONI ANEMIA, DYSKERATOSIS CONGENITA, DIAMOND-BLACKFAN ANEMIA, SHWACHMAN-DIAMOND SYNDROME, GATA2 DEFICIENCY SYNDROME, CONGENITAL AMEGAKARYOCYTIC THROMBOCYTOPENIA) SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 30 GENES, INCLUDING BRCA2, BRIP1, DKC1, FANCA, FANCB, FANCC, FANCD2, FANCE, FANCF, FANCG, FANCI, FANCL, GATA1, GATA2, MPL, NHP2, NOP10, PALB2, RAD51C, RPL11, RPL35A, RPL5, RPS10, RPS19, RPS24, RPS26, RPS7, SBDS, TERT, AND TINF2	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
686	81442	NOONAN SPECTRUM DISORDERS (EG, NOONAN SYNDROME, CARDIO-FACIO-CUTANEOUS SYNDROME, COSTELLO SYNDROME, LEOPARD SYNDROME, NOONAN-LIKE SYNDROME), GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 12 GENES, INCLUDING BRAF, CBL, HRAS, KRAS, MAP2K1, MAP2K2, NRAS, PTPN11, RAF1, RIT1, SHOC2, AND SOS1	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	81443	GENETIC TESTING FOR SEVERE INHERITED CONDITIONS (E.G. CYSTIC FIBROSIS, ASHKENAZI JEWISH-ASSOCIATED DISORDERS(EG, BLOOM SYNDROME, CANAVAN DISEASE, FANCONI ANEMIA TYPE C, MUCOLIPIDOSIS TYPE VI, GAUCHER DISEASE, TAY-SACHS DISEASE)), BETA HEMOGLOBINOPATHIES, PHENYLKETONURIA, GALACTOSEMIA, GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 15 GENES(EG, ACADM, ARSA, ASPA, ATP7B, BCKDHA, BCKDHB, BLM, CFTR, DHCR7, FANCC, G6PC, GAA, GALT, GBA, GBE1, HBB, HEXA, IKBKAP, MCOLN1, PAH)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	81445	TARGETED GENOMIC SEQUENCE ANALYSIS PANEL, SOLID ORGAN NEOPLASM, DNA ANALYSIS, 5-50 GENES (E.G., ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, NRAS, MET, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), INTERROGATION FOR SEQUENCE VARIANTS AND COPY NUMBER VARIANTS OR REARRANGEMENTS, IF PERFORMED.	GENETIC TESTING	REQUIRED	No Restriction	PRICED	***NEW CODE Effective 07/01/2023***
PLEASE USE CPT CODE	81449	SOLID ORGAN NEOPLASM, GENOMIC SEQUENCE ANALYSIS PANEL, 5-50 GENES, INTERROGATION FOR SEQUENCE VARIANTS AND COPY NUMBER VARIANTS OR REARRANGEMENTS, IF PERFORMED: RNA ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	81450	TARGETED GENOMIC SEQUENCE ANALYSIS PANEL, HEMATOLYMPHOID NEOPLASM DISORDER, DNA AND RNA ANALYSIS WHEN PERFORMED, 5-50 GENES (E.G., BRAF, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KRAS, KIT, MLL, NRAS, NPM1, NOTCH1), INTERROGATION FOR SEQUENCE VARIANTS, AND COPY NUMBER VARIANTS OR REARRANGEMENTS, OR ISOFORM EXPRESSION OR MRNA EXPRESSION LEVELS, IF PERFORMED	GENETIC TESTING	REQUIRED	No Restriction	PRICED	***NEW CODE Effective 07/01/2023***
PLEASE USE CPT CODE	81451	HEMATOLYMPHOID NEOPLASM OR DISORDER, GENOMIC SEQUENCE ANALYSIS PANEL, 5-50 GENES, INTERROGATION FOR SEQUENCE VARIANTS, AND COPY NUMBER VARIANTS OR REARRANGEMENTS, OR ISOFORM EXPRESSION OR MRNA EXPRESSION LEVELS, IF PERFORMED: RNA ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	

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PLEASE USE CPT CODE	81455	TARGETED GENOMIC SEQUENCE ANALYSIS PANEL, SOLID ORGAN OR HEMATOLYMPHOID NEOPLASM, DNA AND RNA ANALYSIS WHEN PERFORMED, 51 OR GREATER GENES (E.G., ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MLL, NPM1, NRAS, MET, NOTCH1, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), INTERROGATION FOR SEQUENCE VARIANTS AND COPY NUMBER VARIANTS OR REARRANGEMENTS, IF PERFORMED.	GENETIC TESTING	REQUIRED	No Restriction	PRICED	***NEW CODE Effective 07/01/2023***
