

Prior Authorization Requirements for Medicaid and CHIP Services

Procedure Code	Procedure Code Detail Description	Medicaid/CHIP Prior Authorization Requirements	Prior Authorization Effective Date
00100	ANES- INTEG HEAD &/OR SALIV GLAND INCL BX; NOS	No pre-authorization is required for all providers.	N/A
00102	ANES- INTEG HEAD/SALIV GLAND W/BX; REPR CLEFT	No pre-authorization is required for all providers.	N/A
00103	ANES- INTEG HEAD/SALIV INCL BX; BLEPHAROPLASTY	No pre-authorization is required for all providers.	N/A
00104	ANES- ELEC-CONVULS THERAP	No pre-authorization is required for all providers.	N/A
00120	ANES- EXT, MID, & INNER EAR INCL BX; NOS	No pre-authorization is required for all providers.	N/A
00124	ANES- EXT, MID, & INNER EAR INCL BX; OTOSCOPY	No pre-authorization is required for all providers.	N/A
00125	PERIODIC ORAL EXAM - CHILD	This service is not covered by Superior HealthPlan.	N/A
00126	ANES- EXT, MID, & INNER EAR INCL BX; TYMPANOTOMY	No pre-authorization is required for all providers.	N/A
00140	ANES- EYE; NOS	No pre-authorization is required for all providers.	N/A
00142	ANES- EYE; LENS SURG	No pre-authorization is required for all providers.	N/A
00144	ANES- EYE; CORNEAL TRANSP	No pre-authorization is required for all providers.	N/A
00145	ANES- EYE; VITRECTOMY	No pre-authorization is required for all providers.	N/A
00147	ANES- EYE; IRIDECTOMY	No pre-authorization is required for all providers.	N/A
00148	ANES- EYE; OPHTH	No pre-authorization is required for all providers.	N/A
00150	INITIAL ORAL EXAM	This service is not covered by Superior HealthPlan.	N/A
00160	ANES- NOSE & ACCES SINUSES; NOS	No pre-authorization is required for all providers.	N/A
00162	ANES- NOSE & ACCES SINUSES; RADICAL SURG	No pre-authorization is required for all providers.	N/A
00164	ANES- NOSE & ACCES SINUSES; BX, SOFT TISS	No pre-authorization is required for all providers.	N/A
00170	ANES- INTRAORAL PROC, INCL BX; NOS	Pre-authorization is required for members under 21 years of age.	Prior to 09/01/2019
00172	ANES- INTRAORAL PROC, INCL BX; REPR CLEFT PALATE	No pre-authorization is required for all providers.	N/A
00174	ANES- INTRAORAL INCL BX; EXC RETROPHARYNG TUMOR	No pre-authorization is required for all providers.	N/A
00176	ANES- INTRAORAL PROC, INCL BX; RADICAL SURG	No pre-authorization is required for all providers.	N/A
00190	ANES- FACIAL BONES; NOS	No pre-authorization is required for all providers.	N/A
00192	ANES- FACIAL BONES; RADICAL SURG	No pre-authorization is required for all providers.	N/A
00210	ANES- INTRACRAN PROC; NOS	No pre-authorization is required for all providers.	N/A
00211	ANESTH CRAN SURG HEMOTOMA	No pre-authorization is required for all providers.	N/A
00212	ANES- INTRACRAN PROC; SUBDURAL TAPS	No pre-authorization is required for all providers.	N/A
00214	ANES- INTRACRAN PROC; BURR HOLES	No pre-authorization is required for all providers.	N/A
00215	ANES- INTRACRAN; ELEVAT DEPRES SKULL FX-XTRADURL	No pre-authorization is required for all providers.	N/A
00216	ANES- INTRACRAN PROC; VASCULAR PROC	No pre-authorization is required for all providers.	N/A
00218	ANES- INTRACRAN PROC; PROC SITTING POSIT	No pre-authorization is required for all providers.	N/A
00220	ANES- INTRACRAN PROC; SPINAL FLUID SHUNTING PROC	No pre-authorization is required for all providers.	N/A
00222	ANES- INTRACRAN; ELECTROCOAGULAT INTRACRAN NERV	No pre-authorization is required for all providers.	N/A
00230	INTRAORAL PERIAPICAL XRAY ADDL	This service is not covered by Superior HealthPlan.	N/A
00232	INTRAORAL PERIAPICAL XRAY TWO ADDL	This service is not covered by Superior HealthPlan.	N/A
00233	INTRAORAL PERIAPICAL XRAY THREE ADDL	This service is not covered by Superior HealthPlan.	N/A
00234	INTRAORAL PERIAPICAL XRAY FOUR ADDL	This service is not covered by Superior HealthPlan.	N/A
00235	INTRAORAL PERIAPICAL XRAY FIVE ADDL	This service is not covered by Superior HealthPlan.	N/A
00236	INTRAORAL PERIAPICAL XRAY SIX ADDL	This service is not covered by Superior HealthPlan.	N/A
00240	INTRAORAL OCCLUSAL FILM	This service is not covered by Superior HealthPlan.	N/A
00250	EXTRAORAL FIRST FILM	This service is not covered by Superior HealthPlan.	N/A
00260	EXTRAORAL EACH ADDL FILM	This service is not covered by Superior HealthPlan.	N/A
00270	BITEWINGS SINGLE FILM	This service is not covered by Superior HealthPlan.	N/A
00272	BITEWINGS TWO FILMS	This service is not covered by Superior HealthPlan.	N/A
00273	BITEWINGS THREE FILMS	This service is not covered by Superior HealthPlan.	N/A
00274	BITEWINGS FOUR FILMS	This service is not covered by Superior HealthPlan.	N/A
00300	ANES- ALL PROC INTEG SYST NECK, INCL SUBQ TISS	No pre-authorization is required for all providers.	N/A
00320	ANES-ESOPH THYRD TRACHEA;NOS 1 YR/>	No pre-authorization is required for all providers.	N/A
00322	ANES- PROC ESOPH/THYROID/TRACH; NEEDLE BX THYRO	No pre-authorization is required for all providers.	N/A
00326	ANES-LARYNX&TRACH CHLD < 1 YR AGE	No pre-authorization is required for all providers.	N/A
00330	PANORAMIC FILM	This service is not covered by Superior HealthPlan.	N/A
00340	CEPHALMOETRIC FILM	This service is not covered by Superior HealthPlan.	N/A
00350	ANES- MAJOR VESSELS NECK; NOS	No pre-authorization is required for all providers.	N/A
00352	ANES- MAJOR VESSELS NECK; SIMPL LIG	No pre-authorization is required for all providers.	N/A
00400	ANES- ANT INTEG SYST CHEST, INCL SUBQ TISS; NOS	No pre-authorization is required for all providers.	N/A
00402	ANES- ANT INTEG CHEST W/SUBQ TISS; RECON BREAST	No pre-authorization is required for all providers.	N/A
00404	ANES- ANT INTEG CHEST W/SUBQ; RAD/MOD RAD BREAST	No pre-authorization is required for all providers.	N/A
00406	ANES- ANT INTEG CHEST; RAD BREAST W/ NODE DISSEC	No pre-authorization is required for all providers.	N/A
00410	ANES- INTEG CHEST W/SUBQ TISS; ELEC CONVER ARRHY	No pre-authorization is required for all providers.	N/A
00450	ANES- CLAV & SCAPULA; NOS	No pre-authorization is required for all providers.	N/A
00452	ANES- CLAV & SCAPULA; RADICAL SURG	This is no longer a valid code.	N/A
00454	ANES- CLAV & SCAPULA; BX CLAV	No pre-authorization is required for all providers.	N/A
00470	ANES- PART RIB RESECT; NOS	No pre-authorization is required for all providers.	N/A
00472	ANES- PART RIB RESECT; THORACOPLASTY	No pre-authorization is required for all providers.	N/A
00474	ANES- PART RIB RESECT; RADICAL PROC	No pre-authorization is required for all providers.	N/A
00500	ANES- ALL PROC ESOPHAGUS	No pre-authorization is required for all providers.	N/A
00520	ANES- CLO CHEST PROC; NOS	No pre-authorization is required for all providers.	N/A
00522	ANES- CLO CHEST PROC; NEEDLE BX PLEURA	No pre-authorization is required for all providers.	N/A
00524	ANES- CLO CHEST PROC; PNEUMOCENTESIS	No pre-authorization is required for all providers.	N/A
00528	ANES-CLO CHST MEDIASTNSCP NO 1 LUNG	No pre-authorization is required for all providers.	N/A
00529	ANES-CLOS CHST MEDIASTNSCPY 1 LUNG	No pre-authorization is required for all providers.	N/A
00530	ANES- TRANSVENOUS PACEMAKER INSRT	No pre-authorization is required for all providers.	N/A
00532	ANES- ACCES TO CENTRAL VENOUS CIRCULATION	No pre-authorization is required for all providers.	N/A
00534	ANES- TRANSVENOUS INSRT/REPLC CARDIOVERTER/DEFIB	No pre-authorization is required for all providers.	N/A
00537	ANES- CARD EPS W/RADIOFREQ ABLAT	No pre-authorization is required for all providers.	N/A
00539	ANES-TRACHEOBRONCHIAL RECONSTRUCT	No pre-authorization is required for all providers.	N/A
00540	ANES- THORACOTOMY INVOLV LUNGS; NOS	No pre-authorization is required for all providers.	N/A
00541	ANES-THORACOT; UTIL 1 LUNG VENT	No pre-authorization is required for all providers.	N/A
00542	ANES- THORACOTOMY INVOLV LUNGS; DECORTIC	No pre-authorization is required for all providers.	N/A
00546	ANES- THORACOTOMY INVOLV LUNGS; W/THORACOPLASTY	No pre-authorization is required for all providers.	N/A
00548	ANES- THORACOT INVOLV LUNGS; INTHOR TRACH/BRONCH	No pre-authorization is required for all providers.	N/A
00550	ANES- STERNAL DEBRID	No pre-authorization is required for all providers.	N/A
00560	ANES- HEART/GREAT VESSELS; WO PUMP OXYGENATOR	No pre-authorization is required for all providers.	N/A
00561	ANES-HRT PRICRD SAC> VES CHST;PUMP OXYGNTR<1YR	No pre-authorization is required for all providers.	N/A
00562	ANESTH HRT SURG W/PMP AGE 1+	No pre-authorization is required for all providers.	N/A
00563	ANES- HEART; W/PUMP W/HYPOTHRM ARST	No pre-authorization is required for all providers.	N/A
00566	ANESTH CABG W/O PUMP	No pre-authorization is required for all providers.	N/A
00567	ANESTH CABG W/PUMP	No pre-authorization is required for all providers.	N/A
00580	ANES- HEART TRANSP OR HEART/LUNG TRANSP	No pre-authorization is required for all providers.	N/A
00600	ANES- CERV SPINE & CORD; NOS	No pre-authorization is required for all providers.	N/A
00604	ANES- CERV SPINE/CORD; POST CERV LAMINEC SITTING	No pre-authorization is required for all providers.	N/A
00620	ANES- THORACIC SPINE & CORD; NOS	No pre-authorization is required for all providers.	N/A
00622	ANES- THORACIC SPINE; THORACOLUMBAR SYMPATHECTMY	This is no longer a valid code.	N/A
00625	ANESTHESIA FOR PROCEDURES ON THE THORACIC SPINE AND CORD	No pre-authorization is required for all providers.	N/A
00626	UTILIZING ONE LUNG VENTILATION	No pre-authorization is required for all providers.	N/A
00630	ANES- PROC LUMBAR REGION; NOS	No pre-authorization is required for all providers.	N/A
00632	ANES- PROC LUMBAR REGION; LUMBAR SYMPATHECTOMY	No pre-authorization is required for all providers.	N/A
00634	ANES- PROC LUMBAR REGION; CHEMONUCLEOLYSIS	This is no longer a valid code.	N/A
00635	ANES- LUMB; DX/THERAP LUMB PUNCT	No pre-authorization is required for all providers.	N/A
00640	ANES-MANIP SPN/CLOS PROC SPN	No pre-authorization is required for all providers.	N/A
00670	ANES- EXTEN SPINE & SPINAL CORD PROC	No pre-authorization is required for all providers.	N/A
00700	ANES- UPPER ANT ABD WALL; NOS	No pre-authorization is required for all providers.	N/A
00702	ANES- UPPER ANT ABD WALL; PERCUT LIVER BX	No pre-authorization is required for all providers.	N/A
00730	ANES- UPPER POST ABD WALL	No pre-authorization is required for all providers.	N/A
00731	ANES UPR GI NDSC PX NOS	No pre-authorization is required for all providers.	N/A
00732	ANES UPR GI NDSC PX ERCP	No pre-authorization is required for all providers.	N/A

00740	ANES- UPPER GI ENDO PROC	This is no longer a valid code.	N/A
00750	ANES- HERNIA REPR UPPER ABD; NOS	No pre-authorization is required for all providers.	N/A
00752	ANES- HERNIA REPR UP ABD; LUMBAR &/OR DEHISCENCE	No pre-authorization is required for all providers.	N/A
00754	ANES- HERNIA REPR UPPER ABD; OMPHALOCELE	No pre-authorization is required for all providers.	N/A
00756	ANES- HERNIA REPR UP ABD; TRANSABD DIAPHRAGMATIC	No pre-authorization is required for all providers.	N/A
00770	ANES- ALL PROC MAJOR ABD BLD VESSELS	No pre-authorization is required for all providers.	N/A
00790	ANES- INTRAPERITONEAL UPPER ABD W/LAP; NOS	No pre-authorization is required for all providers.	N/A
00792	ANES- INTRAPERITONEAL, W/LAP; PART HEPATECTOMY	No pre-authorization is required for all providers.	N/A
00794	ANES- INTRAPERITONEAL W/LAP; PANCREATECTOMY	No pre-authorization is required for all providers.	N/A
00796	ANES- INTRAPERITONEAL W/LAP; LIVER TRANSPL	No pre-authorization is required for all providers.	N/A
00797	ANESTHESIA FOR SURGERY FOR MORBID OBESITY	No pre-authorization is required for all providers.	N/A
00800	ANES- LOWER ANT ABD WALL; NOS	No pre-authorization is required for all providers.	N/A
00802	ANES- LOWER ANT ABD WALL; PANNICULECTOMY	No pre-authorization is required for all providers.	N/A
00810	ANES- INTESTINAL ENDO PROC	This is no longer a valid code.	N/A
00811	ANES LWR INTST NDSC NOS	No pre-authorization is required for all providers.	N/A
00812	ANES LWR INTST SCR COLSC	No pre-authorization is required for all providers.	N/A
00813	ANES UPR LWR GI NDSC PX	No pre-authorization is required for all providers.	N/A
00820	ANES- LOWER POST ABD WALL	No pre-authorization is required for all providers.	N/A
00830	ANES- HERNIA REPR LOWER ABD; NOS	No pre-authorization is required for all providers.	N/A
00832	ANES- HERNIA REPR LO ABD; VENTRAL & INCS HERNIAS	No pre-authorization is required for all providers.	N/A
00834	ANES-HERN REPR NOS UNDER 1 YR AGE	No pre-authorization is required for all providers.	N/A
00836	ANES-HERN NOS<37WK BRTH &<50WK SURG	No pre-authorization is required for all providers.	N/A
00840	ANES- INTRAPERITONEAL LOWER ABD W/LAP; NOS	No pre-authorization is required for all providers.	N/A
00842	ANES- INTRAPERITONEAL LOWER ABD W/LAP; AMNIOCENT	No pre-authorization is required for all providers.	N/A
00844	ANES- INTRAPERITONEAL LO ABD W/LAP; ABD-PERINEAL	No pre-authorization is required for all providers.	N/A
00846	ANES- INTRAPERITONEAL LO ABD W/LAP; RAD HYST	No pre-authorization is required for all providers.	N/A
00848	ANES- INTRAPERITONEAL ABD; PELVIC EXENTERATION	No pre-authorization is required for all providers.	N/A
00851	ANESTHESIA FOR TUBAL LIGATION	No pre-authorization is required for all providers.	N/A
00860	ANES- EXTRAPERITONEAL INCL URINARY TRACT; NOS	No pre-authorization is required for all providers.	N/A
00862	ANES- EXTRAPERITONEAL; UP 1/3 URETER/DONOR NEPHR	No pre-authorization is required for all providers.	N/A
00864	ANES- EXTRAPERITONEAL INCL URINARY; TOT CYSTECT	No pre-authorization is required for all providers.	N/A
00865	ANES- EXTRAPERITONEAL; RAD PROSTATECTOMY	No pre-authorization is required for all providers.	N/A
00866	ANES- EXTRAPERITONEAL INCL URINARY; ADRENALECTMY	No pre-authorization is required for all providers.	N/A
00868	ANES- EXTRAPERITONEAL INCL URINARY; RENAL TRNSPL	No pre-authorization is required for all providers.	N/A
00870	ANES- EXTRAPERITONEAL INCL URINARY; CYSTOLITHOTO	No pre-authorization is required for all providers.	N/A
00872	ANES- LITH EXTRACORPOREAL SHOCK WAVE; W/H2O BATH	No pre-authorization is required for all providers.	N/A
00873	ANES- LITH EXTRACORPOREAL SHOCK WAVE;WO H2O BATH	No pre-authorization is required for all providers.	N/A
00880	ANES- MAJOR LOWER ABD VESSELS; NOS	No pre-authorization is required for all providers.	N/A
00882	ANES- MAJOR ABD VESSELS; INFERIOR VENA CAVA LIG	No pre-authorization is required for all providers.	N/A
00902	ANES- PERINEAL INTEG SYST; ANORECTAL PROC	No pre-authorization is required for all providers.	N/A
00904	ANES- PERINEAL INTEG SYST; RADICAL PERINEAL PROC	No pre-authorization is required for all providers.	N/A
00906	ANES- PERINEAL INTEG SYST; VULVECTOMY	No pre-authorization is required for all providers.	N/A
00908	ANES- PERINEAL INTEG SYST; PERINEAL PROSTATECTMY	No pre-authorization is required for all providers.	N/A
00910	ANES- TRANSURETHRAL PROC; NOS	No pre-authorization is required for all providers.	N/A
00912	ANES- TRANSURETHRAL; RESECT BLADDER TUMOR	No pre-authorization is required for all providers.	N/A
00914	ANES- TRANSURETHRAL; TURP	No pre-authorization is required for all providers.	N/A
00916	ANES- TRANSURETHRAL; POST RESECT BLEEDING	No pre-authorization is required for all providers.	N/A
00918	ANES- TRANSURETHRAL; W/ FRAGMEN/REMOV CALCU	No pre-authorization is required for all providers.	N/A
00920	ANES- MALE EXT GENIT; NOS	No pre-authorization is required for all providers.	N/A
00921	ANES-MALE GNT; VASECT UNILAT/BILAT	No pre-authorization is required for all providers.	N/A
00922	ANES- MALE EXT GENIT; SEMINAL VESICLES	No pre-authorization is required for all providers.	N/A
00924	ANES- MALE EXT GENIT; UNDESCEND TESTIS UNI/BILAT	No pre-authorization is required for all providers.	N/A
00926	ANES- MALE EXT GENIT; RADICAL ORCHIECTOMY, ING	No pre-authorization is required for all providers.	N/A
00928	ANES- MALE EXT GENIT; RADICAL ORCHIECTOMY; ABD	No pre-authorization is required for all providers.	N/A
00930	ANES- MALE GENIT; ORCHIOPEXY UNI/BILAT	No pre-authorization is required for all providers.	N/A
00932	ANES- MALE EXT GENIT; COMPLT AMPUTA PENIS	No pre-authorization is required for all providers.	N/A
00934	ANES- MALE; RAD AMPUT PENIS W/BIL ING LYMPHADENE	No pre-authorization is required for all providers.	N/A
00936	ANES- MALE; RAD AMP PENIS W/BIL ING & ILIAC LYMP	No pre-authorization is required for all providers.	N/A
00938	ANES- MALE EXT GENIT; INSRP PENILE PROSTH	This service is not covered by Superior HealthPlan.	N/A
00940	ANES- VAG PROC; NOS	No pre-authorization is required for all providers.	N/A
00942	ANES- VAG; COLPOTOMY, COLPECTOMY, COLPORRHAPHY	No pre-authorization is required for all providers.	N/A
00944	ANES- VAG PROC; VAG HYST	No pre-authorization is required for all providers.	N/A
00948	ANES- VAG PROC; CERV CERCLAGE	No pre-authorization is required for all providers.	N/A
00950	ANES- VAG PROC; CULDOSCOPY	No pre-authorization is required for all providers.	N/A
00952	ANES- VAG PROC; HYSTEROSCOPY	No pre-authorization is required for all providers.	N/A
00955	CONT EPIDURAL ANALGESIA, LABOR & VAG DELIV	No pre-authorization is required for all providers.	N/A
01112	ANES- BONE MARR ASP/BX A/P ILIAC CR	No pre-authorization is required for all providers.	N/A
01120	ANES- BONY PELVIS	No pre-authorization is required for all providers.	N/A
01130	ANES- BODY CAST APPLIC OR REVIS	No pre-authorization is required for all providers.	N/A
01140	ANES- INTERPELVIABDOMINAL AMPUTA	No pre-authorization is required for all providers.	N/A
01150	ANES- RAD PROC TUMOR PELVIS EX HINDQUARTER AMPUT	No pre-authorization is required for all providers.	N/A
01160	ANES- CLO PROC W/SYMPHYSIS PUBIS/SACROILIAC JT	No pre-authorization is required for all providers.	N/A
01170	ANES- OPEN PROC W/SYMPHYS PUBIS OR SACROILIAC JT	No pre-authorization is required for all providers.	N/A
01173	ANES-OPN REP FX PELV/COLUMN ACETAB	No pre-authorization is required for all providers.	N/A
01200	ANES- ALL CLO PROC INVOLV HIP JT	No pre-authorization is required for all providers.	N/A
01201	TOPICAL APPL FLUORIDE INC PROP	This service is not covered by Superior HealthPlan.	N/A
01202	ANES- ARTHROSCOPIC PROC HIP JT	No pre-authorization is required for all providers.	N/A
01203	TOPICAL APPL FLUORIDE EXCL PRO	This service is not covered by Superior HealthPlan.	N/A
01204	TOPICAL APPL FLUOR EXCL PROP	This service is not covered by Superior HealthPlan.	N/A
01205	TOPICAL APPL FLUOR PROP	This service is not covered by Superior HealthPlan.	N/A
01210	ANES- OPEN PROC INVOLV HIP JT; NOS	No pre-authorization is required for all providers.	N/A
01212	ANES- OPEN PROC INVOLV HIP JT; HIP DIASART	No pre-authorization is required for all providers.	N/A
01214	ANES- OPEN INVOLV HIP JT; TOT HIP REPLAC/REVIS	No pre-authorization is required for all providers.	N/A
01215	ANES- OP HIP; TOT HIP REVIS	No pre-authorization is required for all providers.	N/A
01220	ANES- ALL CLO PROC INVOLV UPPER 2/3 FEMUR	No pre-authorization is required for all providers.	N/A
01230	ANES- OPEN PROC INVOLV UPPER 2/3 FEMUR; NOS	No pre-authorization is required for all providers.	N/A
01232	ANES- OPEN PROC INVOLV UPPER 2/3 FEMUR; AMPUTA	No pre-authorization is required for all providers.	N/A
01234	ANES- OPEN INVOLV UP 2/3 FEMUR; RAD RESECT	No pre-authorization is required for all providers.	N/A
01240	ANES- ALL PROC INTEG SYST UPPER LEG	No pre-authorization is required for all providers.	N/A
01250	ANES- ALL NERV/MUSCL/TENDON/FASCIA/BURSAE UP LEG	No pre-authorization is required for all providers.	N/A
01260	ANES- ALL INVOLV VEINS UP LEG INCL EXPLOR	No pre-authorization is required for all providers.	N/A
01270	ANES- INVOLV ART UP LEG INCL BYPASS GFT; NOS	No pre-authorization is required for all providers.	N/A
01272	ANES- INVOLV ART UP LEG INCL GFT; FEM ART LIG	No pre-authorization is required for all providers.	N/A
01274	ANES- INVOLV ART UP LEG INCL GFT; FEM ART EMBOLLE	No pre-authorization is required for all providers.	N/A
01320	ANES- NERV/MUSCL/TENDON/FASCIA/BURSAE KNEE/POP	No pre-authorization is required for all providers.	N/A
01340	ANES- ALL CLO PROC LOWER 1/3 FEMUR	No pre-authorization is required for all providers.	N/A
01351	SEALANT PER TOOTH	This service is not covered by Superior HealthPlan.	N/A
01360	ANES- ALL OPEN PROC LOWER 1/3 FEMUR	No pre-authorization is required for all providers.	N/A
01380	ANES- ALL CLO PROC KNEE JT	No pre-authorization is required for all providers.	N/A
01382	ANES-DX ARTHROSCOPIC PROC KNEE JNT	No pre-authorization is required for all providers.	N/A
01390	ANES- ALL CLO UP ENDS TIBIA/FIBULA &/OR PATELLA	No pre-authorization is required for all providers.	N/A
01392	ANES- ALL OPEN UPPER ENDS TIB/FIB &/OR PATELLA	No pre-authorization is required for all providers.	N/A
01400	ANES-OPEN/SCOPE PROC KNEE JNT; NOS	No pre-authorization is required for all providers.	N/A
01402	ANES-OPEN/SCOPE KNEE JNT; TOT PLSTY	No pre-authorization is required for all providers.	N/A
01404	ANES-OPEN/SCOPE KNEE JNT; DISARTIC	No pre-authorization is required for all providers.	N/A
01420	ANES- ALL CAST APPLIC/REMOV/REPR INVOLV KNEE JT	No pre-authorization is required for all providers.	N/A
01430	ANES- VEINS KNEE & POP AREA; NOS	No pre-authorization is required for all providers.	N/A
01432	ANES- VEINS KNEE & POP AREA; AV FISTULA	No pre-authorization is required for all providers.	N/A
01440	ANES- ART KNEE & POP AREA; NOS	No pre-authorization is required for all providers.	N/A
01442	ANES- ART KNEE; POP THROMBOENDART W/WO PATCH GFT	No pre-authorization is required for all providers.	N/A
01444	ANES- ART KNEE; POP EXC/GFT/REPR OCCLUS/ANEURYSM	No pre-authorization is required for all providers.	N/A

01462	ANES- ALL CLO PROC LOWER LEG, ANK, & FT	No pre-authorization is required for all providers.	N/A
01464	ANES-ARTHROSCOPIC PROC ANK &OR FOOT	No pre-authorization is required for all providers.	N/A
01470	ANES- NERV/MUSCL/FASCIA LOW LEG/ANK/FT; NOS	No pre-authorization is required for all providers.	N/A
01472	ANES- NERV/MUSCL LO LEG; REPR ACHILLES W/WO GFT	No pre-authorization is required for all providers.	N/A
01474	ANES- NERV/MUSCL LO LEG; GASTROCNEMIUS RECESSIO	No pre-authorization is required for all providers.	N/A
01480	ANES- OPEN PROC BONES LOWER LEG, ANK, & FT; NOS	No pre-authorization is required for all providers.	N/A
01482	ANES- OPEN BONES LO LEG/ANK/FT; RADICAL RESECT	No pre-authorization is required for all providers.	N/A
01484	ANES- OPEN BONES LO LEG/ANK/FT; OSTEOTMY TIB/FIB	No pre-authorization is required for all providers.	N/A
01486	ANES- OPEN BONES LO LEG/ANK/FT; TOT ANK REPLAC	No pre-authorization is required for all providers.	N/A
01490	ANES- LOWER LEG CAST APPLIC, REMOV, OR REPR	No pre-authorization is required for all providers.	N/A
01500	ANES- ART LOWER LEG, INCL BYPASS GFT; NOS	No pre-authorization is required for all providers.	N/A
01502	ANES- ART LO LEG W/BYPASS GFT; EMBOLEC DIR/CATH	No pre-authorization is required for all providers.	N/A
01510	SPACE MAINTENANCE FIXED UNILA	This service is not covered by Superior HealthPlan.	N/A
01515	SPACE MAINTENANCE FIXED BILAT	This service is not covered by Superior HealthPlan.	N/A
01520	ANES- VEINS LOWER LEG; NOS	No pre-authorization is required for all providers.	N/A
01522	ANES- VEINS LO LEG; VENOUS THROMBEC DIRECT/CATH	No pre-authorization is required for all providers.	N/A
01550	RECEMENATION OF MAINTAINER	This service is not covered by Superior HealthPlan.	N/A
01610	ANES- ALL NERV/MUSCL/FASCIA/BURSAE SHOULDER/AXIL	No pre-authorization is required for all providers.	N/A
01620	ANES- ALL CLO HUMERAL/AC/SHLDR JT	No pre-authorization is required for all providers.	N/A
01622	ANES-DX ARTHROSCOPIC PROC SHLDR JNT	No pre-authorization is required for all providers.	N/A
01630	ANES-OPEN/SCOPE HUM SC AC&SHLDR;NOS	No pre-authorization is required for all providers.	N/A
01634	ANES-OPN/SCOPE HUM SC&SHLDR;DISARTC	No pre-authorization is required for all providers.	N/A
01636	ANES-OPN/SCOPE HUM SC AC&SHLDR; AMP	No pre-authorization is required for all providers.	N/A
01638	ANES-OPN/SCOPE HUM AC&SHLDR; REPL	No pre-authorization is required for all providers.	N/A
01650	ANES- ART SHOULDER AXILLA; NOS	No pre-authorization is required for all providers.	N/A
01652	ANES- ART SHLDR/AXIL; AXIL-BRACHIAL ANEURY	No pre-authorization is required for all providers.	N/A
01654	ANES- ART SHOULDER & AXILLA; BYPASS GFT	No pre-authorization is required for all providers.	N/A
01656	ANES- ART SHLDR & AXIL; AXILRY-FEMORAL BYPAS GFT	No pre-authorization is required for all providers.	N/A
01670	ANES- ALL PROC VEINS SHOULDER & AXILLA	No pre-authorization is required for all providers.	N/A
01680	ANESTH SHOULDER CASTING	No pre-authorization is required for all providers.	N/A
01682	ANES- SHLDR CAST APPLIC REMOV/REPR; SHLDR SPICA	This is no longer a valid code.	N/A
01710	ANES- NERV/MUSCL/FASCIA/BURSAE UP ARM/ELBOW; NOS	No pre-authorization is required for all providers.	N/A
01712	ANES- NERV UP ARM/ELB; TENOTOMY ELBOW-SHLDR OPEN	No pre-authorization is required for all providers.	N/A
01714	ANES- NERV UP ARM/ELBOW; TENOPLASTY ELBOW-SHLDR	No pre-authorization is required for all providers.	N/A
01716	ANES- NERV UP ARM/ELBOW; TENODESIS RUPT BICEPS	No pre-authorization is required for all providers.	N/A
01730	ANES- ALL CLO PROC HUMERUS & ELBOW	No pre-authorization is required for all providers.	N/A
01732	ANES-DX ARTHROSCOPIC PROC ELB JOINT	No pre-authorization is required for all providers.	N/A
01740	ANES-OPEN/SURG SCOPE PROC ELB; NOS	No pre-authorization is required for all providers.	N/A
01742	ANES-OPEN/SCOPE PROC ELB;OSTEOT HUM	No pre-authorization is required for all providers.	N/A
01744	ANES-OPEN/SCOPE ELB;REP NON/MAL HUM	No pre-authorization is required for all providers.	N/A
01756	ANES-OPEN/SCOPE PROC ELB; RADL PROC	No pre-authorization is required for all providers.	N/A
01758	ANES-OPN/SCOPE ELB;EXC CYST/TUM HUM	No pre-authorization is required for all providers.	N/A
01760	ANES-OPEN/SCOPE ELB; TOT ELB REPL	No pre-authorization is required for all providers.	N/A
01770	ANES- ART UPPER ARM & ELBOW; NOS	No pre-authorization is required for all providers.	N/A
01772	ANES- ART UPPER ARM & ELBOW; EMBOLECTOMY	No pre-authorization is required for all providers.	N/A
01780	ANES- VEINS UPPER ARM & ELBOW; NOS	No pre-authorization is required for all providers.	N/A
01782	ANES- VEINS UPPER ARM & ELBOW; PHLEBORRHAPHY	No pre-authorization is required for all providers.	N/A
01810	ANES- ALL NERV/MUSCL/BURSAE FOREARM/WRIST/HAND	No pre-authorization is required for all providers.	N/A
01820	ANES- ALL CLO RADIUS/ULNA/WRIST/HAND BONES	No pre-authorization is required for all providers.	N/A
01829	ANES-DX ARTHROSCOPIC PROC WRIST	No pre-authorization is required for all providers.	N/A
01830	ANES-OPN/SCOPE/ENDO WRST/HND; NOS	No pre-authorization is required for all providers.	N/A
01832	ANES-OPEN/SCOPE/ENDO WRST/HND; TOT	No pre-authorization is required for all providers.	N/A
01840	ANES- ART FOREARM, WRIST, & HAND; NOS	No pre-authorization is required for all providers.	N/A
01842	ANES- ART FOREARM, WRIST, & HAND; EMBOLECTOMY	No pre-authorization is required for all providers.	N/A
01844	ANES- VASCULAR SHUNT, OR SHUNT REVIS, ANY TYPE	No pre-authorization is required for all providers.	N/A
01850	ANES- VEINS FOREARM, WRIST, & HAND; NOS	No pre-authorization is required for all providers.	N/A
01852	ANES- VEINS FOREARM, WRIST, & HAND; PHLEBORRHAPH	No pre-authorization is required for all providers.	N/A
01860	ANES- FOREARM/WRIST/HAND CAST APPLIC/REMOV/REPR	No pre-authorization is required for all providers.	N/A
01902	ANES- BURR HOLE VENTRICULOGRAPHY	No pre-authorization is required for all providers.	N/A
01904	ANES- INJ PROC PNEUMOENCEPHALOGRAPHY	No pre-authorization is required for all providers.	N/A
01905	ANESTHESIA FOR SPINAL INJECTION/REPAIR	No pre-authorization is required for all providers.	N/A
01916	ANES- ARTERIOGRAMS/NEEDLE; CAROTID/VERTEBRAL	No pre-authorization is required for all providers.	N/A
01920	ANES- CARD CATH W/CORONARY ARTERIOGRAPHY & VENTR	No pre-authorization is required for all providers.	N/A
01921	ANES- ANGIOPLASTY	No pre-authorization is required for all providers.	N/A
01922	ANES- NON-INVASIVE IMAGING/RADIATION THERAP	No pre-authorization is required for all providers.	N/A
01924	ANESTHESIA FOR THERAPEUTIC INTERVENTIONAL RADIOLOGY ARTERIAL PROC	No pre-authorization is required for all providers.	N/A
01925	ANESTHESIA FOR THERAPEUTIC INTERVENTIONAL RADIOLOGY ARTERIAL PROC	No pre-authorization is required for all providers.	N/A
01926	ANES INTRACRANIAL, INTRACARDIAC, OR AORTIC	No pre-authorization is required for all providers.	N/A
01930	ANESTHESIA FOR THERAPEUTIC INTERVENTIONAL RADIOLOGY VENOUS PROC	No pre-authorization is required for all providers.	N/A
01931	ANES THER IVNTL RAD VENS/LYMPHTC INTRHPTC/PORTAL	No pre-authorization is required for all providers.	N/A
01932	ANESTHESIA FOR THERAPETUTIC INTERVENTIONAL RADIOLOGY VENOUS PROC	No pre-authorization is required for all providers.	N/A
01933	ANESTHESIA FOR THERAPETUTIC INTERVENTIONAL RADIOLOGY VENOUS PROC	No pre-authorization is required for all providers.	N/A
01935	ANESTH PERC IMG DX SP PROC	No pre-authorization is required for all providers.	N/A
01936	ANESTH PERC IMG TX SP PROC	No pre-authorization is required for all providers.	N/A
01951	ANES- 2-3 BURN EXC/DEB; <1% TBSA	No pre-authorization is required for all providers.	N/A
01952	ANES- 2-3 BURN EXC/DEB; 1-9% TBSA	No pre-authorization is required for all providers.	N/A
01953	ANES- BURN EXC/DEB; EA ADD 9% TBSA	This service is not covered by Superior HealthPlan.	N/A
01958	ANES-EXTERNAL CEPHALIC VERSION PROC	No pre-authorization is required for all providers.	N/A
01960	ANESTHESIA VAGINAL DELIVERY ONLY	No pre-authorization is required for all providers.	N/A
01961	ANESTHESIA CESAREAN DELIVERY ONLY	No pre-authorization is required for all providers.	N/A
01962	ANES-URGENT HYST FOLLOW DELIV	No pre-authorization is required for all providers.	N/A
01963	ANES-C/S HYST W/O LABR ANALG/ANES	No pre-authorization is required for all providers.	N/A
01965	ANES INCOMPL/MISSED AB	No pre-authorization is required for all providers.	N/A
01966	ANES INDUCED AB	No pre-authorization is required for all providers.	N/A
01967	NEUROAXIAL LABOR ANALGESIA/ANESTHESIA	No pre-authorization is required for all providers.	N/A
01968	ANES-CD FLW NEURAX LABR ANALG/ANES	No pre-authorization is required for all providers.	N/A
01969	ANES-C/S HYST FLW NEURAX LABR ANALG	No pre-authorization is required for all providers.	N/A
01990	PHYSIOLOG SUPPORT HARVEST DONOR ORGAN-BRAIN DEAD	This service is not covered by Superior HealthPlan.	N/A
01991	ANESTH NERVE BLOCK/INJ	No pre-authorization is required for all providers.	N/A
01992	ANESTH N BLOCK/INJ PRONE	No pre-authorization is required for all providers.	N/A
01996	DAILY HOS EPIDURL/SUBARACH CONT RX	No pre-authorization is required for all providers.	N/A
01999	UNLISTED ANES PROC	No pre-authorization is required for all providers.	N/A
02110	AMALGAM 1 SURFACE PRIMARY	This service is not covered by Superior HealthPlan.	N/A
02120	AMALGAM 2 SURFACES PRIMARY	This service is not covered by Superior HealthPlan.	N/A
02130	AMALGAM 3 SURFACES PRIMARY	This service is not covered by Superior HealthPlan.	N/A
02140	AMALGAM 1 SURFACE PERMAN	This service is not covered by Superior HealthPlan.	N/A
02150	AMALGAM 2 SURFACES PERMAN	This service is not covered by Superior HealthPlan.	N/A
02160	AMALGAM 3 SURFACES PERMAN	This service is not covered by Superior HealthPlan.	N/A
02161	AMAGLAM RESTOR 4 OR MOR SURFACES	This service is not covered by Superior HealthPlan.	N/A
02330	RESIN 1 SURFACE ANTERIOR	This service is not covered by Superior HealthPlan.	N/A
02331	RESIN 2 SURFACES ANTERIOR	This service is not covered by Superior HealthPlan.	N/A
02332	RESIN 3 SURFACES ANTERIOR	This service is not covered by Superior HealthPlan.	N/A
02335	RESIN 2 OR MORE SURFACES INCIS	This service is not covered by Superior HealthPlan.	N/A
02340	ACID ETCHING	This service is not covered by Superior HealthPlan.	N/A
02380	RESIN 1 SURFACE POSTERIOR PRIM	This service is not covered by Superior HealthPlan.	N/A
02381	RESIN TWO SURFACES	This service is not covered by Superior HealthPlan.	N/A
02382	RESIN 3+ SURFACES POST PRIM	This service is not covered by Superior HealthPlan.	N/A
02385	RESIN 1 SURFACE POSTERIOR PERM	This service is not covered by Superior HealthPlan.	N/A
02386	RESIN TWO SURFACES POSTERIA PERMANENT	This service is not covered by Superior HealthPlan.	N/A
02387	RESIN 3+ SURFACES.POST PRIM	This service is not covered by Superior HealthPlan.	N/A
02540	DENTAL	This service is not covered by Superior HealthPlan.	N/A