PLEASE USE CPT CODE	81456	SOLID ORGAN OR HEMATOLYMPHOID NEOPLASM OR DISORDER, 51 OR GREATER GENES, GENOMIC SEQUENCE ANALYSIS PANEL, INTERROGATION FOR SEQUENCE VARIANTS AND COPY NUMBER VARIANTS OR REARRANGEMENTS, OR ISOFORM EXPRESSION OR MRNA EXPRESSION LEVELS, IF PERFORMED; RNA ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	81457	SOLID ORGAN NEOPLASM, GENOMIC SEQUENCE ANALYSIS PANEL, INTERROGATION FOR SEQUENCE VARIANTS; DNA ANALYSIS, MICROSATELLITE INSTABILITY	GENETIC TESTING	REQUIRED	No Restriction	PRICED	***NEW CODE FOR 2024***
PLEASE USE CPT CODE	81458	SOLID ORGAN NEOPLASM, GENOMIC SEQUENCE ANALYSIS PANEL, INTERROGATION FOR SEQUENCE VARIANTS; DNA ANALYSIS, COPY NUMBER VARIANTS AND MICROSATELLITE INSTABILITY	GENETIC TESTING	REQUIRED	No Restriction	PRICED	***NEW CODE FOR 2024***
PLEASE USE CPT CODE	81459	SOLID ORGAN NEOPLASM, GENOMIC SEQUENCE ANALYSIS PANEL, INTERROGATION FOR SEQUENCE VARIANTS; DNA ANALYSIS OR COMBINED DNA AND RNA ANALYSIS, COPY NUMBER VARIANTS, MICROSATELLITE INSTABILITY, TUMOR MUTATION BURDEN, AND REARRANGEMENTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	***NEW CODE FOR 2024***
PLEASE USE CPT CODE	81462	SOLID ORGAN NEOPLASM, GENOMIC SEQUENCE ANALYSIS PANEL, CELL-FREE NUCLEIC ACID (E.G., PLASMA), INTERROGATION FOR SEQUENCE VARIANTS; DNA ANALYSIS OR COMBINED DNA AND RNA ANALYSIS, COPY NUMBER VARIANTS AND REARRANGEMENTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	***NEW CODE FOR 2024***
PLEASE USE CPT CODE	81463	SOLID ORGAN NEOPLASM, GENOMIC SEQUENCE ANALYSIS PANEL, CELL-FREE NUCLEIC ACID (E.G., PLASMA), INTERROGATION FOR SEQUENCE VARIANTS; DNA ANALYSIS, COPY NUMBER VARIANTS, AND MICROSATELLITE INSTABILITY	GENETIC TESTING	REQUIRED	No Restriction	PRICED	***NEW CODE FOR 2024***
PLEASE USE CPT CODE	81464	SOLID ORGAN NEOPLASM, GENOMIC SEQUENCE ANALYSIS PANEL, CELL-FREE NUCLEIC ACID (E.G., PLASMA), INTERROGATION FOR SEQUENCE VARIANTS; DNA ANALYSIS OR COMBINED DNA AND RNA ANALYSIS, COPY NUMBER VARIANTS, MICROSATELLITE INSTABILITY, TUMOR MUTATION BURDEN, AND REARRANGEMENTS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	***NEW CODE FOR 2024***
732	81479	UNLISTED MOLECULAR PATHOLOGY PROCEDURE	GENETIC TESTING	REQUIRED	No Restriction	NOT PRICED	
667	81507	FETAL ANEUPLOIDY (TRISOMY 21, AND 18) DNA SEQUENCE ANALYSIS OF SELECTED REGIONS USING MATERNAL PLASMA, ALGORITHM REPORTED AS A RISK SCORE FOR EACH TRISOMY	GENETIC TESTING	REQUIRED	No Restriction	PRICED	

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PLEASE USE CPT CODE	81518	ONCOLOGY (BREAST), MRNA, GENE EXPRESSION PROFILING BY REAL-TIME RT-PCR OF 11 GENES (7 CONTENT AND 4 HOUSEKEEPING), UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHMS REPORTED AS PERCENTAGE RISK FOR METASTATIC RECURRENCE AND LIKELIHOOD OF BENEFIT FROM EXTENDED ENDOCRINE THERAPY	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
698	81519	ONCOLOGY (BREAST), MRNA GENE EXPRESSION PROFILING BY REAL-TIME RT-PCR OF 21 GENES, UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS A RECURRENCE SCORE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	81520	ONCOLOGY (BREAST), MRNA GENE EXPRESSION PROFILING BY HYBRID CAPTURE OF 58 GENES (50 CONTENT AND 8 HOUSEKEEPING), UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS A RECURRENCE RISK SCORE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	81521	ONCOLOGY (BREAST), MRNA, MICROARRAY GENE EXPRESSION PROFILING OF 70 CONTENT GENES AND 465 HOUSEKEEPING GENES, UTILIZING FRESH FROZEN OR FORMALIN-FIXED PARAFFIN EMBEDDED TISSUE, ALGORITHM REPORTED AS INDEX RELATED TO RISK OF DISTANT METASTASIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
896	81522	ONCOLOGY (BREAST), MRNA, GENE EXPRESSION PROFILING BY RT-PCR OF 12 GENES (8 CONTENT AND 4 HOUSEKEEPING), UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS RECURRENCE RISK SCORE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	81523	ONCOLOGY (BREAST), MRNA, NEXT-GENERATION SEQUENCING GENE EXPRESSION PROFILING OF 70 CONTENT GENES AND 31 HOUSEKEEPING GENES, UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS INDEX RELATED TO RISK TO DISTANT METASTASIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
800	81528	ONCOLOGY (COLORECTAL) SCREENING, QUANTITATIVE REAL-TIME TARGET AND SIGNAL AMPLIFICATION OF 10 DNA MARKERS (KRAS MUTATIONS, PROMOTER METHYLATION OF NDRG4 AND BMP3) AND FECAL HEMOGLOBIN, UTILIZING STOOL, ALGORITHM REPORTED AS A POSITIVE OR NEGATIVE RESULT	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
695	81539	ONCOLOGY (HIGH-GRADE PROSTATE CANCER), BIOCHEMICAL ASSAY OF FOUR PROTEINS (TOTAL PSA, FREE PSA, INTACT PSA, AND HUMAN KALLIKREIN-2 [HK2]), UTILIZING PLASMA OR SERUM, PROGNOSTIC ALGORITHM REPORTED AS A PROBABILITY SCORE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
799	81541	ONCOLOGY (PROSTATE), MRNA GENE EXPRESSION PROFILING BY REAL-TIME RT-PCR OF 46 GENES (31 CONTENT AND 15 HOUSEKEEPING), UTILIZING FORMALIN-FIXED PARAFFIN EMBEDDED TISSUE, ALGORITHM REPORTED AS A DISEASE-SPECIFIC MORTALITY RISK SCORE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	81552	ONCOLOGY (UVEAL MELANOMA), MRNA, GENE EXPRESSION PROFILING BY REAL-TIME RT-PCR OF 15 GENES (12 CONTENT AND 3 HOUSEKEEPING), UTILIZING FINE NEEDLE ASPIRATE OR FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS RISK OF METASTASIS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	

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687	81595	CARDIOLOGY (HEART TRANSPLANT), MRNA, GENE EXPRESSION PROFILING BY REAL-TIME QUANTITATIVE PCR OF 20 GENES (11 CONTENT AND 9 HOUSEKEEPING), UTILIZING SUBFRACTION OF PERIPHERAL BLOOD, ALGORITHM REPORTED AS A REJECTION RISK SCORE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
609	81599	UNLISTED MULTIANALYTE ASSAY WITH ALGORITHMIC ANALYSIS	GENETIC TESTING	REQUIRED	No Restriction	NOT PRICED	This code is only open to cover Endopredict- the fee for Endopredict is the same as 81519 Oncotype Dx. May not be billed with 81519 Oncotype Dx
PLEASE USE CPT CODE	82233	BETA-AMYLROID; 1-40 (ABETA 40)	LABORATORY	REQUIRED	No Restriction	PRICED	NEW CODE EFFECTIVE 01/01/2025
PLEASE USE CPT CODE	82234	BETA-AMYLROID; 1-42 (ABETA 42)	LABORATORY	REQUIRED	No Restriction	PRICED	NEW CODE EFFECTIVE 01/01/2025
495	82542	COLUMN CHROMATOGRAPHY/MASS SPECTROMETRY (E.G. GC/MS, OR HPLC/MS), ANALYTE NOT ELSEWHERE SPECIFIED; QUANTITATIVE, SINGLE STATIONARY AND MOBILE PHASE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	83884	NEUROFILAMENT LIGHT CHAIN (NFL)	LABORATORY	REQUIRED	No Restriction	PRICED	NEW CODE EFFECTIVE 01/01/2025