02660	DENTAL	This service is not covered by Superior HealthPlan.	N/A
02910	RECEMENT INLAY	This service is not covered by Superior HealthPlan.	N/A
02920	RECEMENT CROWN	This service is not covered by Superior HealthPlan.	N/A
02930	PREFAB SSC PRIMARY TOOTH	This service is not covered by Superior HealthPlan.	N/A
02931	PREFAB SSC PERM TOOTH	This service is not covered by Superior HealthPlan.	N/A
02932	PREFAB RESIN CROWN	This service is not covered by Superior HealthPlan.	N/A
02933	PREFAB SSC W/RESIN WINDOW	This service is not covered by Superior HealthPlan.	N/A
02940	SEDATIVE FILLING	This service is not covered by Superior HealthPlan.	N/A
02951	PIN RETEN PER TOOTH W/RESTORE	This service is not covered by Superior HealthPlan.	N/A
03110	PULP CAP-DIRECT (EXCLUDING FINAL RESTORATION)	This service is not covered by Superior HealthPlan.	N/A
03120	PULP CAP	This service is not covered by Superior HealthPlan.	N/A
03210	PULPECTOMY	This service is not covered by Superior HealthPlan.	N/A
03220	THERAP PULPOTOMY W/D FINAL RES	This service is not covered by Superior HealthPlan.	N/A
03310	ANTER ROOT CANAL W/O RESTORE	This service is not covered by Superior HealthPlan.	N/A
03320	BICUSPID ROOT CANAL W/O RESTORE	This service is not covered by Superior HealthPlan.	N/A
03330	MOLAR ROOT CANAL W/O RESTORE	This service is not covered by Superior HealthPlan.	N/A
03351	APEX/RECALCIFICATION	This service is not covered by Superior HealthPlan.	N/A
03410	APICOECTOMY/PERIRADICULAR SURGERY	This service is not covered by Superior HealthPlan.	N/A
03430	RETROGRADE FILLING - PER ROOT	This service is not covered by Superior HealthPlan.	N/A
04210	GINGIVECTOMY/GINGIVOPLASTY QUA	This service is not covered by Superior HealthPlan.	N/A
04211	GINGIVECT/GINGIVOPLASTY TOOTH	This service is not covered by Superior HealthPlan.	N/A
04220	SUBGINGIVAL CURETTA	This service is not covered by Superior HealthPlan.	N/A
04260	OSSEOUS SURGERY INC FLAP ENTRY ENCLOSURE	This service is not covered by Superior HealthPlan.	N/A
04261	DENTAL	This service is not covered by Superior HealthPlan.	N/A
04262	DENTAL	This service is not covered by Superior HealthPlan.	N/A
04268	DENTAL	This service is not covered by Superior HealthPlan.	N/A
04320	PROVISIONAL SPLINTING INTRACORONAL	This service is not covered by Superior HealthPlan.	N/A
04341	PERIODONTAL SCALING ROOT PLAN	This service is not covered by Superior HealthPlan.	N/A
04355	FULL MOUTH DEBRIDEMENT	This service is not covered by Superior HealthPlan.	N/A
04910	PERIODONTAL MAINTENCE PRODURES	This service is not covered by Superior HealthPlan.	N/A
05110	COMPLETE UPPER DENTURE	This service is not covered by Superior HealthPlan.	N/A
05120	COMPLETE LOWER DENTURE	This service is not covered by Superior HealthPlan.	N/A
05211	UPPER PARTIAL DENTURE RESIN	This service is not covered by Superior HealthPlan.	N/A
05212	LOWER PARTIAL DENTURE RESIN	This service is not covered by Superior HealthPlan.	N/A
05411	ADJUSTMENT TO DENTURE-LOWER	This service is not covered by Superior HealthPlan.	N/A
05510	REPAIR BROKEN COMPLETE DENTURE	This service is not covered by Superior HealthPlan.	N/A
05520	REPAIR MISSING OR BROKEN DENTURE	This service is not covered by Superior HealthPlan.	N/A
05610	REPAIR RESIN SADDLE/BASE PARTIAL	This service is not covered by Superior HealthPlan.	N/A
05620	REPAIR CAST FRAMEWORK PARTIAL DENTURE	This service is not covered by Superior HealthPlan.	N/A
05630	REPAIR/REPLACE BROKEN CLASP	This service is not covered by Superior HealthPlan.	N/A
05640	REPLACE BROKEN TEETH PER TOOTH	This service is not covered by Superior HealthPlan.	N/A
05650	ADD TOOTH TO EXISTING DENTURE	This service is not covered by Superior HealthPlan.	N/A
05660	ADD CLASP TO EXISTING PARTIAL DENTURE	This service is not covered by Superior HealthPlan.	N/A
05750	RELINE COMPLETE UPPER DENTURE	This service is not covered by Superior HealthPlan.	N/A
05751	RELINE COMPLETE LOWER DENTURE	This service is not covered by Superior HealthPlan.	N/A
05760	RELINE UPPER PARTIAL DENTURE	This service is not covered by Superior HealthPlan.	N/A
05761	RELINE LOWER PARTIAL DENTURE	This service is not covered by Superior HealthPlan.	N/A
05932	OBTURATOR PROSTHESIS DEFINITE	This service is not covered by Superior HealthPlan.	N/A
05955	PALATAL LIFT PROSTHESES DEFINIT	This service is not covered by Superior HealthPlan.	N/A
05999	UNSPEC MAXILLOFACIAL PROSTHESIS	This service is not covered by Superior HealthPlan.	N/A
06030	DENTAL	This service is not covered by Superior HealthPlan.	N/A
06540	DENTAL	This service is not covered by Superior HealthPlan.	N/A
06545	RETAINER-ACID ETCH FIXED PROSTHESIS	This service is not covered by Superior HealthPlan.	N/A
06930	RECEMENT FIXED BRIDGE	This service is not covered by Superior HealthPlan.	N/A
06940	STRESS BREAKER FIXED	This service is not covered by Superior HealthPlan.	N/A
06980	BRIDGE REPAIR	This service is not covered by Superior HealthPlan.	N/A
07110	SINGLE TOOTH EXTRACTION	This service is not covered by Superior HealthPlan.	N/A
07120	EXTRACTION EACH ADDITIONAL TOOTH	This service is not covered by Superior HealthPlan.	N/A
07130	ROOT REMOVAL-EXPOSED ROOTS	This service is not covered by Superior HealthPlan.	N/A
07210	SURGICAL REMOVAL ERUPTED TOOTH	This service is not covered by Superior HealthPlan.	N/A
07220	REMOVAL IMPACTED TOOTH SOFT TS	This service is not covered by Superior HealthPlan.	N/A
07230	REMOVAL IMPACT TOOTH PART BONY	This service is not covered by Superior HealthPlan.	N/A
07240	REMOVAL IMPACT TOOTH COM BONY	This service is not covered by Superior HealthPlan.	N/A
07241	REMOVAL OF IMPACTED TOOTH	This service is not covered by Superior HealthPlan.	N/A
07250	SURG REMOVAL RESIDUAL TOOTH RT	This service is not covered by Superior HealthPlan.	N/A
07260	ORAL ANTRAL FISTULA CLOSURE	This service is not covered by Superior HealthPlan.	N/A
07270	TOOTH REIMPLANT/STABILIZATION	This service is not covered by Superior HealthPlan.	N/A
07271	DENTAL	This service is not covered by Superior HealthPlan.	N/A
07280	SURG EXPOSURE IMPACT/UNERUPTED	This service is not covered by Superior HealthPlan.	N/A
07281	SURG EXPOSURE IMPACT/UNERUPTED	This service is not covered by Superior HealthPlan.	N/A
07285	BIOSPY OF ORAL TISSUE HARD	This service is not covered by Superior HealthPlan.	N/A
07286	BIOSPY OF ORAL TISSUE SOFT	This service is not covered by Superior HealthPlan.	N/A
07290	SURGICAL REPOSITIONING OF TEETH	This service is not covered by Superior HealthPlan.	N/A
07310	ALVEOLOPLASTY	This service is not covered by Superior HealthPlan.	N/A
07420	EXCISION LESION >1.25CM	This service is not covered by Superior HealthPlan.	N/A
07430	EXCISION BENIGN TUMOR UP TO 1.25	This service is not covered by Superior HealthPlan.	N/A
07431	EXCISION BENIGN TUMOR OVER 1.25	This service is not covered by Superior HealthPlan.	N/A
07440	EXCISION MALG TUMOR UP TO 1.25 CM	This service is not covered by Superior HealthPlan.	N/A
07441	EXCISION MALG TUMOR OVER 1.25 CM	This service is not covered by Superior HealthPlan.	N/A
07450	REMOVAL ODONTOGENIC CYST/TUMOR	This service is not covered by Superior HealthPlan.	N/A
07451	REMOVAL ODONTOGENIC CYST/TUMOR	This service is not covered by Superior HealthPlan.	N/A
07460	REMOVAL NONODONTOGEN CYST/TUMOR	This service is not covered by Superior HealthPlan.	N/A
07461	REMOVAL NONODONTOGEN CYST/TUMOR	This service is not covered by Superior HealthPlan.	N/A
07470	REMOVAL EXOSTOSIS MAXILL/MANDIB	This service is not covered by Superior HealthPlan.	N/A
07480	PARTIAL OSECTONY GUT/SAUCIER	This service is not covered by Superior HealthPlan.	N/A
07490	RADICAL RESECT/MANIBLE	This service is not covered by Superior HealthPlan.	N/A
07510	I&D ABCESS INTRAORAL	This service is not covered by Superior HealthPlan.	N/A
07520	I&D ABCESS EXTRAORAL	This service is not covered by Superior HealthPlan.	N/A
07530	REMOVAL OF F/B	This service is not covered by Superior HealthPlan.	N/A
07540	REMOVAL OF REACTION	This service is not covered by Superior HealthPlan.	N/A
07550	SEQUESTRECTOMY FOR OSTEOMYELIT	This service is not covered by Superior HealthPlan.	N/A
07560	MAXILLARY SINUSOTOMY	This service is not covered by Superior HealthPlan.	N/A
07610	MAXILLA OPEN REDUCTION	This service is not covered by Superior HealthPlan.	N/A
07620	MAXILLA CLOSED REDUCTION	This service is not covered by Superior HealthPlan.	N/A
07630	MANDIBLE OPEN REDUCTION	This service is not covered by Superior HealthPlan.	N/A
07640	MANDIBLE CLOSED REDUCTION	This service is not covered by Superior HealthPlan.	N/A
07650	MOLAR/ZYGOMATIC ARCH OPEN REDUCTION	This service is not covered by Superior HealthPlan.	N/A
07660	MOLAR/ZYGOMATIC ARCH CLOSER REDUCTION	This service is not covered by Superior HealthPlan.	N/A
07670	AVELOUS	This service is not covered by Superior HealthPlan.	N/A
07680	FACIAL BONES COMPLICATED REDUCTION	This service is not covered by Superior HealthPlan.	N/A
07710	MAXILLA OPEN REDUCTION COMPOUND	This service is not covered by Superior HealthPlan.	N/A
07720	MAXILLA CLOSED REDUCTION COMPOUND	This service is not covered by Superior HealthPlan.	N/A
07730	MANDIBLE OPEN REDUCTION COMPOUND	This service is not covered by Superior HealthPlan.	N/A
07740	MANDIBLE CLOSED REDUCTION COMP	This service is not covered by Superior HealthPlan.	N/A
07750	MOLAR/ZYGOMATIC OPEN REDUCTION COMPOUND	This service is not covered by Superior HealthPlan.	N/A
07760	MOLAR/ZYGOMATIC CLOSED REDUCTION COMP	This service is not covered by Superior HealthPlan.	N/A
07770	ALVEOLUS COMPOUND	This service is not covered by Superior HealthPlan.	N/A
07780	FACIAL BONES COMPLICATED COMP	This service is not covered by Superior HealthPlan.	N/A
07810	OPEN REDUCTION OF DISLOC TMJ	This service is not covered by Superior HealthPlan.	N/A
07820	CLOSED REDUCTION PF DISLOC TMJ	This service is not covered by Superior HealthPlan.	N/A
07830	MANIPULATION UNDER ANESTH TMJ	This service is not covered by Superior HealthPlan.	N/A

07840	CONDYLECTOMY	This service is not covered by Superior HealthPlan.	N/A
07850	SURG DISCECTOMY W/WO IMPLANT	This service is not covered by Superior HealthPlan.	N/A
07860	ARTHROTOMY TMJ	This service is not covered by Superior HealthPlan.	N/A
07910	SUTURE OF SMALL WOUND UP TO 5C	This service is not covered by Superior HealthPlan.	N/A
07911	COMPLICATED SUTURE UP TO 5CM	This service is not covered by Superior HealthPlan.	N/A
07912	COMPLICATED SUTURE OVER 5CM	This service is not covered by Superior HealthPlan.	N/A
07940	OSTEOPLASTY	This service is not covered by Superior HealthPlan.	N/A
07950	OSSEOUS OSTEOPER/PERIOST/GRAFT	This service is not covered by Superior HealthPlan.	N/A
07960	FRENULECTOMY	This service is not covered by Superior HealthPlan.	N/A
07970	EXCISION OF HYPERPLASTIC TISSUE	This service is not covered by Superior HealthPlan.	N/A
07980	SIALOLITHOTOMY	This service is not covered by Superior HealthPlan.	N/A
07991	CORONOIDECTOMY	This service is not covered by Superior HealthPlan.	N/A
07999	UNSPEC ORAL/MAXILLOFACIAL PROC	This service is not covered by Superior HealthPlan.	N/A
08210	REMOVABLE APPL HARMFUL HABITS	This service is not covered by Superior HealthPlan.	N/A
08220	FIXED APPL HARMFUL HABITS	This service is not covered by Superior HealthPlan.	N/A
08670	PERIODIC ORTHODONTIC TREATMENT VISIT	This service is not covered by Superior HealthPlan.	N/A
09110	PALLIATIVE TREATMENT DENTAL PAIN	This service is not covered by Superior HealthPlan.	N/A
09215	LOCAL ANESTHETIC	This service is not covered by Superior HealthPlan.	N/A
09220	GENERAL ANESTHESIA	No pre-authorization is required for all providers.	N/A
09230	ANALGESIA - INDIANA	This service is not covered by Superior HealthPlan.	N/A
09240	INTRAVENOUS SEDATION	This service is not covered by Superior HealthPlan.	N/A
09420	HOSPITAL CALL	This service is not covered by Superior HealthPlan.	N/A
09610	THERAPEUTIC DRUG INJECTION	This service is not covered by Superior HealthPlan.	N/A
09630	OTHER DRUG & MEDICAMENTS BY REPORT	This service is not covered by Superior HealthPlan.	N/A
09910	APPLICATION DESENSITIZ MEDS	This service is not covered by Superior HealthPlan.	N/A
09920	BEHAVIOR MANAGEMENT - DENTAL	This service is not covered by Superior HealthPlan.	N/A
09922	UNUSUAL SERVICES	No pre-authorization is required for all providers.	N/A
09926	PROFESSIONAL COMPONENT	No pre-authorization is required for all providers.	N/A
09947	ANESTHESIA PROVIDED BY SURGEON	No pre-authorization is required for all providers.	N/A
10004	FINE NEEDLE ASPIRATION BX W/O IMG GDN EA ADDL	No pre-authorization is required for all providers.	N/A
10005	FINE NEEDLE ASPIRATION BX W/US GDN 1ST LESION	No pre-authorization is required for all providers.	N/A
10006	FINE NEEDLE ASPIRATION BX W/US GDN EA ADDL	No pre-authorization is required for all providers.	N/A
10007	FINE NEEDLE ASPIRATION BX W/FLUOR GDN 1ST LESION	No pre-authorization is required for all providers.	N/A
10008	FINE NEEDLE ASPIRATION BX W/FLUOR GDN EA ADDL	No pre-authorization is required for all providers.	N/A
10009	FINE NEEDLE ASPIRATION BX W/CT GDN 1ST LESION	No pre-authorization is required for all providers.	N/A
10010	FINE NEEDLE ASPIRATION BX W/CT GDN EA ADDL	No pre-authorization is required for all providers.	N/A
10011	FINE NEEDLE ASPIRATION BX W/MR GDN 1ST LESION	No pre-authorization is required for all providers.	N/A
10012	FINE NEEDLE ASPIRATION BX W/MR GDN EA ADDL	No pre-authorization is required for all providers.	N/A
10021	FINE NEEDLE ASPIRATION BX W/O IMG GDN 1ST LESION	No pre-authorization is required for all providers.	N/A
10022	FIND NEEDLE ASPIRATION	This is no longer a valid code.	N/A
10030	GUIDE CATHET FLUID DRAINAGE	No pre-authorization is required for all providers.	N/A
10035	PERQ DEV SOFT TISS 1ST IMAG	No pre-authorization is required for all providers.	N/A
10036	PERQ DEV SOFT TISS ADD IMAG	No pre-authorization is required for all providers.	N/A
10040	ACNE SURG	No pre-authorization is required for all providers.	N/A
10060	I&D ABSCESS; SIMPL/SNGL	No pre-authorization is required for all providers.	N/A
10061	I&D ABSCESS; COMPLIC/MX	No pre-authorization is required for all providers.	N/A
10080	I&D PILONIDAL CYST; SIMPL	No pre-authorization is required for all providers.	N/A
10081	I&D PILONIDAL CYST; COMPLIC	No pre-authorization is required for all providers.	N/A
10120	INCS & REMOV FB SUBQ TISS; SIMPL	No pre-authorization is required for all providers.	N/A
10121	INCS & REMOV FB SUBQ TISS; COMPLIC	No pre-authorization is required for all providers.	N/A
10140	I&D HEMATOMA/SEROMA/FLUID COLLEC	No pre-authorization is required for all providers.	N/A
10160	PUNCT ASPIRAT ABSCESS/HEMATOMA/BULLA/CYST	No pre-authorization is required for all providers.	N/A
10180	I&D COMPLX POSTOP WOUND INFEC	No pre-authorization is required for all providers.	N/A
11000	DEBRID EXTEN ECZEMAT/INFEC SKIN; TO 10% BODY SUR	No pre-authorization is required for all providers.	N/A
11001	DEBRIDE INFECTED SKIN ADD-ON	No pre-authorization is required for all providers.	N/A
11004	DEBRID SKN SUBQ TISS MUSC&FASC; EXT GENITL&PERIN	No pre-authorization is required for all providers.	N/A
11005	DEBRID SKN SUBQ TISS MUSC&FASC; ABD WALL	No pre-authorization is required for all providers.	N/A
11006	DEBRID SKN SUBQ TISS; EXT GENIT W/WO FASCL CLOS	No pre-authorization is required for all providers.	N/A
11008	REMOVAL PROSHETIC MATRL ABDL WALL FOR INFECTION	No pre-authorization is required for all providers.	N/A
11010	DEBRIDE SKIN AT FX SITE	No pre-authorization is required for all providers.	N/A
11011	DEBRIDE SKIN MUSC AT FX SIT	No pre-authorization is required for all providers.	N/A
11012	DEB SKIN BONE AT FX SITE	No pre-authorization is required for all providers.	N/A
11042	DEB SUBQ TISSUE 20 SQ CM/<	No pre-authorization is required for all providers.	N/A
11043	DEB MUSC/FASCIA 20 SQ CM/<	No pre-authorization is required for all providers.	N/A
11044	DEB BONE 20 SQ CM/<	No pre-authorization is required for all providers.	N/A
11045	DEB SUBQ TISSUE ADD-ON	No pre-authorization is required for all providers.	N/A
11046	DEB MUSC/FASCIA ADD-ON	No pre-authorization is required for all providers.	N/A
11047	DEB BONE ADD-ON	No pre-authorization is required for all providers.	N/A
11055	PARING/CUTTING BEN HYPERKERATOTIC LES; 1 LES	No pre-authorization is required for all providers.	N/A
11056	PARING/CUTTING BEN HYPERKERATOTIC LES; 2-4 LES	No pre-authorization is required for all providers.	N/A
11057	PARING/CUTTING BEN HYPERKERATOTIC LES; > 4 LES	No pre-authorization is required for all providers.	N/A
11100	BX SKIN &/ SUBQ TISSUE 1 LESION	This is no longer a valid code.	N/A
11101	BX SKIN/SUBQ TISS/MUCOUS MEMB (SEP PRO); EA ADD	This is no longer a valid code.	N/A
11102	TANGENTIAL BIOPSY SKIN SINGLE LESION	No pre-authorization is required for all providers.	N/A
11103	TANGENTIAL BIOPSY SKIN EA SEP/ADDITIONAL LESION	No pre-authorization is required for all providers.	N/A
11104	PUNCH BIOPSY SKIN SINGLE LESION	No pre-authorization is required for all providers.	N/A
11105	PUNCH BIOPSY SKIN EA SEP/ADDITIONAL LESION	No pre-authorization is required for all providers.	N/A
11106	INCISIONAL BIOPSY SKIN SINGLE LESION	No pre-authorization is required for all providers.	N/A
11107	INCISIONAL BIOPSY SKIN EA SEP/ADDITIONAL LESION	No pre-authorization is required for all providers.	N/A
11200	REMOV SKIN TAGS ANY AREA; TO & INCL 15 LES	No pre-authorization is required for all providers.	N/A
11201	REMOVE SKIN TAGS ADD-ON	No pre-authorization is required for all providers.	N/A
11300	SHAVING 1 LES TRUNK/ARMS/LEGS; 0.5CM/LESS	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11301	SHAVING 1 LES TRUNK/ARMS/LEGS; 0.6 TO 1.0 CM	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11302	SHAVING 1 LES TRUNK/ARMS/LEGS; 1.1 TO 2.0 CM	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11303	SHAVING 1 LES TRUNK/ARMS/LEGS; OVER 2.0 CM	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11305	SHAVING 1 LES SCALP/HANDS/FT/GENIT; 0.5 CM/LESS	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11306	SHAVING 1 LES SCALP/HANDS/FT/GENIT; 0.6 TO 1.0CM	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11307	SHAVING 1 LES SCALP/HANDS/FT/GENIT; 1.1 TO 2.0CM	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11308	SHAVING 1 LES SCALP/HANDS/FT/GENIT; OVER 2.0 CM	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11310	SHAVING 1 LES FACE/EARS/NOSE/LIPS; 0.5 CM/LESS	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11311	SHAVING 1 LES FACE/EARS/NOSE/LIPS; 0.6 TO 1.0 CM	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11312	SHAVING 1 LES FACE/EARS/NOSE/LIPS; 1.1 TO 2.0 CM	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11313	SHAVING 1 LES FACE/EARS/NOSE/LIPS; OVER 2.0 CM	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11400	EXC BEN LES TRNK ARM/LEG; .5 CM/<	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11401	EXC BEN LES TRNK ARM/LEG; 0.6-1.0 CM	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11402	EXC BEN LES TRNK ARM/LEG; 1.1-2.0 CM	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11403	EXC BEN LES TRNK ARM/LEG; 2.1-3.0 CM	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11404	EXC BEN LES TRNK ARM/LEG; 3.1-4.0 CM	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11406	EXC BEN LES TRNK ARM/LEG; OVR 4.0 CM	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019

11420	EXC BEN LES SCLP HND FT GNT; 0.5/<	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11421	EXC BEN LES SCLP HND FT GNT;0.6-1.0	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11422	EXC BEN LES SCLP HND FT GNT;1.1-2.0	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11423	EXC BEN LES SCLP HND FT GNT;2.1-3.0	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11424	EXC BEN LES SCLP HND FT GNT;3.1-4.0	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11426	EXC BEN LES SCLP HND FT GNT;OVR 4.0	Pre-authorization is required in an office, outpatient, ambulatory surgical center, Federally Qualified Health Centers and Rural Health Clinics locations.	Prior to 09/01/2019
11440	EXC BEN LES FCE ERS EYELD NSE;0.5/<	No pre-authorization is required for all providers.	N/A
11441	EXC BEN LES FCE ERS EYELD; 0.6-1.0	No pre-authorization is required for all providers.	N/A
11442	EXC BEN LES FCE ERS EYELD; 1.1-2.0	No pre-authorization is required for all providers.	N/A
11443	EXC FACE-MM B9+MARG 2.1-3 CM	No pre-authorization is required for all providers.	N/A
11444	EXC FACE-MM B9+MARG 3.1-4 CM	No pre-authorization is required for all providers.	N/A
11446	EXC BEN LES FCE ERS EYELD NSE; >4.0	No pre-authorization is required for all providers.	N/A
11450	EXC SKIN HIDRADENITIS AX; SIMPL/INTERMED REPR	No pre-authorization is required for all providers.	N/A
11451	EXC SKIN HIDRADENITIS AX; W/COMPLX REPR	No pre-authorization is required for all providers.	N/A
11462	EXC SKIN HIDRADENITIS ING; W/SIMPL/INTERMED REPR	No pre-authorization is required for all providers.	N/A
11463	EXC SKIN HIDRADENITIS ING; W/COMPLX REPR	No pre-authorization is required for all providers.	N/A
11470	EXC SKIN HIDRADENITIS PERIANAL; W/SIMPL/INTERM	No pre-authorization is required for all providers.	N/A
11471	EXC SKIN HIDRADENITIS PERIANAL; W/COMPLX REPR	No pre-authorization is required for all providers.	N/A
11600	EXC MAL LES TRNK ARMS/LEGS; 0.5/<	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
11601	EXC MAL LES TRNK ARMS/LEGS; 0.6-1.0	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
11602	EXC MAL LES TRNK ARMS/LEGS; 1.1-2.0	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
11603	EXC TR-EXT MAL+MARG 2.1-3 CM	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
11604	EXC MAL LES TRNK ARMS/LEGS; 3.1-4.0	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
11606	EXC MAL LES TRNK ARMS/LEGS; OVR 4.0	No pre-authorization is required for all providers.	N/A
11620	EXC MAL LES SCLP HND FT GNT; 0.5/<	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
11621	EXC MAL LES SCLP HND FT GNT;0.6-1.0	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
11622	EXC MAL LES SCLP HND FT GNT;1.1-2.0	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
11623	EXC S/N/H/F/G MAL+MRG 2.1-3	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
11624	EXC MAL LES SCLP HND FT GNT;3.1-4.0	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
11626	EXC MAL LES SCLP HND FT GNT;OVR 4.0	No pre-authorization is required for all providers.	N/A
11640	EXC MAL LES FCE ERS EYELD NSE;0.5/<	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
11641	EXC MAL LES FCE ERS EYELD; 0.6-1.0	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
11642	EXC MAL LES FCE ERS EYELD; 1.1-2.0	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
11643	EXC MAL LES FCE ERS EYELD; 2.1-3.0	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
11644	EXC MAL LES FCE ERS EYELD; 3.1-4.0	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
11646	EXC MAL LES FCE ERS EYELD NSE; >4.0	No pre-authorization is required for all providers.	N/A
11719	TRIM NONDYSTROPHIC NAILS, ANY NUMBER	No pre-authorization is required for all providers.	N/A
11720	DEBRID NAIL(S) ANY METHD(S); ONE TO FIVE	No pre-authorization is required for all providers.	N/A
11721	DEBRID NAIL(S) ANY METHD(S); SIX OR MORE	No pre-authorization is required for all providers.	N/A
11730	AVULSION NAIL PLATE PART/COMPLT SIMPL; SNGL	No pre-authorization is required for all providers.	N/A
11732	AVULSION PLATE PART/COMPLT SIMPL; EA ADD NAIL	No pre-authorization is required for all providers.	N/A
11740	EVACUATION SUBUNGUAL HEMATOMA	No pre-authorization is required for all providers.	N/A
11750	EXC NAIL/MATRIX PART/COMPLT PERM REMOV	No pre-authorization is required for all providers.	N/A
11752	EXC NAIL/MATRIX PART/COMPLT PERM; AMPUT DISTAL	This is no longer a valid code.	N/A
11755	BX NAIL UNIT ANY METHD (SEPART PROC)	No pre-authorization is required for all providers.	N/A
11760	REPR NAIL BED	No pre-authorization is required for all providers.	N/A
11762	RECON NAIL BED W/GFT	No pre-authorization is required for all providers.	N/A
11765	WEDGE EXC SKIN NAIL FOLD	No pre-authorization is required for all providers.	N/A
11770	EXC PILONIDAL CYST/SINUS; SIMPL	No pre-authorization is required for all providers.	N/A
11771	EXC PILONIDAL CYST/SINUS; EXTEN	No pre-authorization is required for all providers.	N/A
11772	EXC PILONIDAL CYST/SINUS; COMPLIC	No pre-authorization is required for all providers.	N/A
11900	INJ INTRALES; UP TO & INCL 7 LES	No pre-authorization is required for all providers.	N/A
11901	INJ INTRALES; MORE THAN 7 LES	No pre-authorization is required for all providers.	N/A
11920	TATTOOING INCL MICROPIGMENTATION; 6.0 SQ CM/LESS	No pre-authorization is required for all providers.	N/A
11921	TATTOOING INCL MICROPIGMENTATION; 6.1-20.0 SQ CM	No pre-authorization is required for all providers.	N/A
11922	CORRECT SKIN COLOR DEFECTS	No pre-authorization is required for all providers.	N/A
11950	SUBQ INJ FILLING MAT; 1 CC/LESS	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
11951	SUBQ INJ FILLING MAT; 1.1 TO 5.0 CC	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
11952	SUBQ INJ FILLING MAT; 5.1 TO 10.0 CC	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
11954	SUBQ INJ FILLING MAT; OVER 10.0 CC	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
11960	INSRT EXPANDER NOT BREAST INCL SUBSQT EXPANSION	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
11970	REPLAC TISS EXPANDER W/PERM PROSTH	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
11971	REMOV TISS EXPANDER WO INSRT PROSTH	No pre-authorization is required for all providers.	N/A
11976	REMOV IMPLNT CONTRACEPTIVE CAPSULES	No pre-authorization is required for all providers.	N/A
11980	HORMONE PELLET IMPLANTATION CODE	No pre-authorization is required for all providers.	N/A
11981	INSERTATION OF DRUG DELIVERY IMPLANT DEVICE	No pre-authorization is required for all providers.	N/A
11982	REMOVAL OF DRUG DELIVERY IMPLANT DEVICE	No pre-authorization is required for all providers.	N/A
11983	REMOVAL AND REINSERTION OF DRUG DELIVERY IMPLANT DEVICE	No pre-authorization is required for all providers.	N/A
12001	SIMPL REPR SCLP/AX/GENIT/TRUNK/EXTREM; 2.5/LESS	No pre-authorization is required for all providers.	N/A
12002	SIMPL REPR SCLP/AX/GENIT/TRUNK/EXTREM; 2.6-7.5CM	No pre-authorization is required for all providers.	N/A
12004	SIMPL REPR SCLP/AX/GENIT/TRUNK/EXTREM; 7.6-12.5	No pre-authorization is required for all providers.	N/A
12005	SIMPL REPR SCLP/AX/GENIT/TRUNK/EXTREM; 12.6-20.0	No pre-authorization is required for all providers.	N/A
12006	SIMPL REPR SCLP/AX/GENIT/TRUNK/EXTREM; 20.1-30.0	No pre-authorization is required for all providers.	N/A
12007	SIMPL REPR SCLP/AX/GENIT/TRUNK/EXTREM; OVER 30.0	No pre-authorization is required for all providers.	N/A
12011	SIMPL REPR FACE/EARS/NOSE/MUCOUS MEMB; 2.5/LESS	No pre-authorization is required for all providers.	N/A
12013	SIMPL REPR FACE/EARS/NOSE/MUCOUS MEMB; 2.6-5.0	No pre-authorization is required for all providers.	N/A
12014	SIMPL REPR FACE/EARS/NOSE/MUCOUS MEMB; 5.1-7.5	No pre-authorization is required for all providers.	N/A
12015	SIMPL REPR FACE/EARS/NOSE/MUCOUS MEMB; 7.6-12.5	No pre-authorization is required for all providers.	N/A
12016	SIMPL REPR FACE/EARS/NOSE/MUCOUS MEMB; 12.6-20.0	No pre-authorization is required for all providers.	N/A
12017	SIMPL REPR FACE/EARS/NOSE/MUCOUS MEMB; 20.1-30.0	No pre-authorization is required for all providers.	N/A
12018	SIMPL REPR FACE/EARS/NOSE/MUCOUS MEMB; OVER 30.0	No pre-authorization is required for all providers.	N/A
12020	TX SUPERF WOUND DEHISCENCE; SIMPL CLO	No pre-authorization is required for all providers.	N/A
12021	TX SUPERF WOUND DEHISCENCE; W/PACKING	No pre-authorization is required for all providers.	N/A
12031	INTMD WND REPAIR S/TR/EXT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
12032	INTMD WND REPAIR S/TR/EXT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
12034	INTMD WND REPAIR S/TR/EXT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
12035	INTMD WND REPAIR S/TR/EXT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
12036	INTMD WND REPAIR S/TR/EXT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
12037	INTMD WND REPAIR S/TR/EXT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
12041	INTMD WND REPAIR N-HF/GENIT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
12042	INTMD WND REPAIR N-HG/GENIT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
12044	INTMD WND REPAIR N-HG/GENIT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
12045	INTMD WND REPAIR N-HG/GENIT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
12046	INTMD WND REPAIR N-HG/GENIT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
12047	INTMD WND REPAIR N-HG/GENIT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
12051	INTMD WND REPAIR FACE/MM	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
12052	INTMD WND REPAIR FACE/MM	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019