PLEASE USE CPT CODE	84393	AU, PHOSPHORYLATED (E.G., PTAU 181, PTAU 217), EACH	LABORATORY	REQUIRED	No Restriction	PRICED	NEW CODE EFFECTIVE 01/01/2025
PLEASE USE CPT CODE	84394	TAU, TOTAL (TTAU)	LABORATORY	REQUIRED	No Restriction	PRICED	NEW CODE EFFECTIVE 01/01/2025
PLEASE USE CPT CODE	84433	THIOPURINE S-METHYLTRANSFERASE (TPMT)	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	84999	UNLISTED CHEMISTRY PROCEDURE	LABORATORY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
PLEASE USE CPT CODE	85999	UNLISTED HEMATOLOGY AND COAGULATION PROCEDURE	LABORATORY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
PLEASE USE CPT CODE	86586	SKIN TEST, UNLISTED	LABORATORY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
536	86711	ANTIBODY; JC (JOHN CUNNINGHAM) VIRUS	LABORATORY	REQUIRED	No Restriction	PRICED	ONE PER LIFETIME
600	86828	ANTIBODY TO HUMAN LEUKOCYTE ANTIGENS (HLA), SOLID PHASE ASSAYS (E.G., MICROSPHERES OR BEADS, ELISA, FLOW CYTOMETRY); QUALITATIVE ASSESSMENT OF THE PRESENCE OR ABSENCE OF ANTIBODY(IES) TO HLA CLASS I AND CLASS II HLA ANTIGENS	LABORATORY	Required - Beyond Service Limits	No Restriction	PRICED	ONE PER LIFETIME
601	86829	ANTIBODY TO HUMAN LEUKOCYTE ANTIGENS (HLA), SOLID PHASE ASSAYS (E.G., MICROSPHERES OR BEADS, ELISA, FLOW CYTOMETRY); QUALITATIVE ASSESSMENT OF THE PRESENCE OR ABSENCE OF ANTIBODY(IES) TO HLA CLASS I OR CLASS II HLA ANTIGENS	LABORATORY	Required - Beyond Service Limits	No Restriction	PRICED	ONE PER LIFETIME
602	86830	ANTIBODY TO HUMAN LEUKOCYTE ANTIGENS (HLA), SOLID PHASE ASSAYS (E.G., MICROSPHERES OR BEADS, ELISA, FLOW CYTOMETRY); ANTIBODY IDENTIFICATION BY QUALITATIVE PANEL USING COMPLETE HLA PHENOTYPES, HLA CLASS I	LABORATORY	Required - Beyond Service Limits	No Restriction	PRICED	ONE PER LIFETIME
603	86831	ANTIBODY TO HUMAN LEUKOCYTE ANTIGENS (HLA), SOLID PHASE ASSAYS (E.G., MICROSPHERES OR BEADS, ELISA, FLOW CYTOMETRY); ANTIBODY IDENTIFICATION BY QUALITATIVE PANEL USING COMPLETE HLA PHENOTYPES, HLA CLASS II	LABORATORY	Required - Beyond Service Limits	No Restriction	PRICED	ONE PER LIFETIME

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604	86832	ANTIBODY TO HUMAN LEUKOCYTE ANTIGENS (HLA), SOLID PHASE ASSAYS (E.G., MICROSPHERES OR BEADS, ELISA, FLOW CYTOMETRY); HIGH-DEFINITION QUALITATIVE PANEL FOR IDENTIFICATION OF ANTIBODY SPECIFICITIES (E.G., INDIVIDUAL ANTIGEN PER BEAD METHODOLOGY), HLA CLASS I	LABORATORY	Required - Beyond Service Limits	No Restriction	PRICED	ONE PER LIFETIME
605	86833	ANTIBODY TO HUMAN LEUKOCYTE ANTIGENS (HLA), SOLID PHASE ASSAYS (E.G., MICROSPHERES OR BEADS, ELISA, FLOW CYTOMETRY); HIGH-DEFINITION QUALITATIVE PANEL FOR IDENTIFICATION OF ANTIBODY SPECIFICITIES (E.G., INDIVIDUAL ANTIGEN PER BEAD METHODOLOGY), HLA CLASS II	LABORATORY	Required - Beyond Service Limits	No Restriction	PRICED	ONE PER LIFETIME
606	86834	ANTIBODY TO HUMAN LEUKOCYTE ANTIGENS (HLA), SOLID PHASE ASSAYS (E.G., MICROSPHERES OR BEADS, ELISA, FLOW CYTOMETRY); SEMI-QUANTITATIVE PANEL (E.G., TITER), HLA CLASS I	LABORATORY	Required - Beyond Service Limits	No Restriction	PRICED	ONE PER LIFETIME
607	86835	ANTIBODY TO HUMAN LEUKOCYTE ANTIGENS (HLA), SOLID PHASE ASSAYS (E.G., MICROSPHERES OR BEADS, ELISA, FLOW CYTOMETRY); SEMI-QUANTITATIVE PANEL (E.G., TITER), HLA CLASS II	LABORATORY	Required - Beyond Service Limits	No Restriction	PRICED	ONE PER LIFETIME