12053	INTMD WND REPAIR FACE/MM	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
12054	INTMD WND REPAIR FACE/MM	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
12055	INTMD WND REPAIR FACE/MM	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
12056	INTMD WND REPAIR FACE/MM	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
12057	INTMD WND REPAIR FACE/MM	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
13100	REPR COMPLX TRUNK; 1.1 CM TO 2.5 CM	No pre-authorization is required for all providers.	N/A
13101	REPR COMPLX TRUNK; 2.6 CM TO 7.5 CM	No pre-authorization is required for all providers.	N/A
13102	REPAIR, COMPLEX TRUNK EACH ADDL 5CM	No pre-authorization is required for all providers.	N/A
13120	REPR COMPLX SCLP/ARMS/LEGS; 1.1 CM TO 2.5 CM	No pre-authorization is required for all providers.	N/A
13121	REPR COMPLX SCLP/ARMS/LEGS; 2.6 CM TO 7.5 CM	No pre-authorization is required for all providers.	N/A
13122	REPAIR, COMPLEX SCALP, ARMS AND/OR LEGS EACH ADDL 5 CM	No pre-authorization is required for all providers.	N/A
13131	REPR COMPLX FOREHEAD/CHIN/AX/GENIT/FT; 1.1-2.5	No pre-authorization is required for all providers.	N/A
13132	REPR COMPLX FOREHEAD/CHIN/AX/GENIT/FT; 2.6-7.5	No pre-authorization is required for all providers.	N/A
13133	REPAIR, COMPLEX, FOREHEAD CHEEKS CHIN MOUTH EACH ADDL 5 CM	No pre-authorization is required for all providers.	N/A
13150	REPR COMPLX LIDS/NOSE/EARS/LIPS; 1.0 CM/LESS	This is no longer a valid code.	N/A
13151	REPR COMPLX LIDS/NOSE/EARS/LIPS; 1.1 TO 2.5 CM	No pre-authorization is required for all providers.	N/A
13152	REPR COMPLX LIDS/NOSE/EARS/LIPS; 2.6 TO 7.5 CM	No pre-authorization is required for all providers.	N/A
13153	REPAIR COMPLEX EYELIDS NOSE EARS AND/OR LIPS EACH ADDL 5CM	No pre-authorization is required for all providers.	N/A
13160	SECNDRY CLO SURG WOUND/DEHISCENCE EXTEN/COMPLIC	No pre-authorization is required for all providers.	N/A
14000	ADJACENT TISS TRANSF TRUNK; DEFECT 10 SQ CM/LESS	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
14001	ADJACENT TISS TRANSF TRUNK; 10.1 TO 30.0 SQ CM	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
14020	ADJACENT TRANSF SCLP/ARMS/LEGS; 10 SQ CM/LESS	No pre-authorization is required for all providers.	N/A
14021	ADJACENT TRANSF SCLP/ARMS/LEGS; 10.1-30.00 SQ CM	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
14040	ADJACENT TRANSF CHIN/NECK/AX/FT; 10 SQ CM/LESS	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
14041	ADJACENT TRANSF CHIN/NECK/AX/FT; 10.1-30.0 SQ CM	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
14060	ADJACENT TRANSF LIDS/NOSE/LIPS; 10 SQ CM/LESS	No pre-authorization is required for all providers.	N/A
14061	ADJACENT TRANSF LIDS/NOSE/LIPS; 10.1-30.0 SQ CM	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
14300	ADJACENT TRANSF MORE THAN 30.0 SQ CM COMPLIC	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
14301	SKIN TISSUE REARRANGEMENT	No pre-authorization is required for all providers.	N/A
14302	SKIN TISSUE REARRANGE ADD-ON	No pre-authorization is required for all providers.	N/A
14350	FILLETED FINGER/TOE FLAP W/PREP RECIPIENT SITE	No pre-authorization is required for all providers.	N/A
15002	SURGICAL PREPARATION OR CREATION OF RECIPIENT SITE	Pre-authorization is required for all providers.	Prior to 09/01/2019
15003	WOUND PREP ADDL 100 CM	Pre-authorization is required for all providers.	Prior to 09/01/2019
15004	SURGICAL PREPARATION OR CREATION OF RECIPIENT SITE	Pre-authorization is required for all providers.	Prior to 09/01/2019
15005	WOUND PREP F/N/H/F/G ADDL CM	Pre-authorization is required for all providers.	Prior to 09/01/2019
15040	HARVEST SKN TISS CLTR SKN AGRFT 100 CM/<	No pre-authorization is required for all providers.	N/A
15050	PINCH GFT 1/MX TO COVER SMALL AREA UP TO 2 CM	No pre-authorization is required for all providers.	N/A
15100	SPLIT GFT TRUNK; 1ST 100 SQ CM/1% BODY CHILD	No pre-authorization is required for all providers.	N/A
15101	SPLIT GFT TRUNK; EA ADD 100/EA ADD 1% BODY CHILD	No pre-authorization is required for all providers.	N/A
15110	EPIDRM AGRFT T/A/L 1ST 100 CM/<1% BDY INFT/CHLD	No pre-authorization is required for all providers.	N/A
15111	EPIDRM AGRFT T/A/L EA 100 CM/EA 1% BDY INFT/CHLD	No pre-authorization is required for all providers.	N/A
15115	EPIDRM AGRFT F/S/N/H/F/G/M/D GT 1ST 100 CM	No pre-authorization is required for all providers.	N/A
15116	EPIDRM AGRFT F/S/N/H/F/G/M/D GT EA 100 CM/EA	No pre-authorization is required for all providers.	N/A
15120	SPLIT GFT FACE; 1ST 100 SQ CM/LESS/1% BODY CHILD	No pre-authorization is required for all providers.	N/A
15121	SPLIT GFT FACE; EA ADD 100 SQ CM/EA ADD 1% CHILD	No pre-authorization is required for all providers.	N/A
15130	DRM AGRFT T/A/L 1ST 100 CM	No pre-authorization is required for all providers.	N/A
15131	DRM AGRFT T/A/L EA 100 CM/EA	No pre-authorization is required for all providers.	N/A
15135	DRM AGRFT F/S/N/H/F/G/M/D GT 1ST 100	No pre-authorization is required for all providers.	N/A
15136	DRM AGRFT F/S/N/H/F/G/M/D GT EA 100 CM/EA	No pre-authorization is required for all providers.	N/A
15150	CULT SKIN GRFT T/ARM/LEG	No pre-authorization is required for all providers.	N/A
15151	CULT SKIN GRFT T/A/L ADDL	No pre-authorization is required for all providers.	N/A
15152	CULT SKIN GRAFT T/A/L +	No pre-authorization is required for all providers.	N/A
15155	CULT SKIN GRAFT F/N/H/F/G	No pre-authorization is required for all providers.	N/A
15156	CULT SKIN GRFT F/N/H/F/G ADD	No pre-authorization is required for all providers.	N/A
15157	CULT EPIDERM GRFT F/N/H/F/G +	No pre-authorization is required for all providers.	N/A
15200	FULL THICK GFT-FREE-TRUNK; 20 SQ CM/LESS	No pre-authorization is required for all providers.	N/A
15201	SKIN FULL GRAFT TRUNK ADD-ON	No pre-authorization is required for all providers.	N/A
15220	FULL THICK GFT-FREE-SCLP; 20 SQ CM/LESS	No pre-authorization is required for all providers.	N/A
15221	SKIN FULL GRAFT ADD-ON	No pre-authorization is required for all providers.	N/A
15240	FULL THICK GFT CHIN/NECK/AX/HANDS/FT; 20 SQ CM	No pre-authorization is required for all providers.	N/A
15241	SKIN FULL GRAFT ADD-ON	No pre-authorization is required for all providers.	N/A
15260	FULL THICK GFT NOSE/EARS/LIDS/LIPS; 20 SQ CM	No pre-authorization is required for all providers.	N/A
15261	SKIN FULL GRAFT ADD-ON	No pre-authorization is required for all providers.	N/A
15271	SKIN SUB GRAFT TRNK/ARM/LEG	No pre-authorization is required for all providers.	N/A
15272	SKIN SUB GRAFT T/A/L ADD-ON	No pre-authorization is required for all providers.	N/A
15273	SKIN SUB GRFT T/ARM/LG CHILD	No pre-authorization is required for all providers.	N/A
15274	SKN SUB GRFT T/A/L CHILD ADD	No pre-authorization is required for all providers.	N/A
15275	SKIN SUB GRAFT FACE/NK/H/F/G	No pre-authorization is required for all providers.	N/A
15276	SKIN SUB GRAFT F/N/H/F/G ADDL	No pre-authorization is required for all providers.	N/A
15277	SKN SUB GRFT F/N/H/F/G CHILD	No pre-authorization is required for all providers.	N/A
15278	SKN SUB GRFT F/N/H/F/G CH ADD	No pre-authorization is required for all providers.	N/A
15570	FORMATION DIR/TUBED PEDICLE W/WO TRANSF; TRUNK	No pre-authorization is required for all providers.	N/A
15572	FORMATION DIR/TUBED PEDICLE W/WO TRANSF; SCLP	No pre-authorization is required for all providers.	N/A
15574	FORM DIR PEDICLE W/WO TRANSF; CHEEKS/CHIN/AX/FT	No pre-authorization is required for all providers.	N/A
15576	FORM DIR PEDICLE W/WO TRANSF; LIDS/NOSE/EARS/LIP	No pre-authorization is required for all providers.	N/A
15600	DELAY FLAP/SECT FLAP; AT TRUNK	No pre-authorization is required for all providers.	N/A
15610	DELAY FLAP/SECT FLAP; AT SCLP/ARMS/LEGS	No pre-authorization is required for all providers.	N/A
15620	DELAY FLAP/SECT FLAP; FOREHEAD/CHIN/AX/GENIT/FT	No pre-authorization is required for all providers.	N/A
15630	DELAY FLAP/SECT; LIDS/NOSE/EARS/LIPS	No pre-authorization is required for all providers.	N/A
15650	TRANSF INTERMED ANY PEDICLE FLAP ANY LOCATION	No pre-authorization is required for all providers.	N/A
15730	MDFC FLAP W/PRSRV VASC PEDCL	No pre-authorization is required for all providers.	N/A
15731	FOREHEAD FLAP WITH PRESERVATION OF VASCULAR PEDICLE	No pre-authorization is required for all providers.	N/A
15732	MUSCL MYOCUT/FASCIOCUT FLAP; HEAD & NECK	This is no longer a valid code.	N/A
15733	MUSC MYOQ/FSCQ FLP H&N PEDCL	No pre-authorization is required for all providers.	N/A
15734	MUSCL MYOCUT/FASCIOCUT FLAP; TRUNK	No pre-authorization is required for all providers.	N/A
15736	MUSCL MYOCUT/FASCIOCUT FLAP; UP EXTREM	No pre-authorization is required for all providers.	N/A
15738	MUSCL MYOCUT/FASCIOCUT FLAP; LOWER EXTREM	No pre-authorization is required for all providers.	N/A
15740	ISLAND PEDICLE FLAP GRAFT	No pre-authorization is required for all providers.	N/A
15750	FLAP; NEUROVASCULAR PEDICLE	No pre-authorization is required for all providers.	N/A
15756	FREE MUSC/MYOCUT FLP MICVSC ANASTOM	No pre-authorization is required for all providers.	N/A
15757	FREE SKIN FLAP W/MICROVASC ANASTOM	No pre-authorization is required for all providers.	N/A
15758	FREE FASCIAL FLAP W/MICROVASC ANASTOM	No pre-authorization is required for all providers.	N/A
15760	GFT; COMPOSITE INCL PRIM CLO DONOR AREA	No pre-authorization is required for all providers.	N/A
15769	GRAFTING OF AUTOLOGOUS SOFT TISS BY DIRECT EXC	Pre-authorization required for all providers.	Prior to 09/01/2019
15770	GFT; DERM-FAT-FASCIA	No pre-authorization is required for all providers.	N/A
15771	GRAFTING OF AUTOLOGOUS FAT BY LIPO 50 CC OR LESS	Pre-authorization required for all providers.	Prior to 09/01/2019
15772	GRAFTING OF AUTOLOGOUS FAT BY LIPO EA ADDL 50 CC	Pre-authorization required for all providers.	Prior to 09/01/2019
15773	GRAFTING OF AUTOLOGOUS FAT BY LIPO 25 CC OR LESS	Pre-authorization required for all providers.	Prior to 09/01/2019
15774	GRAFTING OF AUTOLOGOUS FAT BY LIPO EA ADDL 25 CC	Pre-authorization required for all providers.	Prior to 09/01/2019
15775	PUNCH GFT HAIR TRANSPL; 1 TO 15 PUNCH GFT	This service is not covered by Superior HealthPlan.	N/A
15776	PUNCH GFT HAIR TRANSPL; MORE THAN 15 PUNCH GFT	This service is not covered by Superior HealthPlan.	N/A
15777	ACELLULAR DERM MATRIX IMPLT	No pre-authorization is required for all providers.	N/A
15780	DERMABRASION; TOT FACE	Pre-authorization is required for all providers.	Prior to 09/01/2019
15781	DERMABRASION; SEGMT FACE	Pre-authorization is required for all providers.	Prior to 09/01/2019
15782	DERMABRASION; REGIONAL NOT FACE	Pre-authorization is required for all providers.	Prior to 09/01/2019
15783	DERMABRASION; SUPERF ANY SITE	Pre-authorization is required for all providers.	Prior to 09/01/2019
15786	ABRASION; SNGL LES	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
15787	ABRASION; EA ADD 4 LES/LESS	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
15788	CHEM PEEL FACIAL; EPIDERMAL	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
15789	CHEM PEEL FACIAL; DERMAL	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
15792	CHEM PEEL; NONFACIAL; EPIDERMAL	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
15793	CHEM PEEL; NONFACIAL; DERMAL	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019

15819	CERVICOPLASTY	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
15820	BLEPHAROPLASTY LOWER EYELID	Pre-authorization is required for all providers.	Prior to 09/01/2019
15821	BLEPHAROPLASTY LOW; W/EXTEN HERNIAT FAT PAD	Pre-authorization is required for all providers.	Prior to 09/01/2019
15822	BLEPHAROPLASTY UPPER EYELID	Pre-authorization is required for all providers.	Prior to 09/01/2019
15823	BLEPHAROPLASTY UPPER; W/EXCESS SKIN WT DOWN LID	Pre-authorization is required for all providers.	Prior to 09/01/2019
15824	RHYTIDECTOMY; FOREHEAD	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
15825	RHYTIDECTOMY; NECK W/PLATYSMAL TIGHTENING	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
15826	RHYTIDECTOMY; GLABELLAR FROWN LINES	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
15828	RHYTIDECTOMY; CHEEK/CHIN/NECK	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
15829	RHYTIDECTOMY; SUPERF MUSCULOAPONEUROTIC SYST FLA	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
15830	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
15832	EXC EXCESSIVE SKIN & SUBQ TISS; THIGH	This service is not covered by Superior HealthPlan.	N/A
15833	EXC EXCESSIVE SKIN & SUBQ TISS; LEG	This service is not covered by Superior HealthPlan.	N/A
15834	EXC EXCESSIVE SKIN & SUBQ TISS; HIP	This service is not covered by Superior HealthPlan.	N/A
15835	EXC EXCESSIVE SKIN & SUBQ TISS; BUTTOCK	This service is not covered by Superior HealthPlan.	N/A
15836	EXC EXCESSIVE SKIN & SUBQ TISS; ARM	This service is not covered by Superior HealthPlan.	N/A
15837	EXC EXCESSIVE SKIN & SUBQ TISS; FOREARM/HAND	This service is not covered by Superior HealthPlan.	N/A
15838	EXC EXCESS SKIN SUBQ TISS; SUBMENTAL FAT PAD	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
15839	EXC EXCESSIVE SKIN & SUBQ TISS; OTHER AREA	This service is not covered by Superior HealthPlan.	N/A
15840	GFT FACIAL NERV PARALYSIS; FREE FASCIA GFT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
15841	GFT FACIAL NERV PARALYSIS; FREE MUSCL GFT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
15842	GFT FACE NERV PARALYSIS; MUSCL GFT-MICRO TECH	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
15845	GFT FACIAL NERV PARALYSIS; REGIONAL MUSCL TRANSF	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
15847	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
15850	REMOV SUTURES UNDER ANES SAME SURG	No pre-authorization is required for all providers.	N/A
15851	REMOV SUTURES UNDER ANES OTHER SURG	No pre-authorization is required for all providers.	N/A
15852	DSG CHANGE UNDER ANES	No pre-authorization is required for all providers.	N/A
15860	IV INJ AGENT TO TEST BLD FLOW FLAP/GFT	No pre-authorization is required for all providers.	N/A
15876	SUCTION ASSISTED LIPECTOMY; HEAD & NECK	No pre-authorization is required for all providers.	N/A
15877	SUCTION ASSISTED LIPECTOMY; TRUNK	This service is not covered by Superior HealthPlan.	N/A
15878	SUCTION ASSISTED LIPECTOMY; UPPER EXTREM	This service is not covered by Superior HealthPlan.	N/A
15879	SUCTION ASSISTED LIPECTOMY; LOWER EXTREM	This service is not covered by Superior HealthPlan.	N/A
15920	EXC COCCYGEAL ULCER W/COCCYGECTOMY; PRIM SUTURE	No pre-authorization is required for all providers.	N/A
15922	EXC COCCYGEAL ULCER W/COCCYGECTOMY; FLAP CLO	No pre-authorization is required for all providers.	N/A
15931	EXC SACRAL PRESS ULCER W/PRIM SUTURE	No pre-authorization is required for all providers.	N/A
15933	EXC SACRAL PRESS ULCER W/PRIM SUTURE; W/OSTECTMY	No pre-authorization is required for all providers.	N/A
15934	EXC SACRAL PRESS ULCER W/SKIN FLAP CLO	No pre-authorization is required for all providers.	N/A
15935	EXC SACRAL ULCER W/SKIN FLAP CLO; W/OSTECTOMY	No pre-authorization is required for all providers.	N/A
15936	EXC SACRAL ULCER PREP-FLAP/SKIN GFT CLO;	No pre-authorization is required for all providers.	N/A
15937	EXC SACRAL ULCER PREP-FLAP/SKIN GFT; W/OSTECT	No pre-authorization is required for all providers.	N/A
15940	EXC ISCHIAL PRESS ULCER W/PRIM SUTURE	No pre-authorization is required for all providers.	N/A
15941	EXC ISCHIAL ULCER W/PRIM SUTURE; W/OSTECTOMY	No pre-authorization is required for all providers.	N/A
15944	EXC ISCHIAL PRESS ULCER W/SKIN FLAP CLO	No pre-authorization is required for all providers.	N/A
15945	EXC ISCHIAL ULCER W/SKIN FLAP CLO; W/OSTECTOMY	No pre-authorization is required for all providers.	N/A
15946	EXC ISCHIAL ULCER W/OSTECT PREP-FLAP/SKIN GFT	No pre-authorization is required for all providers.	N/A
15950	EXC TROCH PRESS ULCER W/PRIM SUTURE	No pre-authorization is required for all providers.	N/A
15951	EXC TROCH ULCER W/PRIM SUTURE; W/OSTECTOMY	No pre-authorization is required for all providers.	N/A
15952	EXC TROCH PRESS ULCER W/SKIN FLAP CLO	No pre-authorization is required for all providers.	N/A
15953	EXC TROCH ULCER W/SKIN FLAP CLO; W/OSTECTOMY	No pre-authorization is required for all providers.	N/A
15956	EXC TROCH ULCER PREP-FLAP/SKIN GFT CLO;	No pre-authorization is required for all providers.	N/A
15958	EXC TROCH ULCER PREP-FLAP/SKIN GFT; W/ OSTECT	No pre-authorization is required for all providers.	N/A
15999	UNLISTED PROC EXC PRESS ULCER	No pre-authorization is required for all providers.	N/A
16000	INIT TX 1ST DEGREE BURN WHEN LOCAL TX REQUIRED	No pre-authorization is required for all providers.	N/A
16020	DSG &/OR DEBRID INIT/SUBSQ; WO ANES OFC/HOSP SM	No pre-authorization is required for all providers.	N/A
16025	DSG &/OR DEBRID INIT/SUBSQ; WO ANES MEDIUM	No pre-authorization is required for all providers.	N/A
16030	DSG &/OR DEBRID INIT/SUBSQ; WO ANES LARGE	No pre-authorization is required for all providers.	N/A
16035	ESCHAROTOMY	No pre-authorization is required for all providers.	N/A
16036	ESCHAROTOMY; EA ADD INCIS 2.32	No pre-authorization is required for all providers.	N/A
17000	DESTRUCTION PREMALIGNANT LESIONS, FIRST LESION	No pre-authorization is required for all providers.	N/A
17003	DESTRCT-ANY METHD-BEN LES W/ANES; 2-14 LES, EA	No pre-authorization is required for all providers.	N/A
17004	DESTRUCTION PREMALIGNANT LESIONS, 15 OR MORE LESIONS	No pre-authorization is required for all providers.	N/A
17106	DESTRCT CUT VASCULAR PROLIFERAT LES; < 10 SQ CM	No pre-authorization is required for all providers.	N/A
17107	DESTRCT CUT VASCULAR PROLIF LES; 10.0-50.0 SQ CM	No pre-authorization is required for all providers.	N/A
17108	DESTRCT CUT VASCULAR PROLIF LES; > 50.0 SQ CM	No pre-authorization is required for all providers.	N/A
17110	DESTRUCTION BENIGN LESIONS UP TO 14	No pre-authorization is required for all providers.	N/A
17111	DSTRJ B9 SK TGS/CUTAN VASC 15/	No pre-authorization is required for all providers.	N/A
17250	CHEM CAUT OF GRANLTJ TISSUE	No pre-authorization is required for all providers.	N/A
17260	DESTRCT MALIG LES TRUNK/ARMS/LEGS; 0.5 CM/LESS	No pre-authorization is required for all providers.	N/A
17261	DESTRCT MALIG LES TRUNK/ARMS/LEGS; 0.6-1.0 CM	No pre-authorization is required for all providers.	N/A
17262	DESTRCT MALIG LES TRUNK/ARMS/LEGS; 1.1-2.0 CM	No pre-authorization is required for all providers.	N/A
17263	DESTRCT MALIG LES TRUNK/ARMS/LEGS; 2.1-3.0 CM	No pre-authorization is required for all providers.	N/A
17264	DESTRCT MALIG LES TRUNK/ARMS/LEGS; 3.1-4.0 CM	No pre-authorization is required for all providers.	N/A
17266	DESTRCT MALIG LES TRUNK/ARMS/LEGS; OVER 4.0 CM	No pre-authorization is required for all providers.	N/A
17270	DESTRCT MALIG LES SCLP/HANDS/GENIT; 0.5 CM/LESS	No pre-authorization is required for all providers.	N/A
17271	DESTRCT MALIG LES SCLP/HANDS/GENIT; 0.6-1.0 CM	No pre-authorization is required for all providers.	N/A
17272	DESTRCT MALIG LES SCLP/HANDS/GENIT; 1.1-2.0 CM	No pre-authorization is required for all providers.	N/A
17273	DESTRCT MALIG LES SCLP/HANDS/GENIT; 2.1-3.0 CM	No pre-authorization is required for all providers.	N/A
17274	DESTRCT MALIG LES SCLP/HANDS/GENIT; 3.1-4.0 CM	No pre-authorization is required for all providers.	N/A
17276	DESTRCT MALIG LES SCLP/HANDS/GENIT; OVER 4.0 CM	No pre-authorization is required for all providers.	N/A
17280	DESTRCT MALIG LES FACE/EARS/LIDS; 0.5 CM/LESS	No pre-authorization is required for all providers.	N/A
17281	DESTRCT MALIG LES FACE/EARS/LIDS; 0.6-1.0 CM	No pre-authorization is required for all providers.	N/A
17282	DESTRCT MALIG LES FACE/EARS/LIDS; 1.1-2.0 CM	No pre-authorization is required for all providers.	N/A
17283	DESTRCT MALIG LES FACE/EARS/LIDS; 2.1-3.0 CM	No pre-authorization is required for all providers.	N/A
17284	DESTRCT MALIG LES FACE/EARS/LIDS; 3.1-4.0 CM	No pre-authorization is required for all providers.	N/A
17286	DESTRCT MALIG LES FACE/EARS/LIDS; OVER 4.0 CM	No pre-authorization is required for all providers.	N/A
17311	MOHS MICROGRAPHIC TECHNIQUE,	No pre-authorization is required for all providers.	N/A
17312	EACH ADDITIONAL STAGE AFTER THE FIRST STAGE, UP TO 5 TISSUE BLOCKS	No pre-authorization is required for all providers.	N/A
17313	MOHS MICROGRAPHIC TECHNIQUE	No pre-authorization is required for all providers.	N/A
17314	EACH ADDITIONAL STAGE AFTER THE FIRST STAGE, UP TO 5 TISSUE BLOCKS	No pre-authorization is required for all providers.	N/A
17315	MOHS MICROGRAPHIC TECHNIQUE	No pre-authorization is required for all providers.	N/A
17340	CRYOTHERAPY-ACNE	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
17360	CHEM EXFOLIATION ACNE	This service is not covered by Superior HealthPlan.	N/A
17380	ELECTROLYSIS EPILATION EA 1/2 HR	This service is not covered by Superior HealthPlan.	N/A
17999	UNLISTED PROC SKIN/MUCOS MEMBRN/SUBQ TISS	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19000	PUNCT ASPIRAT CYST BREAST	No pre-authorization is required for all providers.	N/A
19001	PUNCT ASPIRAT CYST BREAST; EA ADD CYST	No pre-authorization is required for all providers.	N/A
19020	MASTOTOMY W/EXPLOR/ DRAINAGE ABSCESS DEEP	No pre-authorization is required for all providers.	N/A
19030	INJ PROC ONLY-MAMMARY DUCTOGRAM/GALACTOGRAM	No pre-authorization is required for all providers.	N/A
19081	BX BREAST 1ST LESION STRTCTC	No pre-authorization is required for all providers.	N/A
19082	BX BREAST ADD LESION STRTCTC	No pre-authorization is required for all providers.	N/A
19083	BX BREAST 1ST LESION US IMAG	No pre-authorization is required for all providers.	N/A
19084	BX BREAST ADD LESION US IMAG	No pre-authorization is required for all providers.	N/A
19085	BX BREAST 1ST LESION MR IMAG	No pre-authorization is required for all providers.	N/A
19086	BX BREAST ADD LESION MR IMAG	No pre-authorization is required for all providers.	N/A
19100	BX BREAST; NEEDLE CORE (SEPART PROC)	No pre-authorization is required for all providers.	N/A
19101	BX BREAST; INCS	No pre-authorization is required for all providers.	N/A
19102	BX BREAST; NEEDLE CORE W/GUID 6.66	This is no longer a valid code.	N/A
19103	BX BREAST; PERC-VACUUM DEV W/IMAG 13.28	This is no longer a valid code.	N/A
19105	ABLATION CRYOSURGICAL OF FIBROADENOMA INCL ULTRASOUND GUIDANCE	This service is not covered by Superior HealthPlan.	N/A
19110	NIPPLE EXPLOR W/WO EXC SOLITARY/PAPILLOMA DUCT	No pre-authorization is required for all providers.	N/A
19112	EXC LACTIFEROUS DUCT FISTULA	No pre-authorization is required for all providers.	N/A
19120	EXCISION CYST FIBROADENOMA OR OTH BENIGN OR MALIGN TUMOR ABERRANT BR TIS	No pre-authorization is required for all providers.	N/A