PLEASE USE CPT CODE	86999	UNLISTED TRANSFUSION MEDICINE PROCEDURE	LABORATORY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
696	87999	UNLISTED MICROBIOLOGY PROCEDURE - WHEN USED FOR TROFILE TESTING	LABORATORY	REQUIRED	No Restriction	NOT PRICED	
PLEASE USE CPT CODE	88199	UNLISTED CYTOPATHOLOGY PROCEDURE	LABORATORY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
PLEASE USE CPT CODE	88299	UNLISTED CYTOGENETIC STUDY	LABORATORY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
PLEASE USE CPT CODE	88399	UNLISTED SURGICAL PATHOLOGY PROCEDURE	LABORATORY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
PLEASE USE CPT CODE	89240	UNLISTED MISCELLANEOUS PATHOLOGY TEST	LABORATORY	REQUIRED	No Restriction	NOT PRICED	NEW CODE EFFECTIVE 05/01/2024
389	92133	COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING (E.G., OPTICAL COHERENCE TOMOGRAPHY [OCT]), POSTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL; OPTIC NERVE	RADIOLOGY	Required - Beyond Service Limits	No Restriction	PRICED	1 per calendar year without PA PA Required for additional events based on medical necessity DIAGNOSTIC RESTRICTIONS APPLY
389	92134	COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING (E.G., OPTICAL COHERENCE TOMOGRAPHY [OCT]), POSTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL; RETINA	RADIOLOGY	Required - Beyond Service Limits	No Restriction	PRICED	4 per calendar year without PA PA Required for additional events based on medical necessity. DIAGNOSTIC RESTRICTIONS APPLY
745	0008M	ONCOLOGY, BREAST; MRNA ANALYSIS OF 58 GENES USING HYBRID CAPTURE ON FORMALIN FIXED PARAFFIN EMBEDDED (FFPE) TISSUE, PROGNOSTIC ALGORITHM REPORTED AS A RISK SCORE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
668	0009M	FETAL ANEUPLOIDY (TRISOMY 21, AND 18) DNA SEQUENCE ANALYSIS OF SELECTED REGIONS USING MATERNAL PLASMA, ALGORITHM REPORTED AS A RISK SCORE FOR EACH TRISOMY	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	0037U	TARGETED GENOMIC SEQUENCE ANALYSIS, SOLID ORGAN NEOPLASM, DNA ANALYSIS OF 324 GENES, INTERROGATION FOR SEQUENCE VARIANTS, GENE COPY NUMBER AMPLIFICATIONS, GENE REARRANGEMENTS, MICROSATELLITE INSTABILITY AND TUMOR MUTATIONAL BURDEN	GENETIC TESTING	REQUIRED	No Restriction	PRICED	

WV MEDICAID PRIOR AUTHORIZATION CODE LISTING

LABORATORY, IMAGING & RADIOLOGY SERVICES

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Service Group Code	Service Code	Code Description	ATREZZO Service Type	PRIOR AUTH REQUIRED?	AGE RESTRICTION	PRICED OR NOT PRICED	ADDITIONAL INFORMATION
904	0047U	ONCOLOGY (PROSTATE), MRNA, GENE EXPRESSION PROFILING BY REAL-TIME RT-PCR OF 17 GENES (12 CONTENT AND 5 HOUSEKEEPING), UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS A RISK SCORE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	0172U	ONCOLOGY (SOLID TUMOR AS INDICATED BY THE LABEL), SOMATIC MUTATION ANALYSIS OF BRCA1 (BRCA1, DNA REPAIR ASSOCIATED), BRCA2 (BRCA2, DNA REPAIR ASSOCIATED) AND ANALYSIS OF HOMOLOGOUS RECOMBINATION DEFICIENCY PATHWAYS, DNA, FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM QUANTIFYING TUMOR GENOMIC INSTABILITY SCORE	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	0239U	TARGETED GENOMIC SEQUENCE ANALYSIS PANEL, SOLID ORGAN NEOPLASM, CELL-FREE DNA, ANALYSIS OF 311 OR MORE GENES, INTERROGATION FOR SEQUENCE VARIANTS, INCLUDING SUBSTITUTIONS, INSERTIONS, DELETIONS, SELECT REARRANGEMENTS, AND COPY NUMBER VARIATIONS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	