19125	EXC BREAST LES-ID PRE-OP PLCMT RAD MARKER; 1 LES	No pre-authorization is required for all providers.	N/A
19126	EXC BREAST LES; EA ADD LES-SEPART ID RAD MARKER	No pre-authorization is required for all providers.	N/A
19260	EXC CHEST WALL TUMOR INCL RIBS	No pre-authorization is required for all providers.	N/A
19271	EXC CHEST WALL TUMOR W/PLSTC RECON; WO LYMPHADEN	No pre-authorization is required for all providers.	N/A
19272	EXC CHEST WALL TUMOR W/PLSTC RECON; W/LYMPHADEN	No pre-authorization is required for all providers.	N/A
19281	PERQ DEVICE BREAST 1ST IMAG	No pre-authorization is required for all providers.	N/A
19282	PERQ DEVICE BREAST EA IMAG	No pre-authorization is required for all providers.	N/A
19283	PERQ DEV BREAST 1ST STRTCTC	No pre-authorization is required for all providers.	N/A
19284	PERQ DEV BREAST ADD STRTCTC	No pre-authorization is required for all providers.	N/A
19285	PERQ DEV BREAST 1ST US IMAG	No pre-authorization is required for all providers.	N/A
19286	PERQ DEV BREAST ADD US IMAG	No pre-authorization is required for all providers.	N/A
19287	PERQ DEV BREAST 1ST MR GUIDE	No pre-authorization is required for all providers.	N/A
19288	PERQ DEV BREAST ADD MR GUIDE	No pre-authorization is required for all providers.	N/A
19290	PREOPERATIVE PLCMT NEEDLE LOCALIZ WIRE BREAST	This is no longer a valid code.	N/A
19291	PREOP PLCMT NEEDLE LOCAL WIRE BREAST; EA ADD LES	This is no longer a valid code.	N/A
19294	PREP TUM CAV IORT PRTL MAST	No pre-authorization is required for all providers.	N/A
19295	IMAG GUID PLC CLIP-PERC-DUR BRST BX 2.62	This is no longer a valid code.	N/A
19296	PLACE PO BREAST CATH FOR RAD	No pre-authorization is required for all providers.	N/A
19297	PLACE BREAST CATH FOR RAD	No pre-authorization is required for all providers.	N/A
19298	PLACE BREAST RAD TUBE/CATHS	No pre-authorization is required for all providers.	N/A
19300	MASTECTOMY FOR GYNECOMASTIA	Pre-authorization is required for all providers.	Prior to 09/01/2019
19301	MASTECTOMY, PARTIAL	No pre-authorization is required for all providers.	N/A
19302	WITH AXILLARY LYMPHADENECTOMY	No pre-authorization is required for all providers.	N/A
19303	MASTECTOMY, SIMPLE, COMPLETE	No pre-authorization is required for all providers.	N/A
19304	MASTECTOMY, SUBCUTANEOUS	No pre-authorization is required for all providers.	N/A
19305	MASTECTOMY, RADICAL	No pre-authorization is required for all providers.	N/A
19306	MASTECTOMY, RADICAL	No pre-authorization is required for all providers.	N/A
19307	MASTECTOMY	No pre-authorization is required for all providers.	N/A
19316	MASTOPEXY	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19318	REDUCTION MAMMAPLASTY	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19324	MAMMAPLASTY AUGMEN; WO PROSTH IMPLNT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19325	MAMMAPLASTY AUGMEN; W/PROSTH IMPLNT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19328	REMOV INTACT MAMMARY IMPLNT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19330	REMOV MAMMARY IMPLNT MAT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19340	IMMED INSRT BREAST PROSTH AFTER MASTOPEX/MASTECT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19342	DELAYED INSRT PROSTH AFTER MASTOPEX/MASTECT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19350	NIPPLE/AREOLA RECON	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19355	CORRECT INVERTED NIPPLES	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19357	BREAST RECON IMMED/DELAY W/EXPANDR W/SUBSQT EXPA	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19361	BREAST RECONSTRUCTION W LATISSIMUS DORSI FLAP W/OUT PROSTHETIC IMPLANT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19364	BREAST RECON W/FREE FLAP	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19366	BREAST RECON W/OTHER TECH	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19367	BREAST RECON W/TRAM FLAP-1 PEDICLE INCL CLO;	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19368	BREAST RECON W/TRAM FLAP-1 PEDICLE; W/MICRO ANAS	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19369	BREAST RECON W/TRAM FLAP-2 PEDICLE INCL CLO	No pre-authorization is required for all providers.	N/A
19370	OPEN PERIPROSTHETIC CAPSULOTOMY BREAST	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19371	PERIPROSTHETIC CAPSULECTOMY BREAST	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19380	REVIS RECON BREAST	No pre-authorization is required for all providers.	N/A
19396	PREP MOULAGE CUSTOM BREAST IMPLNT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
19499	UNLISTED PROC BREAST	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
20000	INCS SOFT TISS ABSCESS; SUPERF	This is no longer a valid code.	N/A
20005	I&D ABSCESS SUBFASCIAL	This is no longer a valid code.	N/A
20100	EXPLOR PENETRATING WOUND (SEPART PROC); NECK	No pre-authorization is required for all providers.	N/A
20101	EXPLOR PENETRATING WOUND (SEPART PROC); CHEST	No pre-authorization is required for all providers.	N/A
20102	EXPLOR PENETRAT WOUND (SEP PROC); ABD/FLANK/BACK	No pre-authorization is required for all providers.	N/A
20103	EXPLOR PENETRATING WOUND (SEPART PROC); EXTREM	No pre-authorization is required for all providers.	N/A
20150	EXC EPIPHYSEAL BAR W/WO AUTOG GFT THRU SAME INCS	No pre-authorization is required for all providers.	N/A
20200	BX MUSCL; SUPERF	No pre-authorization is required for all providers.	N/A
20205	BX MUSCL; DEEP	No pre-authorization is required for all providers.	N/A
20206	BX MUSCL PERCUT NEEDLE	No pre-authorization is required for all providers.	N/A
20220	BX BONE TROCAR/NEEDLE; SUPERF	No pre-authorization is required for all providers.	N/A
20225	BX BONE TROCAR/NEEDLE; DEEP	No pre-authorization is required for all providers.	N/A
20240	BONE BIOPSY OPEN SUPERFICIAL	No pre-authorization is required for all providers.	N/A
20245	BONE BIOPSY OPEN DEEP	No pre-authorization is required for all providers.	N/A
20250	BX VERTEBRAL BODY OPEN; THORACIC	No pre-authorization is required for all providers.	N/A
20251	BX VERTEBRAL BODY OPEN; LUMBAR/CERV	No pre-authorization is required for all providers.	N/A
20500	INJ SINUS TRACT; THERAP (SEPART PROC)	No pre-authorization is required for all providers.	N/A
20501	INJ SINUS TRACT; DX	No pre-authorization is required for all providers.	N/A
20520	REMOV FB MUSCL/TENDON SHEATH; SIMPL	No pre-authorization is required for all providers.	N/A
20525	REMOV FB MUSCL/TENDON SHEATH; DEEP/COMPLIC	No pre-authorization is required for all providers.	N/A
20526	CARPAL TUNNEL THERAPEUTIC INJECTION	No pre-authorization is required for all providers.	N/A
20527	INJ DUPUYTREN CORD W/ENZYME	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
20550	INJ SINGLE TENDON SHEATH OR LIGAMENT	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
20551	SINGLE TENDON ORIGIN/INSERTION	No pre-authorization is required for all providers.	N/A
20552	INJ SINGLE/MX TRIG POINT 1/2 MUSCL	No pre-authorization is required for all providers.	N/A
20553	INJ; SINGLE/MX TRIG POINT 3/> MUSCL	No pre-authorization is required for all providers.	N/A
20555	PLACE NDL MUSC/TIS FOR RT	This service is not covered by Superior HealthPlan.	N/A
20560	NEEDLE INSERTION W/O INJECTION 1 OR 2 MUSCLES	This service is not covered by Superior HealthPlan.	N/A
20561	NEEDLE INSERTION W/O INJECTION 3 OR MORE MUSCLES	This service is not covered by Superior HealthPlan.	N/A
20600	DRAIN/INJ JOINT/BURSA W/O US	No pre-authorization is required for all providers.	N/A
20604	DRAIN/INJ JOINT/BURSA W/US	No pre-authorization is required for all providers.	N/A
20605	DRAIN/INJ JOINT/BURSA W/O US	No pre-authorization is required for all providers.	N/A
20606	DRAIN/INJ JOINT/BURSA W/US	No pre-authorization is required for all providers.	N/A
20610	DRAIN/INJ JOINT/BURSA W/O US	No pre-authorization is required for all providers.	N/A
20611	DRAIN/INJ JOINT/BURSA W/US	No pre-authorization is required for all providers.	N/A
20612	ASPIR & INJ GANG CYSTS ANT LOCATION	No pre-authorization is required for all providers.	N/A
20615	ASPIRAT & INJ TX BONE CYST	No pre-authorization is required for all providers.	N/A
20650	INSRT WIRE W/APPLIC TRACT W/REMOV (SEPART PROC)	No pre-authorization is required for all providers.	N/A
20660	APPLICATION CRANIAL TONG/STRTCTC FRAME W/REMOVAL	No pre-authorization is required for all providers.	N/A
20661	APPLIC HALO INCL REMOV; CRANIAL	No pre-authorization is required for all providers.	N/A
20662	APPLIC HALO INCL REMOV; PELVIC	No pre-authorization is required for all providers.	N/A
20663	APPLIC HALO INCL REMOV; FEMORAL	No pre-authorization is required for all providers.	N/A
20664	APPLICATION OF HALO	No pre-authorization is required for all providers.	N/A
20665	REMOVAL OF FIXATION DEVICE	No pre-authorization is required for all providers.	N/A
20670	REMOV IMPLNT; SUPERF (SEPART PROC)	No pre-authorization is required for all providers.	N/A
20680	REMOV IMPLNT; DEEP	No pre-authorization is required for all providers.	N/A
20690	APPLICATION UNIPLANE EXTERNAL FIXATION SYSTEM	No pre-authorization is required for all providers.	N/A
20692	APPLICATION MULTIPLANE EXTERNAL FIXATION SYSTEM	No pre-authorization is required for all providers.	N/A
20693	ADJUSTMENT/REVIS EXT FIXA SYST REQUIRING ANES	No pre-authorization is required for all providers.	N/A
20694	REMOV UNDER ANES EXT FIXA SYST	No pre-authorization is required for all providers.	N/A
20696	COMP MULTIPLANE EXT FIXATION	No pre-authorization is required for all providers.	N/A
20697	COMP EXT FIXATE STRUT CHANGE	No pre-authorization is required for all providers.	N/A
20700	MANUAL PREP AND INSERTION DEEP DRUG DELIVERY DEV	No pre-authorization is required for all providers.	N/A
20701	REMOVAL DEEP DRUG DELIVERY DEVICE	No pre-authorization is required for all providers.	N/A
20702	MANUAL PREP AND INSJ INTRAMEDULLARY DRUG DLVR DEVICE	No pre-authorization is required for all providers.	N/A
20703	REMOVAL INTRAMEDULLARY DRUG DELIVERY DEVICE	No pre-authorization is required for all providers.	N/A
20704	MANUAL PREP AND INSJ I-ARTIC DRUG DELIVERY DEVICE	No pre-authorization is required for all providers.	N/A
20705	REMOVAL INTRA-ARTICULAR DRUG DELIVERY DEVICE	No pre-authorization is required for all providers.	N/A
20802	REPLANTATION ARM; COMPLT AMPUTA	No pre-authorization is required for all providers.	N/A
20805	REPLANTATION FOREARM; COMPLT AMPUTA	No pre-authorization is required for all providers.	N/A
20808	REPLANTATION HAND; COMPLT AMPUTA	No pre-authorization is required for all providers.	N/A
20816	REPLANTATION DIGIT (INCL MCP JT); COMPLT AMPUTA	No pre-authorization is required for all providers.	N/A

20822	REPLANTATION DIGIT (DISTAL TIP); COMPLT AMPUTA	No pre-authorization is required for all providers.	N/A
20824	REPLANTATION THUMB (CM JT-MP JT); COMPLT AMPUTA	No pre-authorization is required for all providers.	N/A
20827	REPLANTATION THUMB (DISTAL TIP); COMPLT AMPUTA	No pre-authorization is required for all providers.	N/A
20838	REPLANTATION FT; COMPLT AMPUTA	No pre-authorization is required for all providers.	N/A
20900	BONE GRAFT ANY DONOR AREA MINOR/SMALL	No pre-authorization is required for all providers.	N/A
20902	BONE GRAFT ANY DONOR AREA MAJOR/LARGE	No pre-authorization is required for all providers.	N/A
20910	CARTILAGE GRAFT COSTOCHONDRAL	No pre-authorization is required for all providers.	N/A
20912	CARTILAGE GRAFT NASAL SEPTUM	No pre-authorization is required for all providers.	N/A
20920	FASCIA LATA GRAFT BY STRIPPER	No pre-authorization is required for all providers.	N/A
20922	FASCIA LATA GRAFT INCISION&AREA EXPOSURE	No pre-authorization is required for all providers.	N/A
20924	TENDON GRAFT FROM A DISTANCE	No pre-authorization is required for all providers.	N/A
20926	TISSUE GRAFTS OTHER	No pre-authorization is required for all providers.	N/A
20930	SP BONE ALGRFT MORSEL ADD-O	This service is not covered by Superior HealthPlan.	N/A
20931	SP BONE ALGRFT STRUCT ADD-O	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
20932	OSTEOARTICULAR ALLOGRAFT W/ARTICULAR SURF AND BONE	No pre-authorization is required for all providers.	N/A
20933	HEMICORTICAL INTERCALARY ALLOGRAFT PARTIAL	No pre-authorization is required for all providers.	N/A
20934	INTERCALARY ALLOGRAFT COMPLETE	No pre-authorization is required for all providers.	N/A
20936	AUTOGRAFT SPINE SURGERY LOCAL FROM SAME INCISION	This service is not covered by Superior HealthPlan.	N/A
20937	AUTOGRAFT SPINE SURGERY MORSELIZED SEP INCISION	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
20938	AUTOGRAFT SPINE SURGERY BICORT/TRICORT SEP INC	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
20939	BONE MARROW ASPIR BONE GRFG	No pre-authorization is required for all providers.	N/A
20950	MONITOR INTERSTITIAL PRESS-DETECT MUSCL COMPARTM	No pre-authorization is required for all providers.	N/A
20955	BONE GFT W/MICROVASCULAR ANASTOM; FIBULA	No pre-authorization is required for all providers.	N/A
20956	BONE GFT W/MICROVASC ANASTOM; ILIAC CREST	No pre-authorization is required for all providers.	N/A
20957	BONE GFT W/MICROVASC ANASTOM; METATARSAL	No pre-authorization is required for all providers.	N/A
20962	BONE GFT W/MICROVASC ANAST; NOT FIB/ILIAC/METATAR	No pre-authorization is required for all providers.	N/A
20969	FREE OSTEOCUT FLAP; NOT ILIAC/METATARS/GR TOE	No pre-authorization is required for all providers.	N/A
20970	FREE OSTEOCUT FLAP W/MICROVASC ANASTOM; ILIAC	No pre-authorization is required for all providers.	N/A
20972	FREE OSTEOCUT FLAP W/MICROVASC ANASTOM; METATARS	No pre-authorization is required for all providers.	N/A
20973	FREE OSTEOCUT FLAP W/MICROVASC ANASTOM; GRT TOE	No pre-authorization is required for all providers.	N/A
20974	ELEC STIM TO AID BONE HEALING; NONINVASIVE	No pre-authorization is required for all providers.	N/A
20975	ELEC STIM TO AID BONE HEALING; INVASIVE	No pre-authorization is required for all providers.	N/A
20979	LOW INTENSITY ULTRASOUND STIMULATION, NONINVASIVE	No pre-authorization is required for all providers.	N/A
20982	ABLATE BONE TUMOR(S) PERQ	No pre-authorization is required for all providers.	N/A
20983	ABLATE BONE TUMOR(S) PERQ	This service is not covered by Superior HealthPlan.	N/A
20985	CPTR-ASST DIR MS PX	This service is not covered by Superior HealthPlan.	N/A
20999	UNLISTED PROC MS SYST GEN	No pre-authorization is required for all providers.	N/A
21010	ARTHROTOMY TEMPOROMANDIBULAR JT	No pre-authorization is required for all providers.	N/A
21011	EXC FACE LES SC < 2 CM	No pre-authorization is required for all providers.	N/A
21012	EXC FACE LES SC = 2 CM	No pre-authorization is required for all providers.	N/A
21013	EXC FACE TUM DEEP < 2 CM	No pre-authorization is required for all providers.	N/A
21014	EXC FACE TUM DEEP = 2 CM	No pre-authorization is required for all providers.	N/A
21015	RESECT FACE/SCALP TUM < 2 CM	No pre-authorization is required for all providers.	N/A
21016	RESECT FACE/SCALP TUM 2 CM>	No pre-authorization is required for all providers.	N/A
21025	EXC BONE; MANDIB	No pre-authorization is required for all providers.	N/A
21026	EXC BONE; FACIAL BONE	No pre-authorization is required for all providers.	N/A
21029	REMOV BY CONTOURING BEN TUMOR FACIAL BONE	No pre-authorization is required for all providers.	N/A
21030	EXC BEN TUMR MAX/ZYGO ENUCLAT&CURET	No pre-authorization is required for all providers.	N/A
21031	EXC TORUS MANDIBULARIS	No pre-authorization is required for all providers.	N/A
21032	EXC MAXIL TORUS PALATINUS	No pre-authorization is required for all providers.	N/A
21034	EXCISION MALIG TUMOR MAXILLA/ZYGOMA	No pre-authorization is required for all providers.	N/A
21040	EXC BEN TUMR MAND ENUCLEAT&CURET	No pre-authorization is required for all providers.	N/A
21044	EXC MALIG TUMOR MANDIB	No pre-authorization is required for all providers.	N/A
21045	EXC MALIG TUMOR MANDIB; RADICAL RESECT	No pre-authorization is required for all providers.	N/A
21046	EXC BEN TUMR MAND; INTRA-ORL OSTEOT	No pre-authorization is required for all providers.	N/A
21047	EXC BEN TUMR MAND; PART MANDIBULECT	No pre-authorization is required for all providers.	N/A
21048	EXC BEN TUMR MAX; INTRA-ORL OSTEOT	No pre-authorization is required for all providers.	N/A
21049	EXC BEN TUMR MAX; PART MAXLECT	No pre-authorization is required for all providers.	N/A
21050	CONDYLECTOMY TEMPOROMANDIBULAR JT (SEPART PROC)	No pre-authorization is required for all providers.	N/A
21060	MENISCECTOMY PART/COMPLT TMJ (SEPART PROC)	No pre-authorization is required for all providers.	N/A
21070	CORONOIDECTOMY (SEPART PROC)	No pre-authorization is required for all providers.	N/A
21073	MNPJ OF TMJ W/ANESTH	No pre-authorization is required for all providers.	N/A
21076	IMPRESSION & CUSTOM PREP; SURG OBTUR PROSTH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
21077	IMPRESSION & CUSTOM PREP; ORBIT PROSTH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
21079	IMPRESS & CUST PREP; INTERIM OBTURATOR PROSTH	No pre-authorization is required for all providers.	N/A
21080	IMPRESS & CUST PREP; DEFINITIVE OBTURATOR PROSTH	No pre-authorization is required for all providers.	N/A
21081	IMPRESS & CUST PREP; MANDIB RESECT PROSTH	No pre-authorization is required for all providers.	N/A
21082	IMPRESS & CUST PREP; PALATAL AUGMEN PROSTH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
21083	IMPRESS & CUST PREP; PALATAL LIFT PROSTH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
21084	IMPRESS & CUST PREP; SPEECH AID PROSTH	No pre-authorization is required for all providers.	N/A
21085	IMPRESS & CUST PREP; ORAL SURG SPLINT	No pre-authorization is required for all providers.	N/A
21086	IMPRESS & CUST PREP; AURICULAR PROSTH	No pre-authorization is required for all providers.	N/A
21087	IMPRESS & CUST PREP; NASAL PROSTH	No pre-authorization is required for all providers.	N/A
21088	IMPRESS & CUST PREP; FACIAL PROSTH	No pre-authorization is required for all providers.	N/A
21089	UNLISTED MAXILLOFACIAL PROSTH PROC	No pre-authorization is required for all providers.	N/A
21100	APPLIC HALO-MAXILLOFAC INCL REMOV (SEPART PROC)	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
21110	APPLIC INTERDENTAL DEVICE-NOT FX DISLOC W/REMOV	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
21116	INJ PROC TEMPOROMANDIBULAR JT ARTHROGRAPHY	No pre-authorization is required for all providers.	N/A
21120	GENIOPLASTY; AUGMEN	No pre-authorization is required for all providers.	N/A
21121	GENIOPLASTY; SLIDING OSTEOTOMY SNGL PIECE	No pre-authorization is required for all providers.	N/A
21122	GENIOPLASTY; SLIDING OSTEOTOMIES 2/MORE	No pre-authorization is required for all providers.	N/A
21123	GENIOPLASTY; SLIDING AUGMEN W/INTERPOSIT GFT	No pre-authorization is required for all providers.	N/A
21125	AUGMEN MANDIB BODY/ANGLE; PROSTH MAT	No pre-authorization is required for all providers.	N/A
21127	AUGMEN MANDIB BODY/ANGLE; W/BONE GFT ONLAY	No pre-authorization is required for all providers.	N/A
21137	REDUCTION FOREHEAD; CONTOURING ONLY	No pre-authorization is required for all providers.	N/A
21138	REDUCT FOREHEAD; CONTOUR/APPLIC PROSTH/BONE GFT	No pre-authorization is required for all providers.	N/A
21139	REDUCT FOREHEAD; SETBACK ANT FRONTAL SINUS WALL	No pre-authorization is required for all providers.	N/A
21141	RECON MIDFACE LEFORT I; 1 PIECE WO BONE GFT	No pre-authorization is required for all providers.	N/A
21142	RECON MIDFACE LEFORT I; 2 PIECE WO BONE GFT	No pre-authorization is required for all providers.	N/A
21143	RECON MIDFACE LEFORT I; 3/MORE PIECE WO BONE GFT	No pre-authorization is required for all providers.	N/A
21145	RECON MIDFACE LEFORT I; 1 PIECE REQ BONE GFT	No pre-authorization is required for all providers.	N/A
21146	RECON MIDFACE LEFORT I; 2 PIECES REQ BONE GFT	No pre-authorization is required for all providers.	N/A
21147	RECON MIDFACE LEFORT I; 3/MORE PIECES REQ GFT	No pre-authorization is required for all providers.	N/A
21150	RECON MIDFACE LEFORT II; ANT INTRUSION	No pre-authorization is required for all providers.	N/A
21151	RECON MIDFACE LEFORT II; ANY DIRECT REQ BONE GFT	No pre-authorization is required for all providers.	N/A
21154	RECON MIDFACE LEFORT III REQ GFT; WO LEFORT I	No pre-authorization is required for all providers.	N/A
21155	RECON MIDFACE LEFORT III REQ GFT; W/LEFORT I	No pre-authorization is required for all providers.	N/A
21159	RECON MIDFACE FOREHEAD ADVANC W/GFT; WO LEFORT I	No pre-authorization is required for all providers.	N/A
21160	RECON MIDFACE FOREHEAD ADVANC W/GFT; W/LEFORT I	No pre-authorization is required for all providers.	N/A
21172	RECON SUP-LAT ORBITAL RIM/LO FOREHEAD W/WO GFTS	No pre-authorization is required for all providers.	N/A
21175	RECON BIFRONTAL ORBIT RIMS/LO FOREHEAD W/WO GFTS	No pre-authorization is required for all providers.	N/A
21179	RECON MAJORITY FOREHEAD/SUPRAORBITAL RIMS; W/GFT	No pre-authorization is required for all providers.	N/A
21180	RECON MAJ FOREHEAD/SUPRAORBIT RIMS; W/AUTOGFT	No pre-authorization is required for all providers.	N/A
21181	RECON CONTOUR BEN TUMOR CRANIAL BONE EXTRACRANI	No pre-authorization is required for all providers.	N/A
21182	RECON ORBIT-EXC BONE TUM; BONE GFT < 40 CM2	No pre-authorization is required for all providers.	N/A
21183	RECON ORBIT-EXC TUM; BONE GFT > 40 BUT < 80 CM2	No pre-authorization is required for all providers.	N/A
21184	RECON ORBIT-EXC BONE TUM; BONE GFT > 80 CM2	No pre-authorization is required for all providers.	N/A
21188	RECON MIDFACE OSTEOTOMIES & BONE GFT	No pre-authorization is required for all providers.	N/A
21193	RECON MANDIB RAMI OSTEOTOMY; WO BONE GFT	No pre-authorization is required for all providers.	N/A
21194	RECON MANDIB RAMI OSTEOTOMY; W/BONE GFT	No pre-authorization is required for all providers.	N/A
21195	RECON MANDIB RAMI/BODY SAGIT SPLIT; WO INT FIXA	No pre-authorization is required for all providers.	N/A

21196	RECON MANDIB RAMI/BODY SAGIT SPLIT; W/INT FIXA	No pre-authorization is required for all providers.	N/A
21198	OSTEOTOMY MANDIB SEGMENT	No pre-authorization is required for all providers.	N/A
21199	OSTEOT MAND SEGMENT; W/GENIO ADVANCE 27.53	No pre-authorization is required for all providers.	N/A
21206	OSTEOTOMY MAXIL SEGMENT	No pre-authorization is required for all providers.	N/A
21208	OSTEOPLASTY FACIAL BONES; AUGMENT	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
21209	OSTEOPLASTY FACIAL BONES; REDUCTION	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
21210	GFT BONE; NASAL/MAXIL/MALAR AREAS	No pre-authorization is required for all providers.	N/A
21215	GFT BONE; MANDIB	No pre-authorization is required for all providers.	N/A
21230	GFT; RIB CARTILAGE AUTOGEN-FACE/CHIN/NOSE/EAR	No pre-authorization is required for all providers.	N/A
21235	GFT; EAR CARTILAGE AUTOGEN NOSE/EAR	No pre-authorization is required for all providers.	N/A
21240	ARTHROPLASTY TEMPOROMANDIBULAR JT W/WO AUTOGFT	No pre-authorization is required for all providers.	N/A
21242	ARTHROPLASTY TEMPOROMANDIBULAR JT W/ALLOGFT	No pre-authorization is required for all providers.	N/A
21243	ARTHROPLASTY TMJ W/PROSTH JT REPLAC	No pre-authorization is required for all providers.	N/A
21244	RECON MANDIB EXTRAORAL W/TRANSOSTEAL BONE PLATE	No pre-authorization is required for all providers.	N/A
21245	RECON MANDIB/MAXIL SUBPERIOSTEAL IMPLNT; PART	No pre-authorization is required for all providers.	N/A
21246	RECON MANDIB/MAXIL SUBPERIOSTEAL IMPLNT; COMPL	No pre-authorization is required for all providers.	N/A
21247	RECON MANDIB CONDYLE W/BONE & CARTILAGE AUTOGFT	No pre-authorization is required for all providers.	N/A
21248	RECON MANDIB/MAXIL ENDOSTEAL IMPLNT; PART	This service is not covered by Superior HealthPlan.	N/A
21249	RECON MANDIB/MAXIL ENDOSTEAL IMPLNT; COMPL	This service is not covered by Superior HealthPlan.	N/A
21255	RECON ZYGOMATIC ARCH/GLENOID FOSSA W/BONE-CARTIL	No pre-authorization is required for all providers.	N/A
21256	RECON ORBIT W/OSTEOTOMIES & W/BONE GFT	No pre-authorization is required for all providers.	N/A
21260	PERIORBIT OSTEOTOM-HYPERTELORISM W/GFT; EXTRACRA	No pre-authorization is required for all providers.	N/A
21261	PERIORBIT OSTEOTOMIES W/BONE GFT; INTRA-EXTRACRA	No pre-authorization is required for all providers.	N/A
21263	PERIORBIT OSTEOTOMIES W/BONE GFT; W/FORHD ADVANC	No pre-authorization is required for all providers.	N/A
21267	ORBIT REPOSIT OSTEOT-UNILAT W/GFTS; EXTRACRANIAL	No pre-authorization is required for all providers.	N/A
21268	ORBIT REPOSIT-UNILAT W/GFTS; INTRA-EXTRACRANIAL	No pre-authorization is required for all providers.	N/A
21270	MALAR AUGMENT PROSTH MAT	No pre-authorization is required for all providers.	N/A
21275	SECNDRY REVIS ORBITOCRANIOFACIAL RECON	No pre-authorization is required for all providers.	N/A
21280	MEDIAL CANTHOPEXY (SEPART PROC)	Pre-authorization is required for all providers.	Prior to 09/01/2019
21282	LAT CANTHOPEXY	Pre-authorization is required for all providers.	Prior to 09/01/2019
21295	REDUCT MASSETER MUSCL/BONE; EXTRAORAL	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
21296	REDUCT MASSETER MUSCL/BONE; INTRAORAL	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
21299	UNLISTED CRANIOFACIAL & MAXILLOFACIAL PROC	No pre-authorization is required for all providers.	N/A
21310	CLO TX NASAL BONE FX WO MANIP	No pre-authorization is required for all providers.	N/A
21315	CLO TX NASAL BONE FX; WO STABILIZATION	No pre-authorization is required for all providers.	N/A
21320	CLO TX NASAL BONE FX; W/STABILIZATION	No pre-authorization is required for all providers.	N/A
21325	OPEN TX NASAL FX; UNCOMP	No pre-authorization is required for all providers.	N/A
21330	OPEN TX NASAL FX; COMPLIC-W/INT-EXT SKELETAL FIX	No pre-authorization is required for all providers.	N/A
21335	OPEN TX NASAL FX; W/CONCOMITANT OPEN TX FX SEPTUM	No pre-authorization is required for all providers.	N/A
21336	OPEN TX NASAL SEPTAL FX W/WO STABILIZATION	No pre-authorization is required for all providers.	N/A
21337	CLO TX NASAL SEPTAL FX W/WO STABILIZATION	No pre-authorization is required for all providers.	N/A
21338	OPEN TX NASOETHMOID FX; WO EXT FIXA	No pre-authorization is required for all providers.	N/A
21339	OPEN TX NASOETHMOID FX; W/EXT FIXA	No pre-authorization is required for all providers.	N/A
21340	PERCUT TX NASOETHMOID FX W/FIXA W/REPR NASOLACRL	No pre-authorization is required for all providers.	N/A
21343	OPEN TX DEPRESSED FRONTAL SINUS FX	No pre-authorization is required for all providers.	N/A
21344	OPEN TX COMPLIC FRONTAL SINUS FX VIA CORONAL	No pre-authorization is required for all providers.	N/A
21345	CLO TX NASOMAXIL FX W/INTERDENTAL FIXA/SPLINT	No pre-authorization is required for all providers.	N/A
21346	OPEN TX NASOMAXIL FX; W/WIRING &/OR LOCAL FIXA	No pre-authorization is required for all providers.	N/A
21347	OPEN TX NASOMAXIL FX; REQ MX OPEN APPROACHES	No pre-authorization is required for all providers.	N/A
21348	OPEN TX NASOMAXILLARY COMPLEX FX; W/BONE GFT	No pre-authorization is required for all providers.	N/A
21355	PERCUT TX FX MALAR AREA INCL ZYGOMATIC W/MANIP	No pre-authorization is required for all providers.	N/A
21356	OPEN TX DEPRESSED ZYGOMATIC ARCH FX	No pre-authorization is required for all providers.	N/A
21360	OPEN TX DEPRESS MALAR FX INCL ZYGOMATIC ARCH	No pre-authorization is required for all providers.	N/A
21365	OPEN TX FX MALAR AREA; W/INT FIX & MX APPROACH	No pre-authorization is required for all providers.	N/A
21366	OPEN TX COMPLIC FX MALAR AREA INCL ZYGOMAT ARCH	No pre-authorization is required for all providers.	N/A
21385	OPEN TX ORBIT 'BLOWOUT' FX; TRANSANTRAL APPROACH	No pre-authorization is required for all providers.	N/A
21386	OPEN TX ORBITAL 'BLOWOUT' FX; PERIORBIT APPROACH	No pre-authorization is required for all providers.	N/A
21387	OPEN TX ORBIT FLOOR 'BLOWOUT' FX; COMBO APPROACH	No pre-authorization is required for all providers.	N/A
21390	OPEN TX ORBITAL 'BLOWOUT' FX; PERIORBIT W/IMPLNT	No pre-authorization is required for all providers.	N/A
21395	OPEN TX ORBITAL 'BLOWOUT' FX; PERIORB W/BONE GFT	No pre-authorization is required for all providers.	N/A
21400	CLO TX FX ORBITAL EX 'BLOWOUT'; WO MANIP	No pre-authorization is required for all providers.	N/A
21401	CLO TX FX ORBITAL EX 'BLOWOUT'; W/MANIP	No pre-authorization is required for all providers.	N/A
21406	OPEN TX FX ORBITAL EX 'BLOWOUT'; WO IMPLNT	No pre-authorization is required for all providers.	N/A
21407	OPEN TX FX ORBITAL EX 'BLOWOUT' W/IMPLNT	No pre-authorization is required for all providers.	N/A
21408	OPEN TX FX ORBITAL EX 'BLOWOUT'; W/BONE GFT	No pre-authorization is required for all providers.	N/A
21421	CLO TX PALATAL/MAXIL FX W/INTERDENTAL WIRE FIXA	No pre-authorization is required for all providers.	N/A
21422	OPEN TX PALATAL/MAXIL FX	No pre-authorization is required for all providers.	N/A
21423	OPEN TX PALATAL/MAXIL FX; COMPLIC-MX APPROACHES	No pre-authorization is required for all providers.	N/A
21431	CLO TX CRANIOFAC SEPART USING INTERDENT WIRE FIX	No pre-authorization is required for all providers.	N/A
21432	OPEN TX CRANIOFAC SEPART; W/WIRE &/OR INT FIXA	No pre-authorization is required for all providers.	N/A
21433	OPEN TX CRANIOFAC SEPART; COMPLIC-MX SURG APPRCH	No pre-authorization is required for all providers.	N/A
21435	OPEN TX CRANIOFAC SEPART; COMPLIC W/INT-EXT FIXA	No pre-authorization is required for all providers.	N/A
21436	OPEN TX CRANIOFAC SEPART; COMPLIC W/FIXA W/GFT	No pre-authorization is required for all providers.	N/A
21440	CLO TX MANDIB/MAXIL ALVEOLAR RIDGE FX (SEP PRO)	No pre-authorization is required for all providers.	N/A
21445	OPEN TX MANDIB/MAXIL ALVEOLAR RIDGE FX (SEP PRO)	No pre-authorization is required for all providers.	N/A
21450	CLO TX MANDIB FX; WO MANIP	No pre-authorization is required for all providers.	N/A
21451	CLO TX MANDIB FX; W/MANIP	No pre-authorization is required for all providers.	N/A
21452	PERCUT TX MANDIB FX W/EXT FIXA	No pre-authorization is required for all providers.	N/A
21453	CLO TX MANDIB FX W/INTERDENTAL FIXA	No pre-authorization is required for all providers.	N/A
21454	OPEN TX MANDIB FX W/EXT FIXA	No pre-authorization is required for all providers.	N/A
21461	OPEN TX MANDIB FX; WO INTERDENTAL FIXA	No pre-authorization is required for all providers.	N/A
21462	OPEN TX MANDIB FX; W/INTERDENTAL FIXA	No pre-authorization is required for all providers.	N/A
21465	OPEN TX MANDIB CONDYLAR FX	No pre-authorization is required for all providers.	N/A
21470	OPEN TX MANDIB FX-MX APPROACH W/INT FIXA/SPLINTS	No pre-authorization is required for all providers.	N/A
21480	CLO TX TEMPOROMANDIBULAR DISLOC; INIT/SUBSQT	No pre-authorization is required for all providers.	N/A
21485	CLO TX TM DISLOC; COMPLIC INIT/SUBSQT	No pre-authorization is required for all providers.	N/A
21490	OPEN TX TEMPOROMANDIBULAR DISLOC	No pre-authorization is required for all providers.	N/A
21495	OPEN TX HYOID FX	This is no longer a valid code.	N/A
21497	INTERDENTAL WIRING-CONDITION OTHER THAN FX	No pre-authorization is required for all providers.	N/A
21499	UNLISTED MS PROC HEAD	No pre-authorization is required for all providers.	N/A
21501	I&D DEEP ABSCESS/HEMATOMA SOFT TISS NECK/THORAX	No pre-authorization is required for all providers.	N/A
21502	I&D DEEP ABSCESS SOFT TISS NECK; W/PART RIB OSTE	No pre-authorization is required for all providers.	N/A
21510	INCS DEEP W/OPENING BONE CORTEX THORAX	No pre-authorization is required for all providers.	N/A
21550	BX SOFT TISS NECK/THORAX	No pre-authorization is required for all providers.	N/A
21552	EXC NECK LES SC = 3 CM	No pre-authorization is required for all providers.	N/A
21554	EXC NECK TUM DEEP = 5 CM	No pre-authorization is required for all providers.	N/A
21555	EXC TUMOR SOFT TISS NECK/THORAX; SUBQ	No pre-authorization is required for all providers.	N/A
21556	EXC TUMOR SOFT TISS NECK; DEEP/SUBFACIAL/IM	No pre-authorization is required for all providers.	N/A
21557	RESECT NECK THORAX TUMOR<5CM	No pre-authorization is required for all providers.	N/A
21558	RESECT NECK TUMOR 5 CM/>	No pre-authorization is required for all providers.	N/A
21600	EXC RIB PART	No pre-authorization is required for all providers.	N/A
21601	EXCISION CHEST WALL TUMOR INCLUDING RIBS	No pre-authorization is required for all providers.	N/A
21602	EXCISION CH WAL TUM W/RIB W/O MEDSTNL LYMPHADEC	No pre-authorization is required for all providers.	N/A
21603	EXCISION CH WAL TUM W/RIB W/MEDSTNL LYMPHADEC	No pre-authorization is required for all providers.	N/A
21610	COSTOTRANSVERSECTOMY (SEPART PROC)	No pre-authorization is required for all providers.	N/A
21615	EXC 1ST &/OR CERV RIB;	No pre-authorization is required for all providers.	N/A
21616	EXC 1ST &/OR CERV RIB; W/SYMPATHECTOMY	No pre-authorization is required for all providers.	N/A
21620	OSTECTOMY STERNUM PART	No pre-authorization is required for all providers.	N/A
21627	STERNAL DEBRID	No pre-authorization is required for all providers.	N/A
21630	RADICAL RESECT STERNUM;	No pre-authorization is required for all providers.	N/A
21632	RAD RESECT STERNUM; W/MEDIASTINAL LYMPHADENECTMY	No pre-authorization is required for all providers.	N/A