PLEASE USE CPT CODE	0379U	TARGETED GENOMIC SEQUENCE ANALYSIS PANEL, SOLID ORGAN NEOPLASM, DNA (523 GENES) AND RNA (55 GENES) BY NEXT-GENERATION SEQUENCING, INTERROGATION FOR SEQUENCE VARIANTS, GENE COPY NUMBER AMPLIFICATIONS, GENE REARRANGEMENTS, MICROSATELLITE INSTABILITY, AND TUMOR MUTATIONAL BURDEN	GENETIC TESTING	REQUIRED	No Restriction	PRICED	***NEW CODE FOR 2024***
PLEASE USE CPT CODE	0388U	ONCOLOGY (NON-SMALL CELL LUNG CANCER), NEXT-GENERATION SEQUENCING WITH IDENTIFICATION OF SINGLE NUCLEOTIDE VARIANTS, COPY NUMBER VARIANTS, INSERTIONS AND DELETIONS, AND STRUCTURAL VARIANTS IN 37 CANCER-RELATED GENES, PLASMA, WITH REPORT FOR ALTERATION DETECTION	GENETIC TESTING	REQUIRED	No Restriction	PRICED	***NEW CODE FOR 2024***
PLEASE USE CPT CODE	0391U	ONCOLOGY (SOLID TUMOR), DNA AND RNA BY NEXT-GENERATION SEQUENCING, UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, 437 GENES, INTERPRETIVE REPORT FOR SINGLE NUCLEOTIDE VARIANTS, SPLICE-SITE VARIANTS, INSERTIONS/DELETIONS, COPY NUMBER ALTERATIONS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	***NEW CODE FOR 2024***
PLEASE USE CPT CODE	0409U	ONCOLOGY (SOLID TUMOR), DNA (80 GENES) AND RNA (36 GENES), BY NEXT-GENERATION SEQUENCING FROM PLASMA, INCLUDING SINGLE NUCLEOTIDE VARIANTS, INSERTIONS/DELETIONS, COPY NUMBER ALTERATIONS, MICROSATELLITE INSTABILITY, AND FUSIONS, REPORT SHOWING IDENTIFIED MUTATIONS WITH CLINICAL ACTIONABILITY	GENETIC TESTING	REQUIRED	No Restriction	PRICED	***NEW CODE FOR 2024***
PLEASE USE CPT CODE	0413U	ONCOLOGY (HEMATOLYMPHOID NEOPLASM), OPTICAL GENOME MAPPING FOR COPY NUMBER ALTERATIONS, ANEUPLOIDY, AND BALANCED/COMPLEX STRUCTURAL REARRANGEMENTS, DNA FROM BLOOD OR BONE MARROW, REPORT OF CLINICALLY SIGNIFICANT ALTERATIONS	GENETIC TESTING	REQUIRED	No Restriction	PRICED	***NEW CODE FOR 2024***
PLEASE USE CPT CODE	A9596	GALLIUM GA-68 GOZETOTIDE, DIAGNOSTIC, (ILLUCCIX), 1 MILLICURIE	RADIOLOGY	REQUIRED	No Restriction	PRICED	
608	A9597	POSITRON EMISSION TOMOGRAPHY RADIOPHARMACEUTICAL, DIAGNOSTIC, FOR TUMOR IDENTIFICATION, NOT OTHERWISE CLASSIFIED	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	

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608	A9598	POSITRON EMISSION TOMOGRAPHY RADIOPHARMACEUTICAL, DIAGNOSTIC, FOR NON-TUMOR IDENTIFICATION, NOT OTHERWISE CLASSIFIED	RADIOLOGY	REQUIRED	No Restriction	NOT PRICED	
651	A9606	DRUG TEST(S), DEFINITIVE, UTILIZING DRUG IDENTIFICATION METHODS ABLE TO IDENTIFY INDIVIDUAL DRUGS AND DISTINGUISH BETWEEN STRUCTURAL ISOMERS (BUT NOT NECESSARILY STEREOISOMERS), INCLUDING, BUT NOT LIMITED TO GC/MS (ANY TYPE, SINGLE OR TANDEM) AND LC/MS (ANY TYPE, SINGLE OR TANDEM AND EXCLUDING IMMUNOASSAYS (E.G., IA, EIA, ELISA, EMIT, FPIA) AND ENZYMATIC METHODS (E.G., ALCOHOL DEHYDROGENASE)); QUALITATIVE OR QUANTITATIVE, ALL SOURCES, INCLUDES SPECIMEN VALIDITY TESTING, PER DAY, 1-7 DRUG CLASS(ES), INCLUDING METABOLITE(S) IF PERFORMED.	RADIOLOGY	REQUIRED	No Restriction	PRICED	This is a product specific code that is indicated for the treatment of patients with castration-resistant prostate cancer, symptomatic bone metastases and no known visceral metastatic disease.
744	G0480	DRUG TEST(S), DEFINITIVE, UTILIZING DRUG IDENTIFICATION METHODS ABLE TO IDENTIFY INDIVIDUAL DRUGS AND DISTINGUISH BETWEEN STRUCTURAL ISOMERS (BUT NOT NECESSARILY STEREOISOMERS), INCLUDING, BUT NOT LIMITED TO GC/MS (ANY TYPE, SINGLE OR TANDEM) AND LC/MS (ANY TYPE, SINGLE OR TANDEM AND EXCLUDING IMMUNOASSAYS (E.G., IA, EIA, ELISA, EMIT, FPIA) AND ENZYMATIC METHODS (E.G., ALCOHOL DEHYDROGENASE)); QUALITATIVE OR QUANTITATIVE, ALL SOURCES, INCLUDES SPECIMEN VALIDITY TESTING, PER DAY, 1-7 DRUG CLASS(ES), INCLUDING METABOLITE(S) IF PERFORMED.	LABORATORY	Required - Beyond Service Limits	No Restriction	PRICED	PA required when >12 per year is needed per member treatment plan. May get up to 12 additional units in 180 day authorization period if medically necessary. CALENDAR YEAR AUTHORIZATION
744	G0481	DRUG TEST(S), DEFINITIVE, UTILIZING DRUG IDENTIFICATION METHODS ABLE TO IDENTIFY INDIVIDUAL DRUGS AND DISTINGUISH BETWEEN STRUCTURAL ISOMERS (BUT NOT NECESSARILY STEREOISOMERS), INCLUDING, BUT NOT LIMITED TO GC/MS (ANY TYPE, SINGLE OR TANDEM) AND LC/MS (ANY TYPE, SINGLE OR TANDEM AND EXCLUDING IMMUNOASSAYS (E.G., IA, EIA, ELISA, EMIT, FPIA) AND ENZYMATIC METHODS (E.G., ALCOHOL DEHYDROGENASE)); QUALITATIVE OR QUANTITATIVE, ALL SOURCES, INCLUDES SPECIMEN VALIDITY TESTING, PER DAY, 8-14 DRUG CLASS(ES), INCLUDING METABOLITE(S) IF PERFORMED.	LABORATORY	Required - Beyond Service Limits	No Restriction	PRICED	PA required when >12 per year is needed per member treatment plan. May get up to 12 additional units in 180 day authorization period if medically necessary. CALENDAR YEAR AUTHORIZATION
744	G0482	DRUG TEST(S), DEFINITIVE, UTILIZING DRUG IDENTIFICATION METHODS ABLE TO IDENTIFY INDIVIDUAL DRUGS AND DISTINGUISH BETWEEN STRUCTURAL ISOMERS (BUT NOT NECESSARILY STEREOISOMERS), INCLUDING, BUT NOT LIMITED TO GC/MS (ANY TYPE, SINGLE OR TANDEM) AND LC/MS (ANY TYPE, SINGLE OR TANDEM AND EXCLUDING IMMUNOASSAYS (E.G., IA, EIA, ELISA, EMIT, FPIA) AND ENZYMATIC METHODS (E.G., ALCOHOL DEHYDROGENASE)); QUALITATIVE OR QUANTITATIVE, ALL SOURCES, INCLUDES SPECIMEN VALIDITY TESTING, PER DAY, 15-21 DRUG CLASS(ES), INCLUDING METABOLITE(S) IF PERFORMED.)	LABORATORY	Required - Beyond Service Limits	No Restriction	PRICED	PA required when >12 per year is needed per member treatment plan. May get up to 12 additional units in 180 day authorization period if medically necessary. CALENDAR YEAR AUTHORIZATION

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Service Group Code	Service Code	Code Description	ATREZZO Service Type	PRIOR AUTH REQUIRED?	AGE RESTRICTION	PRICED OR NOT PRICED	ADDITIONAL INFORMATION