21685	HYOID MYOTOMY AND SUSPENSION	No pre-authorization is required for all providers.	N/A
21700	DIVISION SCALENUS ANTICUS; WO RESECT CERV RIB	No pre-authorization is required for all providers.	N/A
21705	DIVISION SCALENUS ANTICUS; W/RESECT CERV RIB	No pre-authorization is required for all providers.	N/A
21720	DIVIS STERNOCLEIDOMASTOID-TORTICOLLIS; WO CAST	No pre-authorization is required for all providers.	N/A
21725	DIVIS STERNOCLEIDOMASTOID-TORTICOLLIS; W/CAST	No pre-authorization is required for all providers.	N/A
21740	RECON REP PECTUS EXCAV/CARNATUM;OPN	No pre-authorization is required for all providers.	N/A
21742	RECON REP PECTUS; W/O THORACSCPY	No pre-authorization is required for all providers.	N/A
21743	RECON REP PECTUS; W/THORACSCPY	No pre-authorization is required for all providers.	N/A
21750	CLO STERNOTOMY SEPART W/WO DEBRID (SEPART PROC)	No pre-authorization is required for all providers.	N/A
21800	CLO TX RIB FX UNCOMP EA	This is no longer a valid code.	N/A
21805	OPEN TX RIB FX WO FIXA EA	This is no longer a valid code.	N/A
21810	TX RIB FX REQUIRING EXT FIXA	This is no longer a valid code.	N/A
21811	OPTX OF RIB FX W/FIX SCOPE	This service is not covered by Superior HealthPlan.	N/A
21812	TREATMENT OF RIB FRACTURE	This service is not covered by Superior HealthPlan.	N/A
21813	TREATMENT OF RIB FRACTURE	This service is not covered by Superior HealthPlan.	N/A
21820	CLO TX STERNUM FX	No pre-authorization is required for all providers.	N/A
21825	OPEN TX STERNUM FX W/WO SKELETAL FIXA	No pre-authorization is required for all providers.	N/A
21899	UNLISTED PROC NECK/THORAX	No pre-authorization is required for all providers.	N/A
21920	BX SOFT TISS BACK/FLANK; SUPERF	No pre-authorization is required for all providers.	N/A
21925	BX SOFT TISS BACK/FLANK; DEEP	No pre-authorization is required for all providers.	N/A
21930	EXC TUMOR SOFT TISS BACK/FLANK	No pre-authorization is required for all providers.	N/A
21931	EXC BACK LES SC = 3 CM	No pre-authorization is required for all providers.	N/A
21932	EXC BACK TUM DEEP < 5 CM	No pre-authorization is required for all providers.	N/A
21933	EXC BACK TUM DEEP = 5 CM	No pre-authorization is required for all providers.	N/A
21935	RESECT BACK TUM < 5 CM	No pre-authorization is required for all providers.	N/A
21936	RESECT BACK TUM 5 CM/>	No pre-authorization is required for all providers.	N/A
22010	I&D OPN DP ABSC PST SPI CRV THRC/CERVICOTHRC	No pre-authorization is required for all providers.	N/A
22015	I&D OPN DP ABSC PST SPI LMBR SAC/LUMBOSAC	No pre-authorization is required for all providers.	N/A
22100	PART EXC POST VERTEB COMPO-1 SEGMENT; CERV	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22101	PART EXC POST VERTEB COMPO-1 SEGMENT; THOR	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22102	PART EXC POST VERTEB COMPO-1 SEGMENT; LUMB	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22103	PART EXC POST VERTEB COMPO-1 SEGMENT; CERV	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22110	PART EXC VERTEB BODY WO DECOMP-1 SEGMENT; CERV	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22112	PART EXC VERTEB BODY WO DECOMP-1 SEGMENT; THOR	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22114	PART EXC VERTEB BODY WO DECOMP-1 SEGMENT; LUMB	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22116	PART EXC VERTEB BODY; EA ADD VERTEB SEGMENT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22206	CUT SPINE 3 COL THOR	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22207	CUT SPINE 3 COL LUMB	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22208	CUT SPINE 3 COL ADDL SEG	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22210	OSTEOT SPINE-POST/POSTLAT APPROACH-1 SEGMENT; CERV	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22212	OSTEOT SPINE-POST/POSTLAT APPROACH-1 SEGMENT; THOR	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22214	OSTEOT SPINE-POST/POSTLAT APPROACH-1 SEGMENT; LUMB	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22216	OSTEOT SPINE-POST/POSTLAT APPROACH; EA ADD SEGMENT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22220	OSTEOT SPINE W/DISKECT-ANT APPRCH-1 SEGMENT; CERV	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22222	OSTEOT SPINE W/DISKECT-ANT APPRCH-1 SEGMENT; THOR	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22224	OSTEOT SPINE W/DISKECT-ANT APPRCH-1 SEGMENT; LUMB	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22226	OSTEOT SPINE W/DISKECT-ANT APPROCH; EA ADD SEGMENT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22305	CLO TX VERTEBRAL PROCESS FX	This is no longer a valid code.	N/A
22310	CLO TX VERTEB BODY FX WO MANIP-W/CAST/BRACE	No pre-authorization is required for all providers.	N/A
22315	TREAT SPINE FRACTURE	No pre-authorization is required for all providers.	N/A
22318	OPEN TRMT AND/OR REDUCTION OF ADONTOID FRAC/DISLOCATION	No pre-authorization is required for all providers.	N/A
22319	OPEN TRMT AND/OR REDUCTION OF ADONTOID FRAC/DISLOCATION W/GRAFTING	No pre-authorization is required for all providers.	N/A
22325	OPEN TX VERT FX/DISLOC-VIA POST-1 SEGMENT; LUMB	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22326	OPEN TX VERT FX/DISLOC-VIA POST-1 SEGMENT; CERV	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22327	OPEN TX VERT FX/DISLOC-VIA POST-1 SEGMENT; THOR	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22328	OPEN TX VERT FX/DISLOC VIA POST; EA ADD VERT/SEG	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22505	MANIP SPINE REQUIRING ANES ANY REGION	No pre-authorization is required for all providers.	N/A
22510	PERQ CERVICOTHORACIC INJECT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22511	PERQ LUMBOSACRAL INJECTION	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22512	VERTEBROPLASTY ADDL INJECT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22513	PERQ VERTEBRAL AUGMENTATION	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22514	PERQ VERTEBRAL AUGMENTATION	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22515	PERQ VERTEBRAL AUGMENTATION	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22520	PERCUT VERTEBROPLASTY THOR	This is no longer a valid code.	N/A
22521	PERCUT VERTEBROPLASTY LUMB	This is no longer a valid code.	N/A
22522	PERCUT VERTEBROPLASTY ADDL	This is no longer a valid code.	N/A
22523	PRQ VRT AGMNTJ MCHNL DEV 1 VRT BDY THRC	This is no longer a valid code.	N/A
22524	PRQ VRT AGMNTJ MCHNL DEV 1 VRT BDY LMBR	This is no longer a valid code.	N/A
22525	PRQ VRT AGMNTJ MCHNL DEV 1 VRT BDY EA THRC/LMBR	This is no longer a valid code.	N/A
22526	PERCUTANEOUS INTRADISCAL ELECTROTHERMAL ANNULOPLASTY	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
22527	ONE OR MORE ADDITIONAL LEVELS	Preauthorization required for all providers	Prior to 09/01/2019
22532	ARTHRODISIS LAT MINI DISKECT THOR	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22533	ARTHRODISIS LAT MINI DISKECT LUMB	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22534	ARTHRODISIS LAT MINI DISKECT EA ADD	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22548	ARTHRODISIS-ANT-C1 C2, W/WO EXC ODONTOID PROCESS	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22551	NECK SPINE FUSE&REMOVE ADDL	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22552	ADDL NECK SPINE FUSION	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22554	ARTHRODISIS-ANT W/MINI DISKECT; CERV BELOW C2	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22556	ARTHRODISIS-ANT INTERBODY W/MINI DISKECT; THOR	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22558	ARTHRODISIS-ANT INTERBODY W/MINI DISKECT; LUMB	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22585	ARTHRODISIS-ANT-W/MINI DISKECT; EA ADD INTERSPACE	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22586	PRESCLR FUSE W/ INSTR L5/S1	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22590	ARTHRODISIS-POST TECH, CRANIOCERV	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22595	ARTHRODISIS-POST TECH, ATLAS-AXIS	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22600	ARTHRODISIS-POST/POSTLAT-1 LEVEL; CERV BELOW C2	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22610	THORAX SPINE FUSION	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22612	LUMBAR SPINE FUSION	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22614	ARTHRODISIS-POST/POSTLAT TECH; EA ADD VERT SEGMENT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22630	ARTHRODISIS-POST INTERBODY-1 INTERSPACE; LUMB	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22632	ARTHRODISIS-POST INTERBODY; EA ADD INTERSPACE	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22633	LUMBAR SPINE FUSION COMBINED	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22634	SPINE FUSION EXTRA SEGMENT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22800	ARTHRODISIS-POST-W/WO CAST; 6/LESS VERTEB SEGMENT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22802	ARTHRODISIS-POST-W/WO CAST; 7 TO 12 VERTEB SEGMENT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22804	ARTHRODISIS-POST-W/WO CAST; 13/MORE VERTEB SEGMENT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22808	ARTHRODISIS-ANT-W/WO CAST; 2 TO 3 VERTEB SEGMENT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22810	ARTHRODISIS-ANT-W/WO CAST; 4 TO 7 VERTEB SEGMENT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22812	ARTHRODISIS-ANT-W/WO CAST; 8/MORE VERTEB SEGMENT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22818	KYPHECTOMY, RESECT VERT SEGMENT; 1-2 SEGMENT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22819	KYPHECTOMY, RESECT VERT SEGMENT; 3/MORE SEGMENT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22830	EXPLOR SPINAL FUSION	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22840	POSTERIOR NON-SEGMENTAL INSTRUMENTATION	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22841	INTERNAL SPINAL FIXATION WIRING SPINOUS PROCESS	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22842	POSTERIOR SEGMENTAL INSTRUMENTATION 3-6 VRT SEG	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22843	POSTERIOR SEGMENTAL INSTRUMENTATION 7-12 VRT SEG	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22844	POSTERIOR SEGMENTAL INSTRUMENTATION 13/> VRT SEG	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22845	ANTERIOR INSTRUMENTATION 2-3 VERTEBRAL SEGMENTS	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22846	ANTERIOR INSTRUMENTATION 4-7 VERTEBRAL SEGMENTS	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22847	ANTERIOR INSTRUMENTATION 8/> VERTEBRAL SEGMENTS	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22848	PELVIC FIXATION OTHER THAN SACRUM	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22849	REINSERTION SPINAL FIXA DEVICE	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22850	REMOV POST NONSEGMENTAL INSTRUM	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22851	APPLY SPINE PROSTH DEVICE	This is no longer a valid code.	N/A

22852	REMOV POST SEGMENT INSTRUM	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22853	INSJ BIOMCHN DEV INTERVERTEBRAL DSC SPC W/ARTHDR	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22854	INSJ BIOMCHN DEV VRT CORPECTOMY DEFECT W/ARTHDR	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22855	REMOV ANT INSTRUM	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22856	CERV ARTIFIC DISKECTOMY	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22857	LUMBAR ARTIF DISKECTOMY	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22858	SECOND LEVEL CER DISKECTOMY	This service is not covered by Superior HealthPlan.	N/A
22859	INSJ BIOMCHN DEV NTRVRT DISC SPACE W/O ARTHDR	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22861	REVISE CERV ARTIFIC DISC	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22862	REVISE LUMBAR ARTIF DISC	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22864	REMOVE CERV ARTIF DISC	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22865	REMOVE LUMB ARTIF DISC	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22867	INSJ STABLJ DEV W/DCMPRN LUMBAR SINGLE LEVEL	This service is not covered by Superior HealthPlan.	N/A
22868	INSJ STABLJ DEV W/DCMPRN LUMBAR SECOND LEVEL	This service is not covered by Superior HealthPlan.	N/A
22869	INSJ STABLJ DEV W/O DCMPRN LUMBAR SINGLE LEVEL	This service is not covered by Superior HealthPlan.	N/A
22870	INSJ STABLJ DEV W/O DCMPRN LUMBAR SECOND LEVEL	This service is not covered by Superior HealthPlan.	N/A
22899	UNLISTED PROC SPINE	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
22900	EXC ABDL TUM DEEP < 5 CM	No pre-authorization is required for all providers.	N/A
22901	EXC ABDL TUM DEEP > 5 CM	No pre-authorization is required for all providers.	N/A
22902	EXC ABD LES SC < 3 CM	No pre-authorization is required for all providers.	N/A
22903	EXC ABD LES SC > 3 CM	No pre-authorization is required for all providers.	N/A
22904	RADICAL RESECT ABD TUMOR<5CM	No pre-authorization is required for all providers.	N/A
22905	RAD RESECT ABD TUMOR 5 CM/>	No pre-authorization is required for all providers.	N/A
22999	UNLISTED PROC ABD MS SYST	No pre-authorization is required for all providers.	N/A
23000	REMOV SUBDELTOID CALCAREOUS DEPOSITS ANY METHD	No pre-authorization is required for all providers.	N/A
23020	CAPSULAR CONTRACTURE RELEASE (SEVER TYPE PROC)	No pre-authorization is required for all providers.	N/A
23030	I&D SHOULDER AREA; DEEP ABSCESS/HEMATOMA	No pre-authorization is required for all providers.	N/A
23031	I&D SHOULDER AREA; INFEC BURSA	No pre-authorization is required for all providers.	N/A
23035	INCS BONE CORTEX SHLDR AREA	No pre-authorization is required for all providers.	N/A
23040	ARTHROT GLENOHUMERAL JT W/EXPLOR-REMOV FB	No pre-authorization is required for all providers.	N/A
23044	ARTHROT AC/STERNOCLAV JT W/EXPLOR-REMOV FB	No pre-authorization is required for all providers.	N/A
23065	BX SOFT TISS SHOULDER AREA; SUPERF	No pre-authorization is required for all providers.	N/A
23066	BX SOFT TISS SHOULDER AREA; DEEP	No pre-authorization is required for all providers.	N/A
23071	EXC SHOULDER LES SC > 3 CM	No pre-authorization is required for all providers.	N/A
23073	EXC SHOULDER TUM DEEP > 5 CM	No pre-authorization is required for all providers.	N/A
23075	EXC SOFT TISS TUMOR SHLDR AREA; SUBQ	No pre-authorization is required for all providers.	N/A
23076	EXC SOFT TISS TUMOR SHLDR AREA; DEEP	No pre-authorization is required for all providers.	N/A
23077	RESECT SHOULDER TUMOR < 5 CM	No pre-authorization is required for all providers.	N/A
23078	RESECT SHOULDER TUMOR 5 CM/>	No pre-authorization is required for all providers.	N/A
23100	ARTHROT GLENOHUMERAL JT INCL BX	No pre-authorization is required for all providers.	N/A
23101	ARTHROT AC/SC JT W/BX &/EXC TORN CARTILAGE	No pre-authorization is required for all providers.	N/A
23105	ARTHROT; GLENOHUMERAL JT W/SYNOVECT W/WO BX	No pre-authorization is required for all providers.	N/A
23106	ARTHROT; SC JT W/SYNOVECT W/WO BX	No pre-authorization is required for all providers.	N/A
23107	ARTHROTOMY-GLENOHUMERAL JT W/EXPLOR W/WO REMOV	No pre-authorization is required for all providers.	N/A
23120	CLAVICULECTOMY; PART	No pre-authorization is required for all providers.	N/A
23125	CLAVICULECTOMY; TOT	No pre-authorization is required for all providers.	N/A
23130	ACROMIOPLAS/ACROMIONECT PART W/WO LIGAMNT RELEASES	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
23140	EXC/CURET BONE CYST/BEN TUMOR CLAV/SCAPULA	No pre-authorization is required for all providers.	N/A
23145	EXC/CURET BONE CYST/TUMOR CLAV/SCAP; W/AUTOGFT	No pre-authorization is required for all providers.	N/A
23146	EXC/CURET BONE CYST/TUMOR CLAV/SCAP; W/ALLOGFT	No pre-authorization is required for all providers.	N/A
23150	EXC/CURET BONE CYST/BEN TUMOR PROX HUMERUS	No pre-authorization is required for all providers.	N/A
23155	EXC/CURET BONE CYST/TUMOR PROX HUMERUS; W/AUTOGF	No pre-authorization is required for all providers.	N/A
23156	EXC/CURET BONE CYST/TUMOR PROX HUMERUS; W/ALLOGF	No pre-authorization is required for all providers.	N/A
23170	SEQUESTRECTOMY CLAV	No pre-authorization is required for all providers.	N/A
23172	SEQUESTRECTOMY SCAPULA	No pre-authorization is required for all providers.	N/A
23174	SEQUESTRECTOMY HUMERAL HEAD TO SURG NECK	No pre-authorization is required for all providers.	N/A
23180	PART EXC BONE CLAV	No pre-authorization is required for all providers.	N/A
23182	PART EXC BONE SCAPULA	No pre-authorization is required for all providers.	N/A
23184	PART EXC BONE PROX HUMERUS	No pre-authorization is required for all providers.	N/A
23190	OSTECTOMY SCAPULA PART	No pre-authorization is required for all providers.	N/A
23195	RESECT HUMERAL HEAD	No pre-authorization is required for all providers.	N/A
23200	RADICAL RESECT TUMOR; CLAV	No pre-authorization is required for all providers.	N/A
23210	RADICAL RESECT TUMOR; SCAPULA	No pre-authorization is required for all providers.	N/A
23220	RAD RESECT BONE TUMOR PROX HUMERUS;	No pre-authorization is required for all providers.	N/A
23330	REMOV FB SHOULDER; SUBQ	No pre-authorization is required for all providers.	N/A
23331	REMOV FB SHLDR; DEEP	This is no longer a valid code.	N/A
23332	REMOV FB SHLDR; COMPLIC (TOT SHLDR)	This is no longer a valid code.	N/A
23333	REMOVE SHOULDER FB DEEP	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
23334	SHOULDER PROSTHESIS REMOVAL	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
23335	SHOULDER PROSTHESIS REMOVAL	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
23350	INJ PROC SHOULDER ARTHROGRAPHY	No pre-authorization is required for all providers.	N/A
23395	MUSCL TRANSF ANY TYPE-SHOULDER/UPPER ARM; SNGL	No pre-authorization is required for all providers.	N/A
23397	MUSCL TRANSF ANY TYPE-SHOULDER/UPPER ARM; MX	No pre-authorization is required for all providers.	N/A
23400	SCAPULOPEXY	No pre-authorization is required for all providers.	N/A
23405	TENOT SHLDR AREA; SNGL TENDON	No pre-authorization is required for all providers.	N/A
23406	TENOT SHLDR AREA; MX TENDONS-SAME INCS	No pre-authorization is required for all providers.	N/A
23410	REP RUP MUSCLOTENDINUS CUFF OPN;AC	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
23412	REP RUP MUSCLOTENDINUS CUFF OPN;CHRN	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
23415	CORACACROMIAL LIG RELEASE W/WO ACROMIOPLASTY	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
23420	RECONS COMPLT SHLDR CUFF AVULS CHRONIC	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
23430	TENODESIS LONG TENDON BICEPS	No pre-authorization is required for all providers.	N/A
23440	RESECT/TRANSPL LONG TENDON BICEPS	No pre-authorization is required for all providers.	N/A
23450	CAPSULORRHAPHY ANT; PUTTI-PLATT/MAGNUSON TYPE	No pre-authorization is required for all providers.	N/A
23455	CAPSULORRHAPHY ANT; W/LABRAL REPR	No pre-authorization is required for all providers.	N/A
23460	CAPSULORRHAPHY ANT ANY TYPE; W/BONE BLOCK	No pre-authorization is required for all providers.	N/A
23462	CAPSULORRHAPHY ANT ANY TYPE; W/CORACOID TRANSF	No pre-authorization is required for all providers.	N/A
23465	CAPSULORRHAPHY GH JT POST W/WO BONE BLOCK	No pre-authorization is required for all providers.	N/A
23466	CAPSULORRHAPHY GH JT ANY MX-DIREC INSTABILITY	No pre-authorization is required for all providers.	N/A
23470	ARTHROPLASTY GLENOHUMERAL JT; HEMIARTHROPLASTY	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
23472	ARTHROPLASTY GH JT; TOT SHLDR HUMERAL REPLACE	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
23473	REVIS RECONST SHOULDER JOINT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
23474	REVIS RECONST SHOULDER JOINT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
23480	OSTEOTOMY CLAV W/WO INT FIXA	No pre-authorization is required for all providers.	N/A
23485	OSTEOTOMY CLAV W/WO INT FIXA; W/GFT-NON/MALUNION	No pre-authorization is required for all providers.	N/A
23490	PROPHYLACTIC TX W/WO METHYLMETHACRYLATE; CLAV	No pre-authorization is required for all providers.	N/A
23491	PROPHYLACTIC TX; PROX HUMERUS	No pre-authorization is required for all providers.	N/A
23500	CLO TX CLAV FX; WO MANIP	No pre-authorization is required for all providers.	N/A
23505	CLO TX CLAV FX; W/MANIP	No pre-authorization is required for all providers.	N/A
23515	OPEN TREATMENT CLAVICULAR FRACTURE INTERNAL FIXJ	No pre-authorization is required for all providers.	N/A
23520	CLO TX STERNOCLAVICULAR DISLOC; W/O MANIP	No pre-authorization is required for all providers.	N/A
23525	CLO TX STERNOCLAVICULAR DISLOC; W/MANIP	No pre-authorization is required for all providers.	N/A
23530	OPEN TX STERNOCLAVICULAR DISLOC ACUTE/CHRONIC	No pre-authorization is required for all providers.	N/A
23532	OPEN TX STERNCLAV DISLOC ACUTE/CHRON; W/FASC GFT	No pre-authorization is required for all providers.	N/A
23540	CLO TX ACROMIOCLAVICULAR DISLOC; WO MANIP	No pre-authorization is required for all providers.	N/A
23545	CLO TX ACROMIOCLAVICULAR DISLOC; W/MANIP	No pre-authorization is required for all providers.	N/A
23550	OPEN TX ACROMIOCLAV DISLOC ACUTE/CHRONIC	No pre-authorization is required for all providers.	N/A
23552	OPEN TX AC DISLOC ACUTE/CHRONIC; W/FASCIAL GFT	No pre-authorization is required for all providers.	N/A
23570	CLO TX SCAPULAR FX; WO MANIP	No pre-authorization is required for all providers.	N/A
23575	CLO TX SCAPULAR FX; W/MANIP W/WO SKELET TRACTION	No pre-authorization is required for all providers.	N/A
23585	TREAT SCAPULA FRACTURE	No pre-authorization is required for all providers.	N/A
23600	CLO TX PROX HUMERAL FX; WO MANIP	No pre-authorization is required for all providers.	N/A
23605	CLO TX PROX HUMERAL FX; W/MANIP W/WO SKELET TRACT	No pre-authorization is required for all providers.	N/A

23615	OPEN TREATMENT PROX HUMERAL FRACTURE	No pre-authorization is required for all providers.	N/A
23616	OPEN PROX HUMERAL FRACTURE PROSHETIC REPLACEMENT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
23620	CLO TX GR HUMERAL TUBEROSITY FX; WO MANIP	No pre-authorization is required for all providers.	N/A
23625	CLO TX GR HUMERAL TUBEROSITY FX; W/MANIP	No pre-authorization is required for all providers.	N/A
23630	OPEN TREATMENT GRTER HUMERAL TUBEROSITY FRACTURE	No pre-authorization is required for all providers.	N/A
23650	CLO TX SHOULDER DISLOC W/MANIP; WO ANES	No pre-authorization is required for all providers.	N/A
23655	CLO TX SHOULDER DISLOC W/MANIP; REQUIRING ANES	No pre-authorization is required for all providers.	N/A
23660	OPEN TX ACUTE SHOULDER DISLOC	No pre-authorization is required for all providers.	N/A
23665	CLO TX SHLDR DISLOC-FX GR HUMERAL TUBER MANIP	No pre-authorization is required for all providers.	N/A
23670	OPEN TX SHOULDER DISLOCATE HUMERAL FRACTURE	No pre-authorization is required for all providers.	N/A
23675	CLO TX SHOULDER DISLOC W/SURG NECK FX W/MANIP	No pre-authorization is required for all providers.	N/A
23680	OPEN TX SHOULDER DISLOCATION W/ NECK FRACTURE	No pre-authorization is required for all providers.	N/A
23700	MANIP W/ANES SHLDR JT INCL APPLIC FIXA APPARATUS	No pre-authorization is required for all providers.	N/A
23800	ARTHRODESIS GLENOHUMERAL JOINT;	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
23802	ARTHRODESIS GLENOHUMERAL JOINT; W/AUTOGFT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
23900	INTERTHORACOSCAPULAR AMPUTA	No pre-authorization is required for all providers.	N/A
23920	DISART SHOULDER	No pre-authorization is required for all providers.	N/A
23921	DISART SHOULDER; SECNDRY CLO/SCAR REVIS	No pre-authorization is required for all providers.	N/A
23929	UNLISTED PROC SHOULDER	No pre-authorization is required for all providers.	N/A
23930	I&D UPPER ARM/ELBOW AREA; DEEP ABSCESS/HEMATOMA	No pre-authorization is required for all providers.	N/A
23931	I&D UPPER ARM/ELBOW AREA; BURSA	No pre-authorization is required for all providers.	N/A
23935	INCS DEEP W/OPEN BONE CORTEX HUMERUS/ELBOW	No pre-authorization is required for all providers.	N/A
24000	ARTHROT ELBOW W/EXPLOR/RAIN/REMOV FB	No pre-authorization is required for all providers.	N/A
24006	ARTHROTOMY ELBOW W/CAPSULAR EXC (SEPART PROC)	No pre-authorization is required for all providers.	N/A
24065	BX SOFT TISS UPPER ARM/ELBOW AREA; SUPERF	No pre-authorization is required for all providers.	N/A
24066	BX SOFT TISS UPPER ARM/ELBOW AREA; DEEP	No pre-authorization is required for all providers.	N/A
24071	EXC ARM/ELBOW LES SC = 3 CM	No pre-authorization is required for all providers.	N/A
24073	EX ARM/ELBOW TUM DEEP > 5 CM	No pre-authorization is required for all providers.	N/A
24075	EXC TUMOR UPPER ARM/ELBOW AREA; SUBQ	No pre-authorization is required for all providers.	N/A
24076	EXC TUMOR UPPER ARM/ELBOW; DEEP/SUBFACIAL/IM	No pre-authorization is required for all providers.	N/A
24077	RESECT ARM/ELBOW TUM < 5 CM	No pre-authorization is required for all providers.	N/A
24079	RESECT ARM/ELBOW TUM 5 CM>	No pre-authorization is required for all providers.	N/A
24100	ARTHROTOMY ELBOW; W/SYNOVIAL BX ONLY	No pre-authorization is required for all providers.	N/A
24101	ARTHROTOMY ELBOW; W/JT EXPLOR W/WO BX-REMOV FB	No pre-authorization is required for all providers.	N/A
24102	ARTHROTOMY ELBOW; W/SYNOVECTOMY	No pre-authorization is required for all providers.	N/A
24105	EXC OLECRANON BURSA	No pre-authorization is required for all providers.	N/A
24110	EXC/CURET BONE CYST/BEN TUMOR HUMERUS	No pre-authorization is required for all providers.	N/A
24115	EXC/CURET BONE CYST/BEN TUMOR HUMERUS; W/AUTOGFT	No pre-authorization is required for all providers.	N/A
24116	EXC/CURET BONE CYST/BEN TUMOR HUMERUS; W/ALLOGFT	No pre-authorization is required for all providers.	N/A
24120	EXC/CURET BONE CYST/BEN TUMOR-HEAD/NECK RADIUS	No pre-authorization is required for all providers.	N/A
24125	EXC/CURET BONE CYST-HEAD/NECK RADIUS; W/AUTOGFT	No pre-authorization is required for all providers.	N/A
24126	EXC/CURET BONE CYST-HEAD/NECK RADIUS; W/ALLOGFT	No pre-authorization is required for all providers.	N/A
24130	EXC RADIAL HEAD	No pre-authorization is required for all providers.	N/A
24134	SEQUESTRECTOMY SHAFT/DISTAL HUMERUS	No pre-authorization is required for all providers.	N/A
24136	SEQUESTRECTOMY RADIAL HEAD/NECK	No pre-authorization is required for all providers.	N/A
24138	SEQUESTRECTOMY OLECRANON PROCESS	No pre-authorization is required for all providers.	N/A
24140	PART EXC BONE HUMERUS	No pre-authorization is required for all providers.	N/A
24145	PART EXC BONE RADIAL HEAD/NECK	No pre-authorization is required for all providers.	N/A
24147	PART EXC BONE OLECRANON PROCESS	No pre-authorization is required for all providers.	N/A
24149	RAD RESECT CAPSULE-SOFT TISS-BONE ELB (SEP PROC)	No pre-authorization is required for all providers.	N/A
24150	RADICAL RESECT TUMOR SHAFT/DISTAL HUMERUS	No pre-authorization is required for all providers.	N/A
24152	RADICAL RESECT TUMOR RADIAL HEAD/NECK	No pre-authorization is required for all providers.	N/A
24155	RESECT ELBOW JT	No pre-authorization is required for all providers.	N/A
24160	REMOVE ELBOW JOINT IMPLANT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
24164	REMOVE RADIUS HEAD IMPLANT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
24200	REMOV FB UPPER ARM/ELBOW AREA; SUBQ	No pre-authorization is required for all providers.	N/A
24201	REMOV FB UPPER ARM/ELBOW AREA; DEEP	No pre-authorization is required for all providers.	N/A
24220	INJ PROC ELBOW ARTHROGRAPHY	No pre-authorization is required for all providers.	N/A
24300	MANIPULATION, ELBOW, UNDER ANESTHESIA .	No pre-authorization is required for all providers.	N/A
24301	MUSCL/TENDON TRANSF UPPER ARM/ELBOW SNGL	No pre-authorization is required for all providers.	N/A
24305	TENDON LENGTHENING UPPER ARM/ELBOW EA TENDON	No pre-authorization is required for all providers.	N/A
24310	TENOT OP ELBOW TO SHLDR EA TENDON	No pre-authorization is required for all providers.	N/A
24320	TENOPLASTY W/MUSCL TRANSF W/WO GFT ELBO-SHLDR 1	No pre-authorization is required for all providers.	N/A
24330	FLEXOR-PLASTY ELBOW	No pre-authorization is required for all providers.	N/A
24331	FLEXOR-PLASTY ELBOW; W/EXTENSOR ADVANCEMENT	No pre-authorization is required for all providers.	N/A
24332	TENOLYSIS OF TRICEPS	No pre-authorization is required for all providers.	N/A
24340	TENODESIS BICEPS TENDON @ ELBOW (SEPART PROC)	No pre-authorization is required for all providers.	N/A
24341	REPR TENDON/MUSC-UP ARM/ELB-EA-PR/SECNDRY	No pre-authorization is required for all providers.	N/A
24342	REINSRT RUPT BICEPS/TRICEPS DISTAL-W/WO TEND GFT	No pre-authorization is required for all providers.	N/A
24343	REPAIR OF ELBOW LIGAMENT	No pre-authorization is required for all providers.	N/A
24344	REPAIR OF ELBOW LIGAMENT	No pre-authorization is required for all providers.	N/A
24345	REPAIR OF ELBOW LIGAMENT	No pre-authorization is required for all providers.	N/A
24346	RECONSTRUCTION LATERAL COLLATERAL LIGAMENT, ELBOW, WITH TENDON GRAFT	No pre-authorization is required for all providers.	N/A
24357	REPAIR ELBOW PERC	No pre-authorization is required for all providers.	N/A
24358	REPAIR ELBOW W/DEB OPEN	No pre-authorization is required for all providers.	N/A
24359	REPAIR ELBOW DEB/ATTCH OPEN	No pre-authorization is required for all providers.	N/A
24360	ARTHROPLASTY ELBOW; W/MEMBRN	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
24361	ARTHROPLASTY ELBOW; W/DISTAL HUMERAL PROSTH REPL	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
24362	ARTHROPLASTY ELBOW; W/IMPLNT & LIGMNT RECON	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
24363	ARTHROPLASTY ELBOW; (TOT ELBOW)	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
24365	ARTHROPLASTY RADIAL HEAD	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
24366	ARTHROPLASTY RADIAL HEAD; W/IMPLNT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
24370	REVISE RECONST ELBOW JOINT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
24371	REVISE RECONST ELBOW JOINT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
24400	OSTEOTOMY HUMERUS W/WO INT FIXA	No pre-authorization is required for all providers.	N/A
24410	MX OSTEOTOMIES W/REALIGN INTRAMEDUL ROD HUMERAL	No pre-authorization is required for all providers.	N/A
24420	OSTEOPLASTY HUMERUS	No pre-authorization is required for all providers.	N/A
24430	REPR NONUNION/MALUNION HUMERUS; WO GFT	No pre-authorization is required for all providers.	N/A
24435	REPR NON-MALUNION HUMERUS; W/ILIAC/OTHER AUTOGFT	No pre-authorization is required for all providers.	N/A
24470	HEMIEPIPHYSEAL ARREST	No pre-authorization is required for all providers.	N/A
24495	DECOMPRESS FASCIOTOMY FOREARM W/BRACH ART EXPLOR	No pre-authorization is required for all providers.	N/A
24498	PROPHYLACTIC TX HUMERAL SHAFT	No pre-authorization is required for all providers.	N/A
24500	CLO TX HUMERAL SHAFT FX; WO MANIP	No pre-authorization is required for all providers.	N/A
24505	CLO TX HUMERAL SHAFT FX; W/MANIP W/WO TRACTION	No pre-authorization is required for all providers.	N/A
24515	OPEN TX HUMERAL FX W/PLATE/SCREWS W/WO CERCLAGE	No pre-authorization is required for all providers.	N/A
24516	TX HUM SHAFT FX W/INSRT IMPL	No pre-authorization is required for all providers.	N/A
24530	CLO TX SUPRA TRANSCONDYLAR HUMERAL FX; WO MANIP	No pre-authorization is required for all providers.	N/A
24535	CLO TX SUPRACONDYL HUMERAL FX; W/MANIP W/WO TRAC	No pre-authorization is required for all providers.	N/A
24538	PERCUT FIXA SUPRACONDYL HUMER FX W/WO INTERCONDY	No pre-authorization is required for all providers.	N/A
24545	OPEN TX HUMERAL SUPRACONDYLAR FRACTURE W/O XTN	No pre-authorization is required for all providers.	N/A
24546	OPEN TX HUMERAL SUPRACONDYLAR FRACTURE W XTN	No pre-authorization is required for all providers.	N/A
24560	CLO TX HUMERAL EPICONDYLAR FX MED/LAT; WO MANIP	No pre-authorization is required for all providers.	N/A
24565	CLO TX HUMERAL EPICONDYLAR FX MED/LAT; W/MANIP	No pre-authorization is required for all providers.	N/A
24566	PERQ SKELET FIX HUMRL EPICONDYL FX MED/LAT W/MAN	No pre-authorization is required for all providers.	N/A
24575	OPEN TX HUMERAL EPICONDYLAR FRACTURE	No pre-authorization is required for all providers.	N/A
24576	CLO TX HUMERAL CONDYL FX MED/LAT; WO MANIP	No pre-authorization is required for all providers.	N/A
24577	CLO TX HUMERAL CONDYL FX MED/LAT; W/MANIP	No pre-authorization is required for all providers.	N/A
24579	OPEN TX HUMERAL CONDYLAR FRACTURE	No pre-authorization is required for all providers.	N/A
24582	PERQ SKELET FIX HUMRL CONDYL FX MED/LAT W/MANIP	No pre-authorization is required for all providers.	N/A
24586	OPEN TX PERIARTICULAR FX &/OR DISLOC ELBOW	No pre-authorization is required for all providers.	N/A
24587	OPEN TX PERIARTIC FX/DISLOC ELB; W/IMPLNT ARTHRO	No pre-authorization is required for all providers.	N/A
24600	TX CLO ELBOW DISLOC; WO ANES	No pre-authorization is required for all providers.	N/A