744	G0483	DRUG TEST(S), DEFINITIVE, UTILIZING DRUG IDENTIFICATION METHODS ABLE TO IDENTIFY INDIVIDUAL DRUGS AND DISTINGUISH BETWEEN STRUCTURAL ISOMERS (BUT NOT NECESSARILY STEREOISOMERS), INCLUDING, BUT NOT LIMITED TO GC/MS (ANY TYPE, SINGLE OR TANDEM) AND LC/MS (ANY TYPE, SINGLE OR TANDEM AND EXCLUDING IMMUNOASSAYS (E.G., IA, EIA, ELISA, EMIT, FPIA) AND ENZYMATIC METHODS (E.G., ALCOHOL DEHYDROGENASE)); QUALITATIVE OR QUANTITATIVE, ALL SOURCES, INCLUDES SPECIMEN VALIDITY TESTING, PER DAY, 22 OR MORE DRUG CLASS(ES), INCLUDING METABOLITE(S) IF PERFORMED.	LABORATORY	REQUIRED	No Restriction	PRICED	PA required when > OR =1 per year is needed per member treatment plan. May get up to 12 additional units in 180 day authorization period if medically necessary. CALENDAR YEAR AUTHORIZATION
746	G0659	DRUG TEST(S), DEFINITIVE, UTILIZING DRUG IDENTIFICATION METHODS ABLE TO IDENTIFY INDIVIDUAL DRUGS AND DISTINGUISH BETWEEN STRUCTURAL ISOMERS (BUT NOT NECESSARILY STEREOISOMERS), INCLUDING BUT NOT LIMITED TO GC/MS (ANY TYPE, SINGLE OR TANDEM) AND LC/MS (ANY TYPE, SINGLE OR TANDEM), EXCLUDING IMMUNOASSAYS (E.G., IA, EIA, ELISA, EMIT, FPIA) AND ENZYMATIC METHODS (E.G., ALCOHOL DEHYDROGENASE), PERFORMED WITHOUT METHOD OR DRUG-SPECIFIC CALIBRATION, WITHOUT MATRIX-MATCHED QUALITY CONTROL MATERIAL, OR WITHOUT USE OF STABLE ISOTOPE OR OTHER UNIVERSALLY RECOGNIZED INTERNAL STANDARD(S) FOR EACH DRUG, DRUG METABOLITE OR DRUG CLASS PER SPECIMEN; QUALITATIVE OR QUANTITATIVE, ALL SOURCES, INCLUDES SPECIMEN VALIDITY TESTING, PER DAY, ANY NUMBER OF DRUG CLASSES.	LABORATORY	REQUIRED	No Restriction	PRICED	PA required when > OR =1 per year is needed per member treatment plan. May get up to 12 additional units in 180 day authorization period if medically necessary. CALENDAR YEAR AUTHORIZATION
608	G6015	INTENSITY MODULATED TREATMENT DELIVERY, SINGLE OR MULTIPLE FIELDS/ARCS, VIA NARROW SPATIALLY AND TEMPORALLY MODULATED BEAMS, BINARY, DYNAMIC MLC, PER TREATMENT SESSION	RADIOLOGY	REQUIRED	No Restriction	PRICED	DIAGNOSTIC RESTRICTIONS APPLY
608	G6016	COMPENSATOR-BASED BEAM MODULATION TREATMENT DELIVERY OF INVERSE PLANNED TREATMENT USING 3 OR MORE HIGH RESOLUTION (MILLED OR CAST) COMPENSATOR, CONVERGENT BEAM MODULATED FIELDS, PER TREATMENT SESSION	RADIOLOGY	REQUIRED	No Restriction	PRICED	DIAGNOSTIC RESTRICTIONS APPLY
376 377 378 379 380 381	R0070	TRANSPORTATION CODE (PORTABLE X-RAYS)	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
376; 377; 378; 379; 380; 381	R0075	TRANSPORTATION CODE (PORTABLE X-RAYS)	RADIOLOGY	REQUIRED POS 12 Only	No Restriction	PRICED	
391	EPSDT	EPSDT SERVICE	BASED ON CODE	REQUIRED	No Restriction	PRICED	For program requirements and additional resources, please visit the following website: https://dhhr.wv.gov/HealthCheck/Pages/default.aspx
390	OONService	OUT-OF-NETWORK SERVICE	BASED ON CODE	REQUIRED	No Restriction	PRICED	For WV Medical, Acentra Health will add a placeholder for an Out-of-Network (OON) Provider. This provider should be selected as the servicing provider for all out-of-network authorization requests. The 'Out-of-Network' provider will be available as a servicing provider for all request types/service codes.