24605	TX CLO ELBOW DISLOC; REQUIRING ANES	No pre-authorization is required for all providers.	N/A
24615	OPEN TX ACUTE/CHRONIC ELBOW DISLOC	No pre-authorization is required for all providers.	N/A
24620	CLO TX MONTEGGIA TYPE FX DISLOC-ELBOW W/MANIP	No pre-authorization is required for all providers.	N/A
24635	OPEN TX MONTEGGIA FRACTURE DISLOCATION ELBOW	No pre-authorization is required for all providers.	N/A
24640	CLO TX RADIAL HEAD SUBLUXATION CHLD W/MANIP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
24646	RECONSTRUCT ELBOW LIGAMENT	No pre-authorization is required for all providers.	N/A
24650	CLO TX RADIAL HEAD/NECK FX; WO MANIP	No pre-authorization is required for all providers.	N/A
24655	CLO TX RADIAL HEAD/NECK FX; W/MANIP	No pre-authorization is required for all providers.	N/A
24665	OPEN TX RADIAL HEAD/NECK FRACTURE	No pre-authorization is required for all providers.	N/A
24666	OPEN TX RADIAL HEAD/NECK FRACTURE PROSTHETIC	No pre-authorization is required for all providers.	N/A
24670	CLOSED TX ULNAR FRACTURE PROX END W/O MANIPULATE	No pre-authorization is required for all providers.	N/A
24675	CLOSED TX ULNAR FRACTURE PROX END W MANIPULATION	No pre-authorization is required for all providers.	N/A
24685	OPEN TX ULNAR FRACTURE PROX END	No pre-authorization is required for all providers.	N/A
24800	ARTHRODESIS ELBOW JT; LOCAL	No pre-authorization is required for all providers.	N/A
24802	ARTHRODESIS ELBOW JT; W/AUTOG GFT	No pre-authorization is required for all providers.	N/A
24900	AMPUTA ARM THRU HUMERUS; W/PRIMARY CLO	No pre-authorization is required for all providers.	N/A
24920	AMPUTA ARM THRU HUMERUS; OPEN CIRCULAR	No pre-authorization is required for all providers.	N/A
24925	AMPUTA ARM THRU HUMERUS; SECNDRY CLO/SCAR REVIS	No pre-authorization is required for all providers.	N/A
24930	AMPUTA ARM THRU HUMERUS; RE-AMPUTA	No pre-authorization is required for all providers.	N/A
24931	AMPUTA ARM THRU HUMERUS; W/IMPLNT	No pre-authorization is required for all providers.	N/A
24935	STUMP ELONGATION UPPER EXTREM	No pre-authorization is required for all providers.	N/A
24940	CINEPLASTY UPPER EXTREM COMPLT PROC	No pre-authorization is required for all providers.	N/A
24999	UNLISTED PROC HUMERUS/ELBOW	No pre-authorization is required for all providers.	N/A
25000	INCIS EXTEN TENDON SHEATH WRIST (DEQUERVAIN'S DZ	No pre-authorization is required for all providers.	N/A
25001	INCISION OF FLEXOR TENDON SHEATH, WRIST	No pre-authorization is required for all providers.	N/A
25020	DECOMP FASCIOT FOREARM/WRIST; FLEXOR/EXTENSOR	No pre-authorization is required for all providers.	N/A
25023	DECOMP FASCIOT FOREARM; W/DEBRID NONVIABLE MUSCL	No pre-authorization is required for all providers.	N/A
25024	DECOMPRESSION FASCIOTOMY OF FOREARM/WRIST	No pre-authorization is required for all providers.	N/A
25025	DECOMPRESSION FASCIOTOMY OF FOREARM/WRIST	No pre-authorization is required for all providers.	N/A
25028	I&D FOREARM/WRIST; DEEP ABSCESS/HEMATOMA	No pre-authorization is required for all providers.	N/A
25031	I&D FOREARM &/OR WRIST; BURSA	No pre-authorization is required for all providers.	N/A
25035	INCS DEEP BONE CORTEX FOREARM &/OR WRIST	No pre-authorization is required for all providers.	N/A
25040	ARTHROTOMY RADIO/MIDCARPAL W/EXPLOR/DRAIN/FB REM	No pre-authorization is required for all providers.	N/A
25065	BX SOFT TISS FOREARM &/OR WRIST; SUPERF	No pre-authorization is required for all providers.	N/A
25066	BX SOFT TISS FOREARM &/OR WRIST; DEEP	No pre-authorization is required for all providers.	N/A
25071	EXC FOREARM LES SC > 3 CM	No pre-authorization is required for all providers.	N/A
25073	EXC FOREARM TUM DEEP = 3 CM	No pre-authorization is required for all providers.	N/A
25075	EXC TUMOR FOREARM &/OR WRIST AREA; SUBQ	No pre-authorization is required for all providers.	N/A
25076	EXC TUMOR FOREARM/WRIST AREA; DEEP/SUBFASCIAL/IM	No pre-authorization is required for all providers.	N/A
25077	RESECT FOREARM/WRIST TUM<3CM	No pre-authorization is required for all providers.	N/A
25078	RESECT FORARM/WRIST TUM 3CM>	No pre-authorization is required for all providers.	N/A
25085	CAPSULOTOMY WRIST	No pre-authorization is required for all providers.	N/A
25100	ARTHROTOMY WRIST JT; W/BX	No pre-authorization is required for all providers.	N/A
25101	ARTHROTOMY WRIST JT; W/EXPLOR W/WO BX/REMOV FB	No pre-authorization is required for all providers.	N/A
25105	ARTHROTOMY WRIST JT; W/SYNOVECTOMY	No pre-authorization is required for all providers.	N/A
25107	ARTHROT DIST RADIOULNAR JT REPR TRIANGULAR CART	No pre-authorization is required for all providers.	N/A
25109	EXCISION OF TENDON, FOREARM AND/OR WRIST, FLEXOR OR EXTENSOR	No pre-authorization is required for all providers.	N/A
25110	EXC LES TENDON SHEATH FOREARM/WRIST	No pre-authorization is required for all providers.	N/A
25111	EXC GANGLION WRIST; PRIM	No pre-authorization is required for all providers.	N/A
25112	EXC GANGLION WRIST; RECURRENT	No pre-authorization is required for all providers.	N/A
25115	RAD EXC BURSA WRIST TENDON SHEATHS; FLEXORS	No pre-authorization is required for all providers.	N/A
25116	RAD EXC BURSA WRIST; EXTENSORS W/WO TRANSPOSIT	No pre-authorization is required for all providers.	N/A
25118	SYNOVECTOMY EXTENSOR TENDON SHEATH WRIST SNGL	No pre-authorization is required for all providers.	N/A
25119	SYNOVECTOMY EXTENSOR WRIST SNGL; RESECT ULNA	No pre-authorization is required for all providers.	N/A
25120	EXC/CURET BONE CYST/BEN TUMOR RADIUS/ULNA	No pre-authorization is required for all providers.	N/A
25125	EXC/CURET BONE CYST/TUMOR RADIUS/ULNA; W/AUTOGFT	No pre-authorization is required for all providers.	N/A
25126	EXC/CURET BONE CYST/TUMOR RADIUS/ULNA; W/ALLOGFT	No pre-authorization is required for all providers.	N/A
25130	EXC/CURET BONE CYST/BEN TUMOR CARPAL BONES	No pre-authorization is required for all providers.	N/A
25135	EXC/CURET BONE CYST/TUMOR CARPAL BONES; W/AUTOGF	No pre-authorization is required for all providers.	N/A
25136	EXC/CURET BONE CYST/TUMOR CARPAL BONES; W/ALLOGF	No pre-authorization is required for all providers.	N/A
25145	SEQUESTRECTOMY FOREARM &/OR WRIST	No pre-authorization is required for all providers.	N/A
25150	PART EXC BONE; ULNA	No pre-authorization is required for all providers.	N/A
25151	PART EXC BONE; RADIUS	No pre-authorization is required for all providers.	N/A
25170	RADICAL RESECT TUMOR RADIUS/ULNA	No pre-authorization is required for all providers.	N/A
25210	CARPECTOMY; 1 BONE	No pre-authorization is required for all providers.	N/A
25215	CARPECTOMY; ALL BONES PROX ROW	No pre-authorization is required for all providers.	N/A
25230	RADIAL STYLOIDECTOMY (SEPART PROC)	No pre-authorization is required for all providers.	N/A
25240	EXC DISTAL ULNA PART/COMPLT	No pre-authorization is required for all providers.	N/A
25246	INJ PROC WRIST ARTHROGRAPHY	No pre-authorization is required for all providers.	N/A
25248	EXPLOR W/REMOV DEEP FB FOREARM/WRIST	No pre-authorization is required for all providers.	N/A
25250	REMOV WRIST PROSTH; (SEPART PROC)	No pre-authorization is required for all providers.	N/A
25251	REMOV WRIST PROSTH; COMPLIC INCL'TOT WRIST'	No pre-authorization is required for all providers.	N/A
25259	MANIPULATION OF WRIST UNDER ANESTHESIA	No pre-authorization is required for all providers.	N/A
25260	REPR TENDON/MUSCL-FLEXOR-WRIST; PRIM SNGL EA	No pre-authorization is required for all providers.	N/A
25263	REPR TENDON/MUSCL-FLEXOR-WRIST; SECNDRY SNGL EA	No pre-authorization is required for all providers.	N/A
25265	REPR TENDON/MUSCL-FLEXOR-WRIST; 2ND W/FREE GFT	No pre-authorization is required for all providers.	N/A
25270	REPR TENDON/MUSCL-EXTENSOR-WRIST; PRIM SNGL EA	No pre-authorization is required for all providers.	N/A
25272	REPR TENDON/MUSCL-EXTENSOR-WRIST; SECNDRY SNGL	No pre-authorization is required for all providers.	N/A
25274	REPR TENDON/MUSCL EXTENSOR SECNDRY W/GFT WRIST	No pre-authorization is required for all providers.	N/A
25275	REPAIR OF TENDON SHEATH, FOREARM/WRIST	No pre-authorization is required for all providers.	N/A
25280	LENGTHEN/SHORTEN FLEX/EXTEN WRIST SNGL EA TENDON	No pre-authorization is required for all providers.	N/A
25290	TENOTOMY OPEN FLEX/EXTEN TENDON WRIST SNGL EA	No pre-authorization is required for all providers.	N/A
25295	TENOLYSIS FLEX/EXTEN-FOREARM/WRIST SNGL EA TENDN	No pre-authorization is required for all providers.	N/A
25300	TENODESIS @ WRIST; FLEXORS FINGERS	No pre-authorization is required for all providers.	N/A
25301	TENODESIS @ WRIST; EXTENSORS FINGERS	No pre-authorization is required for all providers.	N/A
25310	TENDON TRANSPL/TRANSF FLEX/EXTEN WRIST SNGL; EA	No pre-authorization is required for all providers.	N/A
25312	TENDON TRANSPL/TRANSF WRIST SNGL; W/TENDON GFT	No pre-authorization is required for all providers.	N/A
25315	FLEXOR ORIGIN SLIDE FOREARM &/OR WRIST;	No pre-authorization is required for all providers.	N/A
25316	FLEXOR ORIGIN SLIDE WRIST; W/TENDON(S) TRANSF	No pre-authorization is required for all providers.	N/A
25320	CPSLORR/RECSTR WRST OPN CARPAL	No pre-authorization is required for all providers.	N/A
25332	ARTHROPLASTY WRIST; W/WO INTERPOSITION-W/WO FIXA	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
25335	CENTRALIZATION WRIST ULNA	No pre-authorization is required for all providers.	N/A
25337	RECON WRIST-SECNDRY-W/WO OPEN REDUC RADULNAR JT	No pre-authorization is required for all providers.	N/A
25350	OSTEOTOMY RADIUS; DISTAL THIRD	No pre-authorization is required for all providers.	N/A
25355	OSTEOTOMY RADIUS; MID/PROX THIRD	No pre-authorization is required for all providers.	N/A
25360	OSTEOTOMY; ULNA	No pre-authorization is required for all providers.	N/A
25365	OSTEOTOMY; RADIUS & ULNA	No pre-authorization is required for all providers.	N/A
25370	MX OSTEOTOMIES W/REALIGN ON ROD; RADIUS/ULNA	No pre-authorization is required for all providers.	N/A
25375	MX OSTEOTOMIES W/REALIGN ON ROD; RADIUS & ULNA	No pre-authorization is required for all providers.	N/A
25390	OSTEOPLASTY RADIUS/ULNA; SHORTENING	No pre-authorization is required for all providers.	N/A
25391	OSTEOPLASTY RADIUS/ULNA; LENGTHENING W/AUTOGFT	No pre-authorization is required for all providers.	N/A
25392	OSTEOPLASTY RADIUS & ULNA; SHORTENING	No pre-authorization is required for all providers.	N/A
25393	OSTEOPLASTY RADIUS & ULNA; LENGTHENING W/AUTOGFT	No pre-authorization is required for all providers.	N/A
25394	OSTEOPLASTY OF CARPAL BONE	No pre-authorization is required for all providers.	N/A
25400	REPR NON/MALUNION RADIUS/ULNA; WO GFT	No pre-authorization is required for all providers.	N/A
25405	REPR NON/MALUNION RAD/ULNA; W/ILIAC/OTHER AUTOGF	No pre-authorization is required for all providers.	N/A
25415	REPR NONUNION/MALUNION RADIUS & ULNA; WO GFT	No pre-authorization is required for all providers.	N/A
25420	REPR NON/MALUNION RADIUS & ULNA; W/ILIAC/AUTOGFT	No pre-authorization is required for all providers.	N/A
25425	REPR DEFECT W/AUTOGFT; RADIUS/ULNA	No pre-authorization is required for all providers.	N/A
25426	REPR DEFECT W/AUTOGFT; RADIUS & ULNA	No pre-authorization is required for all providers.	N/A
25430	INSRTION VASC PEDICLE IN CARPAL BN	No pre-authorization is required for all providers.	N/A

25431	REPAIR OF NONUNION CARPAL BONE	No pre-authorization is required for all providers.	N/A
25440	REPR NONUNION SCAPHOID W/WO RADIAL STYLOIDECTOMY	No pre-authorization is required for all providers.	N/A
25441	ARTHROPLASTY W/PROSTH REPLAC; DISTAL RADIUS	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
25442	ARTHROPLASTY W/PROSTH REPLAC; DISTAL ULNA	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
25443	ARTHROPLASTY W/PROSTH REPLAC; SCAPHOID	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
25444	ARTHROPLASTY W/PROSTH REPLAC; LUNATE	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
25445	ARTHROPLASTY W/PROSTH REPLAC; TRAPEZIUM	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
25446	ARTHROPLASTY W/PROS REPLAC; DIST RAD/PART CARPUS	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
25447	ARTHROPLAS INTERPOSIT-INTERCARP/CARPOMETACARP JT	No pre-authorization is required for all providers.	N/A
25449	REVIS ARTHROPLASTY INCL REMOV IMPLNT WRIST JT	No pre-authorization is required for all providers.	N/A
25450	EPIPHYSEAL ARREST-STAPLING; DISTAL RADIUS/UNLA	No pre-authorization is required for all providers.	N/A
25455	EPIPHYSEAL ARREST-STAPLING; DIST RADIUS & ULNA	No pre-authorization is required for all providers.	N/A
25490	PROPHYLACTIC TX W/WO METHYLMETHACRYLATE; RADIUS	No pre-authorization is required for all providers.	N/A
25491	PROPHYLACTIC TX W/WO METHYLMETHACRYLATE; ULNA	No pre-authorization is required for all providers.	N/A
25492	PROPHYLACTIC TX W/WO METHYLMETHA; RADIUS & ULNA	No pre-authorization is required for all providers.	N/A
25500	CLO TX RADIAL SHAFT FX; WO MANIP	No pre-authorization is required for all providers.	N/A
25505	CLO TX RADIAL SHAFT FX; W/MANIP	No pre-authorization is required for all providers.	N/A
25515	OPEN TREATMENT RADIAL SHAFT FRACTURE	No pre-authorization is required for all providers.	N/A
25520	CLO TX RADIAL SHAFT FX W/DISLOC DIST RAD-ULNA JT	No pre-authorization is required for all providers.	N/A
25525	OPEN RDL SHAFT FX CLOSED RAD/ULN JT DISLOCATE	No pre-authorization is required for all providers.	N/A
25526	OPEN RDL SHAFT FX OPEN RAD/ULN JT DISLOCATE	No pre-authorization is required for all providers.	N/A
25530	CLO TX ULNAR SHAFT FX; WO MANIP	No pre-authorization is required for all providers.	N/A
25535	CLO TX ULNAR SHAFT FX; W/MANIP	No pre-authorization is required for all providers.	N/A
25545	OPEN TREATMENT OF ULNAR SHAFT FRACTURE	No pre-authorization is required for all providers.	N/A
25560	CLO TX RADIAL & ULNAR SHAFT FX; WO MANIP	No pre-authorization is required for all providers.	N/A
25565	CLO TX RADIAL & ULNAR SHAFT FX; W/MANIP	No pre-authorization is required for all providers.	N/A
25574	OPEN TX RADIAL & ULNAR SHAFT FX FIX RADIUS/ULNA	No pre-authorization is required for all providers.	N/A
25575	OPEN TX RDL & ULNAR SHAFT FX FIX RADIUS & ULNA	No pre-authorization is required for all providers.	N/A
25600	CLOSED DISTAL RAD FRACT OR EPIPHYSEAL SEP, INCL CLOSED FRACT ULNAR STYL	No pre-authorization is required for all providers.	N/A
25605	CLO TX DIST RAD FX W/WO FX ULNA STYLOID; W/MANIP	No pre-authorization is required for all providers.	N/A
25606	PERCUTANEOUS SKELETAL FIXATION OF DISTAL RADIAL FRACTURE	No pre-authorization is required for all providers.	N/A
25607	OPEN TREATMENT OF DISTAL RADIAL EXTRA-ARTICULAR FRACTURE	No pre-authorization is required for all providers.	N/A
25608	OPEN TREATMENT OF DISTAL RADIAL INTRA-ARTICULAR FRACTURE	No pre-authorization is required for all providers.	N/A
25609	WITH INTERNAL FIXATION OF 3 OR MORE FRAGMENTS	No pre-authorization is required for all providers.	N/A
25622	CLO TX CARPAL SCAPHOID FX; WO MANIP	No pre-authorization is required for all providers.	N/A
25624	CLO TX CARPAL SCAPHOID FX; W/MANIP	No pre-authorization is required for all providers.	N/A
25628	OPEN TX CARPAL SCAPHOID NAVICULAR FRACTURE	No pre-authorization is required for all providers.	N/A
25630	CLO TX CARPAL BONE FX; WO MANIP EA BONE	No pre-authorization is required for all providers.	N/A
25635	CLO TX CARPAL BONE FX; W/MANIP EA BONE	No pre-authorization is required for all providers.	N/A
25645	OPEN TX CARPAL BONE FX EA BONE	No pre-authorization is required for all providers.	N/A
25650	CLO TX ULNAR STYLOID FX	No pre-authorization is required for all providers.	N/A
25651	PERCUTANEOUS SKELETAL FIXATION OF ULNAR STYLOID FRACTURE	No pre-authorization is required for all providers.	N/A
25652	OPEN TREATMENT OF ULNAR STYLOID FRACTURE	No pre-authorization is required for all providers.	N/A
25660	CLO TX RADIO-INTERCARPAL DISLOC 1/MORE W/MANIP	No pre-authorization is required for all providers.	N/A
25670	OPEN TX RADIOCARPAL/INTERCARP DISLOC 1/MORE BONE	No pre-authorization is required for all providers.	N/A
25671	PERCUTANEOUS SKELETAL FIXATION OF DISTAL RADIOULNAR DISLOCATION	No pre-authorization is required for all providers.	N/A
25675	CLO TX DISTAL RADIOULNAR DISLOC W/MANIP	No pre-authorization is required for all providers.	N/A
25676	OPEN TX DISTAL RADIOULNAR DISLOC ACUTE/CHRONIC	No pre-authorization is required for all providers.	N/A
25680	CLO TX TRANS-SCAPHOPERILUNAR FX DISLOC W/MANIP	No pre-authorization is required for all providers.	N/A
25685	OPEN TX TRANS-SCAPHOPERILUNAR TYPE FX DISLOC	No pre-authorization is required for all providers.	N/A
25690	CLO TX LUNATE DISLOC W/MANIP	No pre-authorization is required for all providers.	N/A
25695	OPEN TX LUNATE DISLOC	No pre-authorization is required for all providers.	N/A
25800	ARTHRODESIS WRIST; COMPLT WO BONE GFT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
25805	ARTHRODESIS WRIST;W/SLIDING GFT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
25810	ARTHRODESIS WRIST JT; W/ILIAC/OTHER AUTOGFT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
25820	ARTHRODESIS WRIST; LIMITED WO BONE GFT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
25825	ARTHRODESIS WRIST; W/AUTOGFT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
25830	ARTHRODESIS DIST RADIOULNAR JT SEG RESECT ULNA	No pre-authorization is required for all providers.	N/A
25900	AMPUTA FOREARM THRU RADIUS & ULNA	No pre-authorization is required for all providers.	N/A
25905	AMPUTA FOREARM THRU RADIUS & ULNA; OPEN CIRCULAR	No pre-authorization is required for all providers.	N/A
25907	AMPUTA FOREARM; SECNDRY CLO/SCAR REVIS	No pre-authorization is required for all providers.	N/A
25909	AMPUTA FOREARM THRU RADIUS & ULNA; RE-AMPUTA	No pre-authorization is required for all providers.	N/A
25915	KRUKENBERG PROC	No pre-authorization is required for all providers.	N/A
25920	DISART THRU WRIST	No pre-authorization is required for all providers.	N/A
25922	DISART THRU WRIST; SECNDRY CLO/SCAR REVIS	No pre-authorization is required for all providers.	N/A
25924	DISART THRU WRIST; RE-AMPUTA	No pre-authorization is required for all providers.	N/A
25927	TRANSMETACARPAL AMPUTA	No pre-authorization is required for all providers.	N/A
25929	TRANSMETACARPAL AMPUTA; SECNDRY CLO/SCAR REVIS	No pre-authorization is required for all providers.	N/A
25931	TRANSMETACARPAL AMPUTA; RE-AMPUTA	No pre-authorization is required for all providers.	N/A
25999	UNLISTED PROC FOREARM/WRIST	No pre-authorization is required for all providers.	N/A
26010	DRAINAGE FINGER ABSCESS; SIMPL	No pre-authorization is required for all providers.	N/A
26011	DRAINAGE FINGER ABSCESS; COMPLIC	No pre-authorization is required for all providers.	N/A
26020	DRAIN TENDON SHEATH/DIGIT &/OR PALM EA	No pre-authorization is required for all providers.	N/A
26025	DRAIN PALMAR BURSA; SNGL BURSA	No pre-authorization is required for all providers.	N/A
26030	DRAIN PALMAR BURSA; MX BURSA	No pre-authorization is required for all providers.	N/A
26034	INCS BONE CORTEX HAND/FINGR	No pre-authorization is required for all providers.	N/A
26035	DECOMP FINGERS &/OR HAND INJ INJURY	No pre-authorization is required for all providers.	N/A
26037	DECOMP FASCIOTOMY HAND	No pre-authorization is required for all providers.	N/A
26040	FASCIOT PALMAR (DUPUYTREN'S CONTRACT); PERCUT	No pre-authorization is required for all providers.	N/A
26045	FASCIOT PALMAR (DUPUYTREN'S CONTRACT); OP PART	No pre-authorization is required for all providers.	N/A
26055	TENDON SHEATH INCS	No pre-authorization is required for all providers.	N/A
26060	TENOTOMY PERCUT SNGL EA DIGIT	No pre-authorization is required for all providers.	N/A
26070	ARTHROT-EXPLOR/DRAIN/REMOV FB; CARPOMETACARP JT	No pre-authorization is required for all providers.	N/A
26075	ARTHROT W/EXPLOR/DRAIN/REMOV FB; MCP JT EA	No pre-authorization is required for all providers.	N/A
26080	ARTHROT W/EXPLOR/DRAIN/REMOV FB; IP JT EA	No pre-authorization is required for all providers.	N/A
26100	ARTHROT W/BX; CARPOMETACARPAL JT EA	No pre-authorization is required for all providers.	N/A
26105	ARTHROT W/BX; METACARPOPHALANG JT EA	No pre-authorization is required for all providers.	N/A
26110	ARTHROT W/BX; INTERPHALANGEAL JT EA	No pre-authorization is required for all providers.	N/A
26111	EXC HAND LES SC > 1.5 CM	No pre-authorization is required for all providers.	N/A
26113	EXC HAND TUM DEEP > 1.5 CM	No pre-authorization is required for all providers.	N/A
26115	EXC TUMOR/VASCUL MALFORM HAND/FINGER; SUBQ	No pre-authorization is required for all providers.	N/A
26116	EXC TUMOR/VASCULAR MALFORM HAND/FINGER; DEEP/IM	No pre-authorization is required for all providers.	N/A
26117	RAD RESECT HAND TUMOR < 3 CM	No pre-authorization is required for all providers.	N/A
26118	RAD RESECT HAND TUMOR 3 CM/	No pre-authorization is required for all providers.	N/A
26121	FASCIECT PALM ONLY W/WO Z-PLASTY/SKIN GFT (INCL)	No pre-authorization is required for all providers.	N/A
26123	FASCIECT PART PALMAR W/REL 1 DIGT W/WO Z-PLASTY;	No pre-authorization is required for all providers.	N/A
26125	FASCIECT PART PALM W/REL 1 DIGIT; EA ADD DIGIT	No pre-authorization is required for all providers.	N/A
26130	SYNOVECTOMY CARPOMETACARPAL JT	No pre-authorization is required for all providers.	N/A
26135	SYNOVECTOMY MCP JT INCL RELEAS & RECON EA DIGIT	No pre-authorization is required for all providers.	N/A
26140	SYNOVECTOMY PROX IP JT INCL RECON EA IP JT	No pre-authorization is required for all providers.	N/A
26145	SYNOVECT SHEATH/RAD FLEX TENDON PALM/FINGR EA	No pre-authorization is required for all providers.	N/A
26160	EXC LES TENDON SHEATH/CAPSULE HAND/FINGER	No pre-authorization is required for all providers.	N/A
26170	EXCISION TENDOR PALM FLEXOR OR EXTENSOR, SINGLE EACH TENDON	No pre-authorization is required for all providers.	N/A
26180	EXCISION OF TENDOR FINGER FLEXOR OR EXTENSOR, EACH TENDON	No pre-authorization is required for all providers.	N/A
26185	SESAMOIDECTOMY THUMB/FINGER (SEPART PROC)	No pre-authorization is required for all providers.	N/A
26200	EXC/CURET BONE CYST/BEN TUMOR METACARPAL	No pre-authorization is required for all providers.	N/A
26205	EXC/CURET BONE CYST/TUMOR METACARPAL; W/AUTOGFT	No pre-authorization is required for all providers.	N/A
26210	EXC/CURET BONE/TUMOR PROX/MID/DIST PHALANX FINGR	No pre-authorization is required for all providers.	N/A
26215	EXC BONE CYST PROX/MID/DIST PHALANX; W/AUTOGFT	No pre-authorization is required for all providers.	N/A
26230	PART EXC BONE; METACARPAL	No pre-authorization is required for all providers.	N/A
26235	PART EXC BONE; PROX/MID PHALANX-FINGR	No pre-authorization is required for all providers.	N/A

26236	PART EXC BONE; DIST PHALANX-FINGR	No pre-authorization is required for all providers.	N/A
26250	RAD RESECT METACARPAL; (TUMOR)	No pre-authorization is required for all providers.	N/A
26260	RAD RESECT PROX/MID PHALANX FINGR (TUMOR);	No pre-authorization is required for all providers.	N/A
26262	RAD RESECT DISTAL PHALANX FINGR (TUMOR)	No pre-authorization is required for all providers.	N/A
26320	REMOV IMPLNT FROM FINGER/HAND	No pre-authorization is required for all providers.	N/A
26340	MANIPULATION OF FINGER JOINT UNDER ANESTHESIA	No pre-authorization is required for all providers.	N/A
26341	MANIPULAT PALM CORD POST INJ	No pre-authorization is required for all providers.	N/A
26350	REPR FLEX TENDON; PRIM/SECNDRY WO GFT-EA TEND	No pre-authorization is required for all providers.	N/A
26352	REPR FLEX TENDON; SECNDRY W/GFT-EA TENDON	No pre-authorization is required for all providers.	N/A
26356	REP FLX TEND ZONE 2 DIGTL W/O GFT	No pre-authorization is required for all providers.	N/A
26357	SECONDARY WITHOUT FREE GRAFT, EACH TENDON	No pre-authorization is required for all providers.	N/A
26358	REPR FLEX TENDON; SECND W/FREE GFT EA TENDON	No pre-authorization is required for all providers.	N/A
26370	REPR PROFUNDUS TENDON; PRIMARY EA TENDON	No pre-authorization is required for all providers.	N/A
26372	REPR PROFUND TENDON; SECND W/FREE GFT EA TEND	No pre-authorization is required for all providers.	N/A
26373	REPR PROFUNDUS TENDON; SECND WO GFT EA TEND	No pre-authorization is required for all providers.	N/A
26390	EXC FLEX TEND W/ROD DELAY GFT-HAND/FINGR EA TEND	No pre-authorization is required for all providers.	N/A
26392	REMOV ROD-INSRT FLEX TEND GFT HAND/FINGR EA TEND	No pre-authorization is required for all providers.	N/A
26410	REPR EXTEN TENDON HAND PRIM/SEC; WO GFT EA TEND	No pre-authorization is required for all providers.	N/A
26412	REPR EXTEN TENDON HAND PRIM/SEC; W/FREE GFT EA	No pre-authorization is required for all providers.	N/A
26415	EXC EXTEN TENDON W/ROD DELAYED GFT HAND/FINGR	No pre-authorization is required for all providers.	N/A
26416	REMOV ROD-INSRT EXTEN TEND GFT HAND/FINGR EA ROD	No pre-authorization is required for all providers.	N/A
26418	REPR EXTEN TENDON FINGR; WO GFT EA TENDON	No pre-authorization is required for all providers.	N/A
26420	REPR EXTEN TENDON FINGR; W/FREE GFT EA TEND	No pre-authorization is required for all providers.	N/A
26426	REPR EXTEN TEND-CENTRAL SLIP-SECOND; EA TEND	No pre-authorization is required for all providers.	N/A
26428	REPR EXTEN TEND-CENTRAL-SECND; FREE GFT EA TEND	No pre-authorization is required for all providers.	N/A
26432	CLO TX DIST EXTEN TENDON INSRT-W/WO PINNING	No pre-authorization is required for all providers.	N/A
26433	REPR EXTEN TEND-DIST INSRT PRIM/SECND; WO GFT	No pre-authorization is required for all providers.	N/A
26434	REPR EXTEN TEND-DIST INSRT PRIM/SECND; FREE GFT	No pre-authorization is required for all providers.	N/A
26437	REALIGNMENT EXTEN TENDON HAND EA TENDON	No pre-authorization is required for all providers.	N/A
26440	TENOLYS FLX TEND; PALM/FNGR EA TEND	No pre-authorization is required for all providers.	N/A
26442	TENOLYSIS FLEX TENDON; PALM & FINGR EA TENDON	No pre-authorization is required for all providers.	N/A
26445	TENOLYSIS EXTEN TENDON HAND/FINGR EA TENDON	No pre-authorization is required for all providers.	N/A
26449	TENOLYSIS COMPLX-EXTEN-FINGR-FORARM EA TEND	No pre-authorization is required for all providers.	N/A
26450	TENOT FLEX PALM OP EA TENDON	No pre-authorization is required for all providers.	N/A
26455	TENOT FLEX FINGR OP EA TENDON	No pre-authorization is required for all providers.	N/A
26460	TENOT EXTEN HAND/FINGR OP EA TENDON	No pre-authorization is required for all providers.	N/A
26471	TENODESIS; PROX IP JT EA JT	No pre-authorization is required for all providers.	N/A
26474	TENODESIS; DIST JT EA JT	No pre-authorization is required for all providers.	N/A
26476	LENGTHENING TENDON EXTEN HAND/FINGR EA TENDON	No pre-authorization is required for all providers.	N/A
26477	SHORTENING TENDON EXTEN HAND/FINGR EA TENDON	No pre-authorization is required for all providers.	N/A
26478	LENGTHENING TENDON FLEX HAND/FINGR EA TENDON	No pre-authorization is required for all providers.	N/A
26479	SHORTENING TENDON FLEX HAND/FINGR EA TENDON	No pre-authorization is required for all providers.	N/A
26480	TRANSF/TENDON DORSUM HAND; WO GFT EA TENDON	No pre-authorization is required for all providers.	N/A
26483	TRANSF TENDON DORSUM HAND; FREE GFT EA TENDON	No pre-authorization is required for all providers.	N/A
26485	TRANSF/TRANSPL TENDON PALMAR; WO GFT EA TENDON	No pre-authorization is required for all providers.	N/A
26489	TRANSF/TRANSPL TENDON PALMAR; W/GFT EA TENDON	No pre-authorization is required for all providers.	N/A
26490	OPPONENSPLAS; SUPERFICIALIS TEND TRANSF EA TEND	No pre-authorization is required for all providers.	N/A
26492	OPPONENSPLASTY; TENDON TRANSF W/GFT EA TENDON	No pre-authorization is required for all providers.	N/A
26494	OPPONENSPLASTY; HYPOTHENAR MUSCL TRANSF	No pre-authorization is required for all providers.	N/A
26496	OPPONENSPLASTY; OTHER METHD	No pre-authorization is required for all providers.	N/A
26497	TRANSF TENDON -RESTORE FUNCT; RING & SM FINGR	No pre-authorization is required for all providers.	N/A
26498	TRANSF TENDON -RESTORE FUNCT; ALL 4 FINGRS	No pre-authorization is required for all providers.	N/A
26499	CORRECT CLAW FINGER OTHER METHD	No pre-authorization is required for all providers.	N/A
26500	RECONS TENDON PULLEY EA TENDON; LOC TISS (SP)	No pre-authorization is required for all providers.	N/A
26502	RECONS TENDON PULLEY EA TENDON; W/GFT (SP)	No pre-authorization is required for all providers.	N/A
26508	RELEASE THENAR MUSCL (THUMB CONTRACTURE)	No pre-authorization is required for all providers.	N/A
26510	CROSS INTRINSIC TRANSF	No pre-authorization is required for all providers.	N/A
26516	CAPSULODESIS METACARPOPHALANGEAL JT; SNGL	No pre-authorization is required for all providers.	N/A
26517	CAPSULODESIS METACARPOPHALANGEAL JT; 2 DIGITS	No pre-authorization is required for all providers.	N/A
26518	CAPSULODESIS METACARPOPHALANGEAL JT; 3 OR 4	No pre-authorization is required for all providers.	N/A
26520	CAPSULECT/CAPSULOT; MCP JT EA JT	No pre-authorization is required for all providers.	N/A
26525	CAPSULECT/CAPSULOT; IP JT EA JT	No pre-authorization is required for all providers.	N/A
26530	ARTHROPLASTY MCP JT; EA JT	No pre-authorization is required for all providers.	N/A
26531	ARTHROPLASTY MCP JT; W/PROSTH IMPLNT EA JT	No pre-authorization is required for all providers.	N/A
26535	ARTHROPLASTY IP JT; EA JT	No pre-authorization is required for all providers.	N/A
26536	ARTHROPLASTY IP JT; W/PROSTH IMPLNT EA JT	No pre-authorization is required for all providers.	N/A
26540	REPR COLLATERAL LIGAMNT MCP/INTERPHALAN JT	No pre-authorization is required for all providers.	N/A
26541	RECON COLLATERAL LIGAMNT MCP JT-SING; W/TEND GFT	No pre-authorization is required for all providers.	N/A
26542	RECON COLLATERAL LIGAMNT MCP JT-SING; W/LOC TISS	No pre-authorization is required for all providers.	N/A
26545	RECON COLLATERAL LIG IP JT SNGL INCL GFT EA JT	No pre-authorization is required for all providers.	N/A
26546	REPR NON-UNION METACARP/PHALYNX (INCL BONE GFT)	No pre-authorization is required for all providers.	N/A
26548	REPR & RECON FINGER VOLAR PLATE IP JT	No pre-authorization is required for all providers.	N/A
26550	POLLICIZATION A DIGIT	No pre-authorization is required for all providers.	N/A
26551	TRANSF TOE-TO-HAND-MICROVASC ANASTOM; GR TOE	No pre-authorization is required for all providers.	N/A
26553	TRANSF TOE-TO-HAND-MICROVASC ANAST; NOT GR TOE-1	No pre-authorization is required for all providers.	N/A
26554	TRANSF TOE-TO-HAND-MICROVASC ANAST; NOT GR TOE-2	No pre-authorization is required for all providers.	N/A
26555	TRANSF FINGR OTH POSIT WO MICROVASC ANAS	No pre-authorization is required for all providers.	N/A
26556	TRANSF FREE TOE JT W/MICROVASC ANAS	No pre-authorization is required for all providers.	N/A
26560	REPR SYNDACTYLY EA WEB SPACE; W/SKIN FLAPS	No pre-authorization is required for all providers.	N/A
26561	REPR SYNDACTYLY EA WEB SPACE; W/SKIN FLAPS & GFT	No pre-authorization is required for all providers.	N/A
26562	REPR SYNDACTYLY EA WEB SPACE; COMPLX	No pre-authorization is required for all providers.	N/A
26565	OSTEOT; METACARPAL EA	No pre-authorization is required for all providers.	N/A
26567	OSTEOT; PHALANX FINGR EA	No pre-authorization is required for all providers.	N/A
26568	OSTEOPLASTY LENGTHENING METACARPAL/PHALANX	No pre-authorization is required for all providers.	N/A
26580	REPR CLEFT HAND	No pre-authorization is required for all providers.	N/A
26587	RECON SUPERNUMERARY DIGIT SOFT TISS & BONE	No pre-authorization is required for all providers.	N/A
26590	REPR MACRODACTYLIA	No pre-authorization is required for all providers.	N/A
26591	REPR INTRINSIC MUSCL HAND EA MUSCL	No pre-authorization is required for all providers.	N/A
26593	RELEASE INTRINSIC MUSCL HAND EA MUSCL	No pre-authorization is required for all providers.	N/A
26596	EXC CONSTRICTING RING OF FINGER W/MX Z-PLASTIES	No pre-authorization is required for all providers.	N/A
26600	CLO TX METACARPAL FX SNGL; WO MANIP EA BONE	No pre-authorization is required for all providers.	N/A
26605	CLO TX METACARPAL FX SNGL; W/MANIP EA BONE	No pre-authorization is required for all providers.	N/A
26607	CLO TX METACARPAL FX W/MANIP W/FIXA EA BONE	No pre-authorization is required for all providers.	N/A
26608	PERCUT SKELETAL FIXA METACARPAL FX EA BONE	No pre-authorization is required for all providers.	N/A
26615	OPEN TX METACARPAL FRACTURE SINGLE EA BONE	No pre-authorization is required for all providers.	N/A
26641	CLO TX CARPOMETACARPAL DISLOC THUMB W/MANIP	No pre-authorization is required for all providers.	N/A
26645	CLO TX CARPOMETACARPAL FX DISLOC THUMB W/MANIP	No pre-authorization is required for all providers.	N/A
26650	PRQ SKEL FIXATION CARP/MTCRPL FX DISLOCATE THUMB	No pre-authorization is required for all providers.	N/A
26665	OPEN TX CARPOMETACARPAL FRACTURE DISLOCATE THUMB	No pre-authorization is required for all providers.	N/A
26670	CLO TX DISLOC-NOT THUMB-SNGL W/MANIP; WO ANES	No pre-authorization is required for all providers.	N/A
26675	CLO TX DISLOC-NOT THUMB-SNGL W/MANIP; REQ ANES	No pre-authorization is required for all providers.	N/A
26676	PERCUT SKELET FIX DISLOC-NOT THUMB-SNGL; W/MANIP	No pre-authorization is required for all providers.	N/A
26685	OPEN TX CARPOMETACARPAL DISLOCATE NOT THUMB	No pre-authorization is required for all providers.	N/A
26686	OPEN TX DISLOC-NOT THUMB; COMPLX/MX/DELAY REDUCT	No pre-authorization is required for all providers.	N/A
26700	CLO TX MCP DISLOC SNGL W/MANIP; WO ANES	No pre-authorization is required for all providers.	N/A
26705	CLO TX MCP DISLOC SNGL W/MANIP; REQ ANES	No pre-authorization is required for all providers.	N/A
26706	PERCUT SKELETAL FIXA MCP DISLOC SNGL W/MANIP	No pre-authorization is required for all providers.	N/A
26715	OPEN TREATMENT METACARPOPHALANGEAL DISLOCATION 1	No pre-authorization is required for all providers.	N/A
26720	CLO TX PHALANGEAL SHAFT FX PROX/MID; WO MANIP EA	No pre-authorization is required for all providers.	N/A
26725	CLO TX PHALANGEALFX PROX/MID; W/MANIP W/WO TRACT	No pre-authorization is required for all providers.	N/A
26727	PERCUT FIXA UNSTABLE FX PROX/MID W/MANIP EA	No pre-authorization is required for all providers.	N/A

26735	OPEN TX PHALANGEAL SHAFT FRACTURE PROX/MIDDLE EA	No pre-authorization is required for all providers.	N/A
26740	CLO TX ARTICULR FX INVOLV MCP/IP JT; WO MANIP EA	No pre-authorization is required for all providers.	N/A
26742	CLO TX ARTICULAR FX INVOLV MCP/IP JT; W/MANIP EA	No pre-authorization is required for all providers.	N/A
26746	OPEN TX ARTICULAR FRACTURE MCP/IP JOINT EA	No pre-authorization is required for all providers.	N/A
26750	CLO TX DIST PHALANGEAL FX FINGER/THUMB; WO MANIP	No pre-authorization is required for all providers.	N/A
26755	CLO TX DIST PHALANGEAL FX FINGER/THUMB; W/MANIP	No pre-authorization is required for all providers.	N/A
26756	PERCUT SKELETAL FIXA DISTAL PHALANGEAL FX EA	No pre-authorization is required for all providers.	N/A
26765	OPEN TX DISTAL PHALANGEAL FRACTURE EACH	No pre-authorization is required for all providers.	N/A
26770	CLO TX IP JT DISLOC SNGL W/MANIP; WO ANES	No pre-authorization is required for all providers.	N/A
26775	CLO TX IP JT DISLOC SNGL W/MANIP; REQ ANES	No pre-authorization is required for all providers.	N/A
26776	PERCUT SKELETAL FIXA IP JT DISLOC SNGL W/MANIP	No pre-authorization is required for all providers.	N/A
26785	OPEN TX INTERPHALANGEAL JOINT DISLOCATION 1	No pre-authorization is required for all providers.	N/A
26820	ANASTOMOSIS, FOREARM VEIN TRANSPOSITION	No pre-authorization is required for all providers.	N/A
26841	ARTHRODESIS CARPOMETACARPAL JT THUMB W/WO FIXA	No pre-authorization is required for all providers.	N/A
26842	ARTHRODESIS JT THUMB W/WO INT FIXA; W/AUTOGFT	No pre-authorization is required for all providers.	N/A
26843	ARTHRODESIS CARPOMETACARPAL JT DIGITS NOT THUMB	No pre-authorization is required for all providers.	N/A
26844	ARTHRODESIS JT DIGITS NOT THUMB; W/AUTOGFT	No pre-authorization is required for all providers.	N/A
26850	ARTHRODESIS MCP JT W/WO INT FIXA	No pre-authorization is required for all providers.	N/A
26852	ARTHRODESIS MCP JT W/WO INT FIXA; W/AUTOGFT	No pre-authorization is required for all providers.	N/A
26860	ARTHRODESIS IP JT W/WO INT FIXA	No pre-authorization is required for all providers.	N/A
26861	ARTHRODESIS IP JT W/WO INT FIXA; EA ADD IP JT	No pre-authorization is required for all providers.	N/A
26862	ARTHRODESIS IP JT W/WO INT FIXA; W/AUTOGFT	No pre-authorization is required for all providers.	N/A
26863	ARTHRODESIS IP JT W/WO FIX; W/AUTOGFT EA ADD JT	No pre-authorization is required for all providers.	N/A
26910	AMPUTA METACARPAL W/FINGER/THUMB 1 W/WO TRANSF	No pre-authorization is required for all providers.	N/A
26951	AMPUTA FINGER ANY JT INCL NEURECT; W/DIRECT CLO	No pre-authorization is required for all providers.	N/A
26952	AMPUTA FINGER ANY JT; W/LOCAL ADVANCEMENT FLAPS	No pre-authorization is required for all providers.	N/A
26989	UNLISTED PROC HANDS/FINGERS	No pre-authorization is required for all providers.	N/A
26990	I&D PELVIS/HIP JT AREA; DEEP ABSCESS/HEMATOMA	No pre-authorization is required for all providers.	N/A
26991	I&D PELVIS/HIP JT AREA; INFEC BURSA	No pre-authorization is required for all providers.	N/A
26992	INCIS BONE CORTEX PELVIS &/OR HIP JT	No pre-authorization is required for all providers.	N/A
27000	TENOT ADDUCTOR HIP PERCUT (SEPARAT PROC)	No pre-authorization is required for all providers.	N/A
27001	TENOT ADDUCTOR HIP OP	No pre-authorization is required for all providers.	N/A
27003	TENOTOMY ADDUCT SUBQ OPEN W/OBTURATOR NEURECTOMY	No pre-authorization is required for all providers.	N/A
27005	TENOT HIP FLEX OP (SEPART PROC)	No pre-authorization is required for all providers.	N/A
27006	TENOT ABDUCT &/OR EXTEN HIP OP (SEPART PROC)	No pre-authorization is required for all providers.	N/A
27025	FASCIOTOMY HIP/THIGH ANY TYPE	No pre-authorization is required for all providers.	N/A
27027	BUTTOCK FASCIOTOMY	No pre-authorization is required for all providers.	N/A
27030	ARTHROT HIP W/DRAINAGE	No pre-authorization is required for all providers.	N/A
27033	ARTHROT HIP-EXPLOR/REMOV LOOSE BODY/FB	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27035	DENERVAT HIP JT SCIATIC-FEM/OBTURATOR NERV	No pre-authorization is required for all providers.	N/A
27036	CAPSULECT/CAPSULOT HIP W/RELEASE FLEX MUSCL	No pre-authorization is required for all providers.	N/A
27040	BX SOFT TISS PELVIS & HIP AREA; SUPERF	No pre-authorization is required for all providers.	N/A
27041	BX SOFT TISS PELVIS & HIP; DEEP	No pre-authorization is required for all providers.	N/A
27043	EXC HIP PELVIS LES SC > 3 CM	No pre-authorization is required for all providers.	N/A
27045	EXC HIP/PELV TUM DEEP > 5 CM	No pre-authorization is required for all providers.	N/A
27047	EXC TUMOR PELVIS & HIP AREA; SUBQ TISS	No pre-authorization is required for all providers.	N/A
27048	EXC TUMOR PELVIS & HIP AREA; DEEP/SUBFASCIAL/IM	No pre-authorization is required for all providers.	N/A
27049	RESECT HIP/PELV TUM < 5 CM	No pre-authorization is required for all providers.	N/A
27050	ARTHROTOMY W/BX; SACROILIAC JT	No pre-authorization is required for all providers.	N/A
27052	ARTHROTOMY W/BX; HIP JT	No pre-authorization is required for all providers.	N/A
27054	ARTHROTOMY W/SYNOVECTOMY HIP JT	No pre-authorization is required for all providers.	N/A
27057	BUTTOCK FASCIOTOMY W/DBRDMT	No pre-authorization is required for all providers.	N/A
27059	RESECT HIP/PELV TUM 5 CM/>	No pre-authorization is required for all providers.	N/A
27060	EXC; ISCHIAL BURSA	No pre-authorization is required for all providers.	N/A
27062	EXC; TROCH BURSA/CALCIFICATION	No pre-authorization is required for all providers.	N/A
27065	REMOVE HIP BONE LES SUPER	No pre-authorization is required for all providers.	N/A
27066	REMOVE HIP BONE LES DEEP	No pre-authorization is required for all providers.	N/A
27067	REMOVE/GRAFT HIP BONE LESIO	No pre-authorization is required for all providers.	N/A
27070	PART EXC; SUPERF	No pre-authorization is required for all providers.	N/A
27071	PART EXC; DEEP	No pre-authorization is required for all providers.	N/A
27075	RAD RESECT TUMOR/INFEC; WING ILIUM 1 RAMUS/PUBIS	No pre-authorization is required for all providers.	N/A
27076	RAD RESECT TUMOR; ILIUM W/ACETABULUM BOTH RAMI	No pre-authorization is required for all providers.	N/A
27077	RADICAL RESECT TUMOR/INFEC; INNOMINATE BONE TOT	No pre-authorization is required for all providers.	N/A
27078	RAD RESECT TUMOR; ISCHIAL TUBER GRTR TROCHANTER	No pre-authorization is required for all providers.	N/A
27080	COCCYGECTOMY PRIM	No pre-authorization is required for all providers.	N/A
27086	REMOV FB PELVIS/HIP; SUBQ TISS	No pre-authorization is required for all providers.	N/A
27087	REMOV FB PELVIS/HIP; DEEP	No pre-authorization is required for all providers.	N/A
27090	REMOV HIP PROSTH; (SEPART PROC)	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27091	REMOV HIP PROSTH; COMPLIC TOT HIP METHYLMETH	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27093	INJ PROC HIP ARTHROGRAPHY; WO ANES	No pre-authorization is required for all providers.	N/A
27095	INJ PROC HIP ARTHROGRAPHY; W/ANES	No pre-authorization is required for all providers.	N/A
27096	INJECT SACROILIAC JOINT	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
27097	RELEASE/RECESSION HAMSTRING PROX	No pre-authorization is required for all providers.	N/A
27098	TRANSF ADDUCTOR TO ISCHIUM	No pre-authorization is required for all providers.	N/A
27100	TRANSF EXT OBLIQ MUSCL-GR TROCH INCL TENDN EXTEN	No pre-authorization is required for all providers.	N/A
27105	TRANSF PARASPINAL MUSCL TO HIP	No pre-authorization is required for all providers.	N/A
27110	TRANSF ILIOPSOAS; TO GREATER TROCH	No pre-authorization is required for all providers.	N/A
27111	TRANSF ILIOPSOAS; TO FEMORAL NECK	No pre-authorization is required for all providers.	N/A
27120	ACETABULOPLASTY	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27122	ACETABULOPLASTY; RESECT FEM HEAD	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27125	HEMIARTHROPLASTY HIP PART	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27130	ARTHROPLASTY ACETABULAR & PROX FEM PROSTH REPLAC	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27132	CONVERSION PREV HIP TO TOTAL HIP REPLAC W/WO GFT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27134	REVIS TOT HIP ARTHROPLASTY; BOTH COMPON W/WO GFT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27137	REVIS TOT HIP ARTHROPLASTY; ACETABULAR ONLY	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27138	REVIS TOT HIP ARTHROPLASTY; FEMORAL ONLY W/WO GF	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27140	OSTEOTOMY & TRANSF GREATER TROCH (SEPART PROC)	No pre-authorization is required for all providers.	N/A
27146	OSTEOTOMY ILIAC/ACETABULAR/INNOMINATE BONE	No pre-authorization is required for all providers.	N/A
27147	OSTEOTOMY ILIAC/ACETAB/INNOMIN; W/OPEN REDUC HIP	No pre-authorization is required for all providers.	N/A
27151	OSTEOTOMY ILIAC/ACETAB/INNOMIN; W/FEM OSTEOTOMY	No pre-authorization is required for all providers.	N/A
27156	OSTEOTOMY ILIAC; W/FEM OSTEOT & W/OPEN REDUC HIP	No pre-authorization is required for all providers.	N/A
27158	OSTEOT PELVIS BILAT	No pre-authorization is required for all providers.	N/A
27161	OSTEOTOMY FEMORAL NECK (SEPART PROC)	No pre-authorization is required for all providers.	N/A
27165	OSTEOTOMY INTER-/SUBTROCH INCL INT/EXT FIX/CAST	No pre-authorization is required for all providers.	N/A
27170	BONE GFT FEM HEAD/NECK/INTER-SUBTROCH AREA	No pre-authorization is required for all providers.	N/A
27175	TX SLIPPED FEMORAL EPIPHYSIS; BY TRACT WO REDUCT	No pre-authorization is required for all providers.	N/A
27176	TX SLIPPED FEMORAL EPIPHYSIS; BY SNGL/MX PINNING	No pre-authorization is required for all providers.	N/A
27177	OPEN TX SLIP'D FEM EPIPHYS; SNGL/MX PIN/BONE GFT	No pre-authorization is required for all providers.	N/A
27178	OPEN TX SLIP'D FEM EPIPHYS; CLO MANIP W/PINNING	No pre-authorization is required for all providers.	N/A
27179	OPEN TX SLIP'D FEM EPIPHYS; OSTEOPLASTY FEM NECK	No pre-authorization is required for all providers.	N/A
27181	OPEN TX SLIP'D FEM EPIPHYS; OSTEOTOMY & INT FIXA	No pre-authorization is required for all providers.	N/A
27185	EPIPHYSEAL ARREST-EPIPHYSIODESIS/STAPL GRT TROCH	No pre-authorization is required for all providers.	N/A
27187	PROPHYLACTIC TX FEMORAL NECK & PROX FEMUR	No pre-authorization is required for all providers.	N/A
27193	CLO TX PELVIC RING FX/DISLOC/DIASTASIS; WO MANIP	This is no longer a valid code.	N/A
27194	CLO TX PELVIC RING FX/DISLOC; W/MANIP W/ANES	This is no longer a valid code.	N/A
27197	CLSD TX PELVIC RING FX W/O MANIPULATION	No pre-authorization is required for all providers.	N/A
27198	CLSD TX PELVIC RING FX W/MANIPULATION W/ANES	No pre-authorization is required for all providers.	N/A
27200	CLO TX COCCYGEAL FX	No pre-authorization is required for all providers.	N/A
27202	OPEN TX COCCYGEAL FX	No pre-authorization is required for all providers.	N/A
27215	TREAT PELVIC FRACTURE(S)	No pre-authorization is required for all providers.	N/A
27216	TREAT PELVIC RING FRACTURE	No pre-authorization is required for all providers.	N/A

27217	TREAT PELVIC RING FRACTURE	No pre-authorization is required for all providers.	N/A
27218	TREAT PELVIC RING FRACTURE	No pre-authorization is required for all providers.	N/A
27220	CLO TX ACETABULUM FX; WO MANIP	No pre-authorization is required for all providers.	N/A
27222	CLO TX ACETAB FX; W/MANIP W/WO SKELETAL TRACT	No pre-authorization is required for all providers.	N/A
27226	OPEN TX POST/ANT ACETABULAR WALL FX W/INT FIXA	No pre-authorization is required for all providers.	N/A
27227	OPEN TX ACETAB FX INVOL ANT/POST COLUM W/INT FIX	No pre-authorization is required for all providers.	N/A
27228	OPEN TX ACETAB FX W/T-FX W/INT FIXA	No pre-authorization is required for all providers.	N/A
27230	CLO TX FEMORAL FX PROX END NECK; WO MANIP	No pre-authorization is required for all providers.	N/A
27232	CLO TX FEM FX PROX END NECK; W/MANIP W/WO TRACT	No pre-authorization is required for all providers.	N/A
27235	PERCUT SKEL FIX FEM FX PROX END NCK	No pre-authorization is required for all providers.	N/A
27236	OPEN TX FEM FX PROX END NECK INT FIX/PROS REPLAC	No pre-authorization is required for all providers.	N/A
27238	CLO TX INTER/PER-/SUBTROCH FEM FX; WO MANIP	No pre-authorization is required for all providers.	N/A
27240	CLO TX INTER/PER/SUB-TROCHANTER FEM FX; W/MANIP	No pre-authorization is required for all providers.	N/A
27244	TX INTERTROCH FEM FX;PLAT/SCRW IMPL	No pre-authorization is required for all providers.	N/A
27245	TX INTERTROCH FEM FX;IMPL W/WO SCRW	No pre-authorization is required for all providers.	N/A
27246	CLO TX GREATER TROCH FX WO MANIP	No pre-authorization is required for all providers.	N/A
27248	OPEN TREATMENT GREATER TROCHANTERIC FRACTURE	No pre-authorization is required for all providers.	N/A
27250	CLO TX HIP DISLOC TRAUMATIC; WO ANES	No pre-authorization is required for all providers.	N/A
27252	CLO TX HIP DISLOC TRAUMATIC; REQUIRING ANES	No pre-authorization is required for all providers.	N/A
27253	OPEN TX HIP DISLOC TRAUMATIC WO INT FIXA	No pre-authorization is required for all providers.	N/A
27254	OPEN TX HIP DISLOC TRAUMA W/ACETAB & FEM HEAD FX	No pre-authorization is required for all providers.	N/A
27256	TX SPONTAN HIP DISLOC-ABDUCTION; WO ANES/MANIP	No pre-authorization is required for all providers.	N/A
27257	TX SPONTAN HIP DISLOC-ABDUCT; W/MANIP REQ ANES	No pre-authorization is required for all providers.	N/A
27258	OPEN TX SPONTAN HIP DISLOC REPLA FEM HEAD ACETAB	No pre-authorization is required for all providers.	N/A
27259	OPEN TX SPONTAN HIP DISLOC; W/FEM SHAFT SHORTEN	No pre-authorization is required for all providers.	N/A
27265	CLO TX POST HIP ARTHROPLASTY DISLOC; WO ANES	No pre-authorization is required for all providers.	N/A
27266	CLO TX HIP ARTHROPLSTY DISLOC; W/REGION/GEN ANES	No pre-authorization is required for all providers.	N/A
27267	CLTX THIGH FX	No pre-authorization is required for all providers.	N/A
27268	CLTX THIGH FX W/MNPJ	No pre-authorization is required for all providers.	N/A
27269	OPTX THIGH FX	No pre-authorization is required for all providers.	N/A
27275	MANIP HIP JT REQUIRING GEN ANES	No pre-authorization is required for all providers.	N/A
27279	ARTHRODESIS SACROILIAC JOINT	This service is not covered by Superior HealthPlan.	N/A
27280	FUSION OF SACROILIAC JOINT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27282	ARTHRODESIS SYMPHYSIS PUBIS	No pre-authorization is required for all providers.	N/A
27284	ARTHRODESIS HIP JT;	No pre-authorization is required for all providers.	N/A
27286	ARTHRODESIS HIP JT; W/SUBTROCHANTERIC OSTEOT	No pre-authorization is required for all providers.	N/A
27290	INTERPELVABDOMINAL AMPUTA	No pre-authorization is required for all providers.	N/A
27295	DIASART HIP	No pre-authorization is required for all providers.	N/A
27299	UNLISTED PROC PELVIS/HIP JT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27301	I&D DEEP ABSCESS BURSA/HEMATOMA THIGH/KNEE	No pre-authorization is required for all providers.	N/A
27303	INCS DEEP W/OP BONE CORTEX/FEM/KNEE	No pre-authorization is required for all providers.	N/A
27305	FASCIOTOMY ILIOTIBIAL OPEN	No pre-authorization is required for all providers.	N/A
27306	TENOT PERCUT ADDUCT/HAMSTRING; SNGL TENDON (SP)	No pre-authorization is required for all providers.	N/A
27307	TENOT PERCUT ADDUCT/HAMSTRING; MX TENDONS	No pre-authorization is required for all providers.	N/A
27310	ARTHROT KNEE EXPLOR/DRAIN/REMOV FB	No pre-authorization is required for all providers.	N/A
27323	BX SOFT TISS THIGH/KNEE AREA; SUPERF	No pre-authorization is required for all providers.	N/A
27324	BX SOFT TISS THIGH/KNEE AREA; DEEP	No pre-authorization is required for all providers.	N/A
27325	NEURECTOMY, HAMSTRING MUSCLE	No pre-authorization is required for all providers.	N/A
27326	NEURECTOMY, POPLITEAL (GASTROCNEMIUS)	No pre-authorization is required for all providers.	N/A
27327	EXC TUMOR THIGH/KNEE AREA; SUBQ	No pre-authorization is required for all providers.	N/A
27328	EXC TUMOR THIGH/KNEE; DEEP/SUBFASCIAL/IM	No pre-authorization is required for all providers.	N/A
27329	RESECT THIGH/KNEE TUM < 5 CM	No pre-authorization is required for all providers.	N/A
27330	ARTHROTOMY KNEE; W/SYNOVIAL BX ONLY	No pre-authorization is required for all providers.	N/A
27331	ARTHROT KNEE; JT EXPLOR BX/REMOV LOOSE/FB	No pre-authorization is required for all providers.	N/A
27332	ARTHROT EXCIS SEMILUNAR CARTIL KNEE; MEDIAL/LAT	No pre-authorization is required for all providers.	N/A
27333	ARTHROT EXCIS SEMILUNAR CARTIL KNEE; MEDIAL-LAT	No pre-authorization is required for all providers.	N/A
27334	ARTHROT W/SYNOVECT KNEE; ANT/POST	No pre-authorization is required for all providers.	N/A
27335	ARTHROT W/SYNOVECT KNEE; ANT & POST W/POPLITEAL	No pre-authorization is required for all providers.	N/A
27337	EXC THIGH/KNEE LES SC > 3 CM	No pre-authorization is required for all providers.	N/A
27339	EXC THIGH/KNEE TUM DEEP >5CM	No pre-authorization is required for all providers.	N/A
27340	EXC PREPATELLAR BURSA	No pre-authorization is required for all providers.	N/A
27345	EXC SYNOVIAL CYST POPLITEAL SPACE	No pre-authorization is required for all providers.	N/A
27347	EXC LES MENISCUS/CAPSULE KNEE	No pre-authorization is required for all providers.	N/A
27350	PATELLECTOMY/HEMIPATELLECTOMY	No pre-authorization is required for all providers.	N/A
27355	EXC/CURET BONE CYST/BEN TUMOR FEMUR	No pre-authorization is required for all providers.	N/A
27356	EXC/CURET BONE CYST/BEN TUMOR FEMUR; W/ALLOGFT	No pre-authorization is required for all providers.	N/A
27357	EXC/CURET BONE CYST/BEN TUMOR FEMUR; W/AUTOGFT	No pre-authorization is required for all providers.	N/A
27358	EXC/CURET CYST/BEN TUMOR FEM; W/INT FIXA	No pre-authorization is required for all providers.	N/A
27360	PART EXC BONE FEM/PROX TIBIA &/OR FIBULA	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27364	RESECT THIGH/KNEE TUM 5 CM>	No pre-authorization is required for all providers.	N/A
27365	RADICAL RESECT TUMOR BONE FEMUR/KNEE	No pre-authorization is required for all providers.	N/A
27369	NJX PX CNTRST KNE ARTHG CNTRST ENHNCD CT/MRI KNE	No pre-authorization is required for all providers.	N/A
27370	INJECTION FOR KNEE X-RAY	This is no longer a valid code.	N/A
27372	REMOV FB DEEP THIGH REGION/KNEE AREA	No pre-authorization is required for all providers.	N/A
27380	SUTURE INFRAPATELLAR TENDON; PRIM	No pre-authorization is required for all providers.	N/A
27381	SUTURE INFRAPATELLAR TENDON; 2ND RECON INCL GFT	No pre-authorization is required for all providers.	N/A
27385	SUTURE QUADRICEPS/HAMSTRING MUSCL RUPT; PRIM	No pre-authorization is required for all providers.	N/A
27386	SUTURE QUADRICEPS MUSCL RUPT; 2ND RECON INCL GFT	No pre-authorization is required for all providers.	N/A
27390	TENOT OP HAMSTRING KNEE TO HIP; SNGL TENDON	No pre-authorization is required for all providers.	N/A
27391	TENOT OP HAMSTRING KNEE TO HIP; MX TENDON 1 LEG	No pre-authorization is required for all providers.	N/A
27392	TENOT OP HAMSTRING KNEE TO HIP; MX TENDON BILAT	No pre-authorization is required for all providers.	N/A
27393	LENGTHENING HAMSTRING TENDON; SNGL TENDON	No pre-authorization is required for all providers.	N/A
27394	LENGTHENING HAMSTRING TENDON; MX TENDON 1 LEG	No pre-authorization is required for all providers.	N/A
27395	LENGTHENING HAMSTRING TENDON; MX TENDON BILAT	No pre-authorization is required for all providers.	N/A
27396	TRANSPLANT OF THIGH TENDON	No pre-authorization is required for all providers.	N/A
27397	TRANSPLANTS OF THIGH TENDONS	No pre-authorization is required for all providers.	N/A
27400	TRANSF TENDON/MUSCL HAMSTRINGS TO FEM	No pre-authorization is required for all providers.	N/A
27403	ARTHROT W/MENISCUS REPR KNEE	No pre-authorization is required for all providers.	N/A
27405	REPR PRIM TORN LIGAMNT/CAPSULE KNEE; COLLATERAL	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27407	REPR PRIM TORN LIGAMNT/CAPSULE KNEE; CRUCIATE	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27409	REPR PRIM TORN LIGAM KNEE; COLLATERAL & CRUCIATE	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27412	AUTOLOGOUS CHONDROCYTE IMPLANTATION KNEE	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27415	OSTEOCHONDRAL ALLOGRAFT KNEE OPEN	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27416	OSTEOCHONDRAL KNEE AUTOGRAFT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27418	ANT TIBIAL TUBERCLEPLASTY	No pre-authorization is required for all providers.	N/A
27420	RECON DISLOC PATELLA;	No pre-authorization is required for all providers.	N/A
27422	RECON DISLOC PATELLA; EXTEN REALIGNMENT	No pre-authorization is required for all providers.	N/A
27424	RECON RECURRENT DISLOC PATELLA; W/PATELLECTOMY	No pre-authorization is required for all providers.	N/A
27425	LATERAL RETINACULAR RELEASE OPEN	No pre-authorization is required for all providers.	N/A
27427	LIGAMNT RECON KNEE; EXTRA-ARTICULAR	No pre-authorization is required for all providers.	N/A
27428	LIGAMNT RECON KNEE; INTRA-ARTICULAR	No pre-authorization is required for all providers.	N/A
27429	LIGAMNT RECON KNEE; INTRA & EXTRA-ARTICULAR	No pre-authorization is required for all providers.	N/A
27430	QUADRICEPSPLASTY	No pre-authorization is required for all providers.	N/A
27435	CAPSULOT POST CAPSULAR RELEASE KNEE	No pre-authorization is required for all providers.	N/A
27437	ARTHROPLASTY PATELLA; WO PROSTH	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27438	ARTHROPLASTY PATELLA; W/PROSTH	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27440	ARTHROPLASTY KNEE TIBIAL PLATEAU	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27441	ARTHROPLASTY KNEE TIB PLATEAU; W/DEBRID/SYNOVECT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27442	ARTHROPLASTY FEM CONDYLE/TIB PLATEAU KNEES;	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27443	ARTHROPLASTY CONDYLE KNEE; DEBRID PART SYNOVECT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27445	ARTHROPLASTY KNEE HINGE PROSTH	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27446	ARTHROPLASTY KNEE CONDYLE & PLATEAU; MEDIAL/LAT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019

27447	ARTHROPLASTY KNEE CONDYLE & PLATEAU; MED & LAT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27448	OSTEOTOMY FEMUR SHAFT/SUPRACONDYLAR; WO FIXA	No pre-authorization is required for all providers.	N/A
27450	OSTEOTOMY FEMUR SHAFT/SUPRACONDYLAR; W/FIXA	No pre-authorization is required for all providers.	N/A
27454	OSTEOT MX REALIGN INTRAMEDUL ROD FEM SHAFT	No pre-authorization is required for all providers.	N/A
27455	OSTEOTOMY PROX TIBIA; BEFORE EPIPHYSEAL CLO	No pre-authorization is required for all providers.	N/A
27457	OSTEOTOMY PROX TIBIA; AFTER EPIPHYSEAL CLO	No pre-authorization is required for all providers.	N/A
27465	OSTEOPLASTY FEMUR; SHORTENING	No pre-authorization is required for all providers.	N/A
27466	OSTEOPLASTY FEMUR; LENGTHENING	No pre-authorization is required for all providers.	N/A
27468	OSTEOPLASTY FEMUR; COMBO LENGTHEN & SHORTEN	No pre-authorization is required for all providers.	N/A
27470	REPR NON-MALUNION FEMUR DISTAL; WO GFT	No pre-authorization is required for all providers.	N/A
27472	REPR NON-MALUNION FEMUR; W/ILIAC/AUTOGEN GFT	No pre-authorization is required for all providers.	N/A
27475	ARREST EPIPHYSEAL ANY METHD; DIST FEM	No pre-authorization is required for all providers.	N/A
27477	ARREST EPIPHYSEAL ANY METHD; TIBIA & FIBULA PROX	No pre-authorization is required for all providers.	N/A
27479	ARREST EPIPHYSEAL; COMBO DIST FEM PROX TIB-FIB	No pre-authorization is required for all providers.	N/A
27485	ARREST HEMIEPIPHYSEAL DIST FEM/PROX TIBIA/FIBULA	No pre-authorization is required for all providers.	N/A
27486	REVIS TOT KNEE ARTHROPL W/WO ALLOGFT; 1 COMPON	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27487	REVIS TOT KNEE ARTHROPLAS; FEM & WHOLE TIB COMP	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27488	REMOV TOTAL KNEE PROSTH METHYLMETH W/WO SPACER	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27495	PROPHYLACTIC TX W/WO METHYLMETHACRYLATE FEMUR	No pre-authorization is required for all providers.	N/A
27496	DECOMP FASCIOTOMY THIGH &/OR KNEE 1 COMPART	No pre-authorization is required for all providers.	N/A
27497	DECOMP FASCIOT THIGH/KNEE 1 COMPART; W/DEBRID	No pre-authorization is required for all providers.	N/A
27498	DECOMP FASCIOTOMY THIGH &/OR KNEE MX COMPART	No pre-authorization is required for all providers.	N/A
27499	DECOMP FASCIOT THIGH/KNEE MX COMPART; W/DEBRID	No pre-authorization is required for all providers.	N/A
27500	CLO TX FEMORAL SHAFT FX WO MANIP	No pre-authorization is required for all providers.	N/A
27501	CLO TX SUPRA-/TRANSCONDYLAR FEMORAL FX WO MANIP	No pre-authorization is required for all providers.	N/A
27502	CLO TX FEMORAL SHAFT FX W/MANIP W/WO TRACTION	No pre-authorization is required for all providers.	N/A
27503	CLO TX SUPRA-/TRANSCONDYLAR FEM FX W/MANIP	No pre-authorization is required for all providers.	N/A
27506	OPEN TX FEM SHFT FX W/WO FIX W/IMPLNT W/WO SCREW	No pre-authorization is required for all providers.	N/A
27507	OPEN TX FEM SHAFT FX W/PLATE/SCREWS W/WO CERCLAG	No pre-authorization is required for all providers.	N/A
27508	CLO TX FEM FX DIST END MED/LAT CONYLE WO MANIP	No pre-authorization is required for all providers.	N/A
27509	PERCUT SKELET FIX FEM FX DISTAL/FEM EPIPHYSL SEP	No pre-authorization is required for all providers.	N/A
27510	CLO TX FEM FX DIST END MED/LAT CONDYLE W/MANIP	No pre-authorization is required for all providers.	N/A
27511	OPEN TX FEMORAL SUPRACONDYLAR FRACTURE W/O XTN	No pre-authorization is required for all providers.	N/A
27513	OPEN TX FEMORAL SUPRACONDYLAR FRACTURE W XTN	No pre-authorization is required for all providers.	N/A
27514	OPEN TX FEMORAL FRACTURE DISTAL MED/LAT CONDYLE	No pre-authorization is required for all providers.	N/A
27516	CLO TX DIST FEMORAL EPIPHYSEAL SEPART; WO MANIP	No pre-authorization is required for all providers.	N/A
27517	CLO TX FEM EPIPHYSEAL SEPART; W/MANIP W/WO TRACT	No pre-authorization is required for all providers.	N/A
27519	OPEN TX DISTAL FEMORAL EPIPHYSEAL SEPARATION	No pre-authorization is required for all providers.	N/A
27520	CLO TX PATELLAR FX WO MANIP	No pre-authorization is required for all providers.	N/A
27524	OPEN TX PATELLA FX W/FIX PART/COMPLT PATELLECTMY	No pre-authorization is required for all providers.	N/A
27530	CLO TX TIBIAL FX PROX; WO MANIP	No pre-authorization is required for all providers.	N/A
27532	CLO TX TIB FX PROX; W/WO MANIP W/SKELETAL TRACT	No pre-authorization is required for all providers.	N/A
27535	OPEN TX TIBIAL FRACTURE PROXIMAL UNICONDYLAR	No pre-authorization is required for all providers.	N/A
27536	OPEN TX TIBIAL FX PROX; BICONDYLAR W/WO INT FIXA	No pre-authorization is required for all providers.	N/A
27538	CLO TX INTERCOND SPINE/TUBEROS FX KNEE W/WO MANI	No pre-authorization is required for all providers.	N/A
27540	OPEN TX INTERCONDYLAR SPINE/TUBRST FRACTURE KNEE	No pre-authorization is required for all providers.	N/A
27550	CLO TX KNEE DISLOC; WO ANES	No pre-authorization is required for all providers.	N/A
27552	CLO TX KNEE DISLOC; REQUIRING ANES	No pre-authorization is required for all providers.	N/A
27556	OPEN TX KNEE DISLOCATION W/O LIGAMENOUS REPAIR	No pre-authorization is required for all providers.	N/A
27557	OPEN TX KNEE DISLOCATION W LIGAMENOUS REPAIR	No pre-authorization is required for all providers.	N/A
27558	OPEN TX KNEE DISLOCATION W REPAIR/RECONSTRUCTION	No pre-authorization is required for all providers.	N/A
27560	CLO TX PATELLAR DISLOC; WO ANES	No pre-authorization is required for all providers.	N/A
27562	CLO TX PATELLAR DISLOC; REQUIRING ANES	No pre-authorization is required for all providers.	N/A
27566	OPEN TX PATELLA DISLOC W/WO PART/TOT PATELLECTMY	No pre-authorization is required for all providers.	N/A
27570	MANIP KNEE JT UNDER GEN ANES	No pre-authorization is required for all providers.	N/A
27580	ARTHRODESIS KNEE ANY TECH	No pre-authorization is required for all providers.	N/A
27590	AMPUTA THIGH THRU FEMUR ANY LEVEL	No pre-authorization is required for all providers.	N/A
27591	AMPUTA THIGH THRU FEMUR; IMMED FIT INCL 1ST CAST	No pre-authorization is required for all providers.	N/A
27592	AMPUTA THIGH THRU FEMUR ANY LEVEL; OPEN CIRCULAR	No pre-authorization is required for all providers.	N/A
27594	AMPUTA THIGH FEMUR; SECNDRY CLO/SCAR REVIS	No pre-authorization is required for all providers.	N/A
27596	AMPUTA THIGH THRU FEMUR ANY LEVEL; RE-AMPUTA	No pre-authorization is required for all providers.	N/A
27598	DIASART AT KNEE	No pre-authorization is required for all providers.	N/A
27599	UNLISTED PROC FEMUR/KNEE	No pre-authorization is required for all providers.	N/A
27600	DECOMP FASCIOTOMY LEG; ANT &/OR LAT COMPART ONLY	No pre-authorization is required for all providers.	N/A
27601	DECOMP FASCIOTOMY LEG; POST COMPART ONLY	No pre-authorization is required for all providers.	N/A
27602	DECOMP FASCIOT LEG; ANT &/ LAT & POST COMPART	No pre-authorization is required for all providers.	N/A
27603	I&D LEG/ANK; DEEP ABSCESS/HEMATOMA	No pre-authorization is required for all providers.	N/A
27604	I&D LEG/ANK; INFEC BURSA	No pre-authorization is required for all providers.	N/A
27605	TENOT PERCUT ACHILLES (SP); LOCAL ANES	No pre-authorization is required for all providers.	N/A
27606	TENOT PERCUT ACHILLES (SP); GEN ANES	No pre-authorization is required for all providers.	N/A
27607	INCIS LEG/ANK	No pre-authorization is required for all providers.	N/A
27610	ARTHROT ANK-/EXPLOR/DRAIN/REMOV FB	No pre-authorization is required for all providers.	N/A
27612	ARTHROT POST CAPSULAR RELEASE ANK W/WO LENGTHEN	No pre-authorization is required for all providers.	N/A
27613	BX SOFT TISS LEG/ANK AREA; SUPERF	No pre-authorization is required for all providers.	N/A
27614	BX SOFT TISS LEG/ANK AREA; DEEP	No pre-authorization is required for all providers.	N/A
27615	RESECT LEG/ANKLE TUM < 5 CM	No pre-authorization is required for all providers.	N/A
27616	RESECT LEG/ANKLE TUM 5 CM/>	No pre-authorization is required for all providers.	N/A
27618	EXC TUMOR LEG/ANK AREA; SUBQ TISS	No pre-authorization is required for all providers.	N/A
27619	EXC TUMOR LEG/ANK AREA; DEEP	No pre-authorization is required for all providers.	N/A
27620	ARTHROTOMY ANK W/JT EXPLOR W/WO BX-REMOV FB	No pre-authorization is required for all providers.	N/A
27625	ARTHROTOMY W/SYNOVECTOMY ANK;	No pre-authorization is required for all providers.	N/A
27626	ARTHROTOMY W/SYNOVECTOMY ANK; INCL TENOSYNOVECT	No pre-authorization is required for all providers.	N/A
27630	EXC LES TENDON SHEATH/CAPSULE LEG &/OR ANK	No pre-authorization is required for all providers.	N/A
27632	EXC LEG/ANKLE LES SC > 3 CM	No pre-authorization is required for all providers.	N/A
27634	EXC LEG/ANKLE TUM DEEP >5 CM	No pre-authorization is required for all providers.	N/A
27635	EXC/CURET BONE CYST/BEN TUMOR TIBIA/FIBULA	No pre-authorization is required for all providers.	N/A
27637	EXC/CURET BONE CYST/BEN TUMOR TIB/FIB; W/AUTOGFT	No pre-authorization is required for all providers.	N/A
27638	EXC/CURET BONE CYST/BEN TUMOR TIB/FIB; W/ALLOGFT	No pre-authorization is required for all providers.	N/A
27640	PART EXC BONE; TIBIA	No pre-authorization is required for all providers.	N/A
27641	PART EXC BONE; FIBULA	No pre-authorization is required for all providers.	N/A
27645	RADICAL RESECT BONE TUMOR; TIBIA	No pre-authorization is required for all providers.	N/A
27646	RADICAL RESECT BONE TUMOR; FIBULA	No pre-authorization is required for all providers.	N/A
27647	RADICAL RESECT BONE TUMOR; TALUS/CALCAN	No pre-authorization is required for all providers.	N/A
27648	INJ PROC ANK ARTHROGRAPHY	No pre-authorization is required for all providers.	N/A
27650	REPR PRIM OP/PERCUT RUPT ACHILLES TENDON	No pre-authorization is required for all providers.	N/A
27652	REPR PRIM OP/PERCUT RUPT ACHILLES TENDON; W/GFT	No pre-authorization is required for all providers.	N/A
27654	REPR SECNDRY ACHILLES TENDON W/WO GFT	No pre-authorization is required for all providers.	N/A
27656	REPR FASCIAL DEFECT LEG	No pre-authorization is required for all providers.	N/A
27658	REPR FLEX TENDON LEG; PRIM WO GFT EA TENDON	No pre-authorization is required for all providers.	N/A
27659	REPR FLEX TENDON LEG; SECND W/WO GFT EA TENDON	No pre-authorization is required for all providers.	N/A
27664	REPR EXTEN TENDON LEG; PRIM WO GFT EA TENDON	No pre-authorization is required for all providers.	N/A
27665	REPR EXTEN TENDON LEG; SECND W/WO GFT EA TENDON	No pre-authorization is required for all providers.	N/A
27675	REPR DISLOC PERONEAL TENDONS; WO FIB OSTEOT	No pre-authorization is required for all providers.	N/A
27676	REPR DISLOC PERONEAL TENDONS; W/FIB OSTEOT	No pre-authorization is required for all providers.	N/A
27680	TENOLYSIS FLEX/EXTEN-LEG &/OR ANK; 1 EA TENDON	No pre-authorization is required for all providers.	N/A
27681	TENOLYSIS FLEX/EXTEN-LEG &/OR ANK; MX TENDON	No pre-authorization is required for all providers.	N/A
27685	LENGTHEN/SHORTEN TENDON LEG/ANK; SINGL TENDON	No pre-authorization is required for all providers.	N/A
27686	LENGTHEN/SHORTEN TENDON LEG/ANK; MX TENDON	No pre-authorization is required for all providers.	N/A
27687	GASTROCNEMIUS RECESSION	No pre-authorization is required for all providers.	N/A
27690	TRANSF/TRANSPL SNGL TENDON; SUPERF	No pre-authorization is required for all providers.	N/A
27691	TRANSF/TRANSPL SNGL TENDON; DEEP	No pre-authorization is required for all providers.	N/A

27692	TRANSF/TRANSPL SNGL TENDON; EA ADD TENDON	No pre-authorization is required for all providers.	N/A
27695	REPR PRIM DISRUPTED LIGAMNT ANK; COLLATERAL	No pre-authorization is required for all providers.	N/A
27696	REPR PRIM DISRUPTED LIG ANK; BOTH COLLATERAL	No pre-authorization is required for all providers.	N/A
27698	REPR SECNDRY DISRUPTED LIG ANK COLLATERAL	No pre-authorization is required for all providers.	N/A
27700	ARTHROPLASTY ANK	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27702	ARTHROPLASTY ANK; W/IMPLNT (TOT ANK)	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27703	ARTHROPLASTY ANK; REVIS TOT ANK	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27704	REMOV ANK IMPLNT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27705	OSTEOTOMY; TIBIA	No pre-authorization is required for all providers.	N/A
27707	OSTEOTOMY; FIBULA	No pre-authorization is required for all providers.	N/A
27709	OSTEOTOMY; TIBIA & FIBULA	No pre-authorization is required for all providers.	N/A
27712	OSTEOTOMY; MX W/REALIGNMENT INTRAMEDULLARY ROD	No pre-authorization is required for all providers.	N/A
27715	OSTEOPLASTY TIBIA & FIBULA LENGTHEN/SHORTEN	No pre-authorization is required for all providers.	N/A
27720	REPR NONUNION/MALUNION TIBIA; WO GFT	No pre-authorization is required for all providers.	N/A
27722	REPR NONUNION/MALUNION TIBIA; W/SLIDING GFT	No pre-authorization is required for all providers.	N/A
27724	REPR NON/MALUNION TIBIA; W/LIAC-OTHER AUTOGFT	No pre-authorization is required for all providers.	N/A
27725	REPR NON/MALUNION TIBIA; BY SYNSTOSIS W/FIBULA	No pre-authorization is required for all providers.	N/A
27726	REPAIR FIBULA NONUNION	No pre-authorization is required for all providers.	N/A
27727	REPR CONGEN PSEUDARTHROSIS TIBIA	No pre-authorization is required for all providers.	N/A
27730	ARREST EPIPHYSEAL OPEN; DIST TIBIA	No pre-authorization is required for all providers.	N/A
27732	ARREST EPIPHYSEAL OPEN; DIST FIBULA	No pre-authorization is required for all providers.	N/A
27734	ARREST EPIPHYSL OPEN; DIST TIB&FIB	No pre-authorization is required for all providers.	N/A
27740	ARREST EPIPHYSEAL PROX & DIST TIBIA & FIBULA;	No pre-authorization is required for all providers.	N/A
27742	ARREST EPIPHYS PROX-DIST TIBIA-FIBULA; DIST FEM	No pre-authorization is required for all providers.	N/A
27745	PROPHYLACTIC TX W/WO METHYLMETHACRYLATE TIBIA	No pre-authorization is required for all providers.	N/A
27750	CLO TX TIBIAL SHAFT FX; WO MANIP	No pre-authorization is required for all providers.	N/A
27752	CLO TX TIB SHAFT FX; W/MANIP W/WO SKELETAL TRACT	No pre-authorization is required for all providers.	N/A
27756	PERCUT SKELETAL FIXA TIBIAL SHAFT FX	No pre-authorization is required for all providers.	N/A
27758	OPEN TX TIB SHAFT FX W/PLATE/SCREWS W/WO CERCLAG	No pre-authorization is required for all providers.	N/A
27759	TX TIBL SHAFT FX INTRMEDLLRY IMPL	No pre-authorization is required for all providers.	N/A
27760	CLO TX MEDIAL MALLEOLUS FX; WO MANIP	No pre-authorization is required for all providers.	N/A
27762	CLO TX MED MALLEOLUS FX; W/MANIP W/WO TRACTION	No pre-authorization is required for all providers.	N/A
27766	OPEN TREATMENT MEDIAL MALLEOLUS FRACTURE	No pre-authorization is required for all providers.	N/A
27767	CLTX POST ANKLE FX	No pre-authorization is required for all providers.	N/A
27768	CLTX POST ANKLE FX W/MNPJ	No pre-authorization is required for all providers.	N/A
27769	OPTX POST ANKLE FX	No pre-authorization is required for all providers.	N/A
27780	CLO TX PROX FIBULA/SHAFT FX; WO MANIP	No pre-authorization is required for all providers.	N/A
27781	CLO TX PROX FIBULA/SHAFT FX; W/MANIP	No pre-authorization is required for all providers.	N/A
27784	OPEN TREATMENT PROXIMAL FIBULA/SHAFT FRACTURE	No pre-authorization is required for all providers.	N/A
27786	CLO TX DISTAL FIBULAR FX; WO MANIP	No pre-authorization is required for all providers.	N/A
27788	CLO TX DISTAL FIBULAR FX; W/MANIP	No pre-authorization is required for all providers.	N/A
27792	OPEN TX DISTAL FIBULAR FRACTURE LAT MALLEOLUS	No pre-authorization is required for all providers.	N/A
27808	CLOSED TX BIMALLEOLAR ANKLE FRACTURE W/O MNPJ	No pre-authorization is required for all providers.	N/A
27810	CLOSED TX BIMALLEOLAR ANKLE FRACTURE W MNPJ	No pre-authorization is required for all providers.	N/A
27814	OPEN TREATMENT BIMALLEOLAR ANKLE FRACTURE	No pre-authorization is required for all providers.	N/A
27816	CLO TX TRIMALLEOLAR ANK FX; WO MANIP	No pre-authorization is required for all providers.	N/A
27818	CLO TX TRIMALLEOLAR ANK FX; W/MANIP	No pre-authorization is required for all providers.	N/A
27822	OPEN TX TRIMALLEOLAR ANKLE FX W/O FIXJ PST LIP	No pre-authorization is required for all providers.	N/A
27823	OPEN TX TRIMALLEOLAR ANKLE FX W FIXJ PST LIP	No pre-authorization is required for all providers.	N/A
27824	CLO TX FX WT BEARING ARTICUL-DIST TIB; WO MANIP	No pre-authorization is required for all providers.	N/A
27825	CLO TX FX ARTICUL-DIST TIB; W/TRACT/REQ MANIP	No pre-authorization is required for all providers.	N/A
27826	OPEN TREATMENT FRACTURE DISTAL TIBIA FIBULA	No pre-authorization is required for all providers.	N/A
27827	OPEN TREATMENT FRACTURE DISTAL TIBIA ONLY	No pre-authorization is required for all providers.	N/A
27828	OPEN TREATMENT FRACTURE DISTAL TIBIA & FIBULA	No pre-authorization is required for all providers.	N/A
27829	OPEN TX DISTAL TIBIOFIBULAR JOINT DISRUPTION	No pre-authorization is required for all providers.	N/A
27830	CLO TX PROX TIBIOFIBULAR JT DISLOC; WO ANES	No pre-authorization is required for all providers.	N/A
27831	CLO TX PROX TIBIOFIBULAR JT DISLOC; REQ ANES	No pre-authorization is required for all providers.	N/A
27832	OPEN TX PROX TIBFIB JOINT DISLOCATE EXC PROX FIB	No pre-authorization is required for all providers.	N/A
27840	CLO TX ANK DISLOC; WO ANES	No pre-authorization is required for all providers.	N/A
27842	CLO TX ANK DISLOC; REQ ANES W/WO PERCUT SKEL FIX	No pre-authorization is required for all providers.	N/A
27846	OPEN TX ANK DISLOC W/WO PERCUT SKEL FIX; WO REPR	No pre-authorization is required for all providers.	N/A
27848	OPEN TX ANK DISLOC W/WO FIX; W/REPR/INT/EXT FIX	No pre-authorization is required for all providers.	N/A
27860	MANIP ANK UNDER GEN ANES	No pre-authorization is required for all providers.	N/A
27870	ARTHRODESIS, ANKLE, OPEN	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
27871	ARTHRODESIS TIBIOFIBULAR JT PROX/DISTAL	No pre-authorization is required for all providers.	N/A
27880	AMPUTA LEG THRU TIBIA & FIBULA	No pre-authorization is required for all providers.	N/A
27881	AMPUTA LEG THRU TIB & FIB; W/IMMED FIT INCL CAST	No pre-authorization is required for all providers.	N/A
27882	AMPUTA LEG THRU TIBIA & FIBULA; OPEN CIRCULAR	No pre-authorization is required for all providers.	N/A
27884	AMPUTA LEG-TIB & FIB; SECNDRY CLO/SCAR REVIS	No pre-authorization is required for all providers.	N/A
27886	AMPUTA LEG THRU TIBIA & FIBULA; RE-AMPUTA	No pre-authorization is required for all providers.	N/A
27888	AMPUT ANK-MALLEOLI TIBIA/FIBULA PLASTC CLO	No pre-authorization is required for all providers.	N/A
27889	ANK DIASART	No pre-authorization is required for all providers.	N/A
27892	DECOMP FASCIOT LEG; ANT/LAT COMPRT-ONLY W/DEBRID	No pre-authorization is required for all providers.	N/A
27893	DECOMP FASCIOT LEG; POST COMPRT ONLY W/DEBRID	No pre-authorization is required for all providers.	N/A
27894	DECOMP FASCIOT LEG; ANT/LAT/POST COMPRT W/DEBRID	No pre-authorization is required for all providers.	N/A
27899	UNLISTED PROC LEG/ANK	No pre-authorization is required for all providers.	N/A
28001	I&D BURSA FT	No pre-authorization is required for all providers.	N/A
28002	I&D BELOW FASCIA W/WO TENDON FT; 1 BURSAL SPACE	No pre-authorization is required for all providers.	N/A
28003	I&D BELOW FASCIA FT W/WO TENDON; MX AREAS	No pre-authorization is required for all providers.	N/A
28005	INCIS BONE CORTEX FT	No pre-authorization is required for all providers.	N/A
28008	FASCIOTOMY FT &/OR TOE	No pre-authorization is required for all providers.	N/A
28010	TENOT PERCUT TOE; SNGL TENDON	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
28011	TENOT PERCUT TOE; MX TENDON	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
28020	ARTHROT EXPLOR/DRAIN; INTERTARS/TARSOMETATARS JT	No pre-authorization is required for all providers.	N/A
28022	ARTHROT EXPLOR/DRAIN; METATARSOPHALANGEAL JT	No pre-authorization is required for all providers.	N/A
28024	ARTHROT EXPLOR/DRAIN; IP JT	No pre-authorization is required for all providers.	N/A
28035	RELEASE TARSAL TUNNEL	No pre-authorization is required for all providers.	N/A
28039	EXC FOOT/TOE TUM SC > 1.5 CM	No pre-authorization is required for all providers.	N/A
28041	EXC FOOT/TOE TUM DEEP >1.5CM	No pre-authorization is required for all providers.	N/A
28043	EXC TUMOR FT; SUBQ TISS	No pre-authorization is required for all providers.	N/A
28045	EXC TUMOR FT; DEEP/SUBFASCIAL/IM	No pre-authorization is required for all providers.	N/A
28046	RESECT FOOT/TOE TUMOR < 3 CM	No pre-authorization is required for all providers.	N/A
28047	RESECT FOOT/TOE TUMOR 3 CM/>	No pre-authorization is required for all providers.	N/A
28050	ARTHROT W/BX; INTERTARSAL/TARSOMETATARSAL JT	No pre-authorization is required for all providers.	N/A
28052	ARTHROT W/BX; METATARSOPHALANGEAL JT	No pre-authorization is required for all providers.	N/A
28054	ARTHROT W/BX; INTERPHALANGEAL JT	No pre-authorization is required for all providers.	N/A
28055	NEURECTOMY, INTRINSIC MUSCULATURE OF FOOT	No pre-authorization is required for all providers.	N/A
28060	FASCIECTOMY PLANTAR FASCIA; PART (SEP PRO)	No pre-authorization is required for all providers.	N/A
28062	FASCIECTOMY PLANTAR FASCIA; RAD (SEPARAT PRO)	No pre-authorization is required for all providers.	N/A
28070	SYNOVECTOMY; INTERTARSAL/TARSOMETATARSAL JT EA	No pre-authorization is required for all providers.	N/A
28072	SYNOVECTOMY; METATARSOPHALANGEAL JT EA	No pre-authorization is required for all providers.	N/A
28080	EXC INTERDIGITAL NEUROMA SNGL EA	No pre-authorization is required for all providers.	N/A
28086	SYNOVECTOMY TENDON SHEATH FT; FLEXOR	No pre-authorization is required for all providers.	N/A
28088	SYNOVECTOMY TENDON SHEATH FT; EXTENSOR	No pre-authorization is required for all providers.	N/A
28090	EXC LES TENDON/TENDON SHEATH/CAPSULE; FT	No pre-authorization is required for all providers.	N/A
28092	EXC LES TENDON/TENDON SHEATH/CAPSULE; TOE EA	No pre-authorization is required for all providers.	N/A
28100	EXC/CURET BONE CYST/BEN TUMOR TALUS/CALCAN	No pre-authorization is required for all providers.	N/A
28102	EXC/CURET BONE CYST TALUS/CALCAC; W/LIAC/AUTOGFT	No pre-authorization is required for all providers.	N/A
28103	EXC/CURET BONE CYST TALUS/CALCAN; W/ALLOGFT	No pre-authorization is required for all providers.	N/A
28104	EXC/CURET BONE CYST TARSAL/METATARS EX TALUS	No pre-authorization is required for all providers.	N/A

28106	EXC/CURET BONE CYST TARSAL EX TALUS; W/AUTOGFT	No pre-authorization is required for all providers.	N/A
28107	EXC/CURET BONE CYST TARSAL EX TALUS; W/ALLOGFT	No pre-authorization is required for all providers.	N/A
28108	EXC/CURET BONE CYST/BEN TUMOR PHALANGES FT	No pre-authorization is required for all providers.	N/A
28110	OSTEOTOMY PART EXC 5TH METATARSAL HEAD (SEP PRO)	No pre-authorization is required for all providers.	N/A
28111	OSTECTOMY COMPLT EXC; FIRST METATARSAL HEAD	No pre-authorization is required for all providers.	N/A
28112	OSTECTOMY COMPLT EXC; OTHER METATARSAL HEAD	No pre-authorization is required for all providers.	N/A
28113	OSTECTOMY COMPLT EXC; FIFTH METATARSAL HEAD	No pre-authorization is required for all providers.	N/A
28114	OSTEC-COMPLT; ALL METATARS HEADS EXCLD 1ST	No pre-authorization is required for all providers.	N/A
28116	OSTECTOMY EXC TARSAL COALITION	No pre-authorization is required for all providers.	N/A
28118	OSTECTOMY CALCAN	No pre-authorization is required for all providers.	N/A
28119	OSTECTOMY CALCAN; SPUR W/WO PLANTAR FASC RELEASE	No pre-authorization is required for all providers.	N/A
28120	PART EXC BONE; TALUS/CALCAN	No pre-authorization is required for all providers.	N/A
28122	PART EXC BONE; TARSAL/METATARS EX TALUS/CALCAN	No pre-authorization is required for all providers.	N/A
28124	PART EXC BONE; PHALANX TOE	No pre-authorization is required for all providers.	N/A
28126	RESECT PART/COMPLT PHALANX BASE EA TOE	No pre-authorization is required for all providers.	N/A
28130	TALECTOMY	No pre-authorization is required for all providers.	N/A
28140	METATARSECTOMY	No pre-authorization is required for all providers.	N/A
28150	PHALANGECTOMY TOE EA TOE	No pre-authorization is required for all providers.	N/A
28153	RESECT CONDYLE DIST END PHALANX EA TOE	No pre-authorization is required for all providers.	N/A
28160	HEMIPHALANGECT/PT JT EXC TOE PROX PHALANX EA	No pre-authorization is required for all providers.	N/A
28171	RADICAL RESECT BONE TUMOR; TARSAL NOT TALUS/CALC	No pre-authorization is required for all providers.	N/A
28173	RADICAL RESECT BONE TUMOR; METATARSAL	No pre-authorization is required for all providers.	N/A
28175	RADICAL RESECT BONE TUMOR; PHALANX TOE	No pre-authorization is required for all providers.	N/A
28190	REMOV FB FT; SUBQ	No pre-authorization is required for all providers.	N/A
28192	REMOV FB FT; DEEP	No pre-authorization is required for all providers.	N/A
28193	REMOV FB FT; COMPLIC	No pre-authorization is required for all providers.	N/A
28200	REPR TENDON FLEX FT; PRIM/2ND WO GFT EA TENDON	No pre-authorization is required for all providers.	N/A
28202	REPR TENDON FLEX FT; SECND FREE GFT EA TENDON	No pre-authorization is required for all providers.	N/A
28208	REPR TENDON EXTEN FT; PRIM/SECNDRY EA TENDON	No pre-authorization is required for all providers.	N/A
28210	REPR TENDON EXTEN FT; SECND W/GFT EA TENDON	No pre-authorization is required for all providers.	N/A
28220	TENOLYSIS FLEX FT; SINGL TENDON	No pre-authorization is required for all providers.	N/A
28222	TENOLYSIS FLEX FT; MX TENDON	No pre-authorization is required for all providers.	N/A
28225	TENOLYSIS EXTEN FT; SINGL TENDON	No pre-authorization is required for all providers.	N/A
28226	TENOLYSIS EXTEN FT; MX TENDON	No pre-authorization is required for all providers.	N/A
28230	TENOT OP TENDON FLEX; FT SINGL/MX TENDON (SP)	No pre-authorization is required for all providers.	N/A
28232	TENOT OP TENDON FLEX; TOE SINGL TENDON (SP)	No pre-authorization is required for all providers.	N/A
28234	TENOT OP EXTEN FT/TOE EA TENDON	No pre-authorization is required for all providers.	N/A
28238	RECON POST TIBIAL TENDON EXCIS ACCESS NAVICULAR	No pre-authorization is required for all providers.	N/A
28240	TENOTOMY LENGTHEN/RELEASE ABDUCTOR HALLUCIS MUSL	No pre-authorization is required for all providers.	N/A
28250	DIVIS PLANTAR FASCIA & MUSCL (SEPART PROC)	No pre-authorization is required for all providers.	N/A
28260	CAPSULOT MIDFT; MEDIAL RELEASE ONLY (SEP PROC)	No pre-authorization is required for all providers.	N/A
28261	CAPSULOT MIDFOOT; W/TENDON LENGTHENING	No pre-authorization is required for all providers.	N/A
28262	CAPSULOT MIDFT; EXTEN W/POST TALOTIBIAL CAPSUL	No pre-authorization is required for all providers.	N/A
28264	CAPSULOT MIDTARSAL	No pre-authorization is required for all providers.	N/A
28270	CAPSULOT; MTP JT W/WO TENORRHAPHY EA JT (SP)	No pre-authorization is required for all providers.	N/A
28272	CAPSULOT; INTERPHALANGEAL JT-EA JT (SEPART PROC)	No pre-authorization is required for all providers.	N/A
28280	SYNDACTYLIZATION TOES	No pre-authorization is required for all providers.	N/A
28285	CORRECT HAMMERTOES	No pre-authorization is required for all providers.	N/A
28286	CORRECT COCK-UP 5TH TOE W/PLSTC SKIN CLO	No pre-authorization is required for all providers.	N/A
28288	OSTECT PART EXOSTECT/CONDYLECT METATARS HEAD-EA	No pre-authorization is required for all providers.	N/A
28289	CORRJ HALLUX RIGDUS W/O IMPLT	No pre-authorization is required for all providers.	N/A
28290	HALLUX VALGUS-W/WO SESAMOIDECT; SIMPL EXOSTECT	This is no longer a valid code.	N/A
28291	HALLUX RIGIDUS W/CHEILECTOMY 1ST MP JT W/IMPLT	No pre-authorization is required for all providers.	N/A
28292	CORRECTION HALLUX VALGUS	No pre-authorization is required for all providers.	N/A
28293	HALLUX VALGUS W/WO SESAMOIDECT; RESECT JT W/IMPLNT	This is no longer a valid code.	N/A
28294	HALLUX VALGUS W/WO SESAMOIDECT; W/TENDON TRANSPL	This is no longer a valid code.	N/A
28295	CORRJ HALLUX VALGUS W/SESMDC W/PROX METAR OSTEOT	No pre-authorization is required for all providers.	N/A
28296	CORRECTION HALLUX VALGUS	No pre-authorization is required for all providers.	N/A
28297	CORRECTION HALLUX VALGUS	No pre-authorization is required for all providers.	N/A
28298	CORRECTION HALLUX VALGUS	No pre-authorization is required for all providers.	N/A
28299	CORRECTION HALLUX VALGUS	No pre-authorization is required for all providers.	N/A
28300	OSTEOT; CALCAN W/WO INT FIXA	No pre-authorization is required for all providers.	N/A
28302	OSTEOTOMY; TALUS	No pre-authorization is required for all providers.	N/A
28304	OSTEOT TARSAL BONES NOT CALCAN/TALUS;	No pre-authorization is required for all providers.	N/A
28305	OSTEOT TARSAL BONES NOT CALCAN/TALUS; W/AUTOGFT	No pre-authorization is required for all providers.	N/A
28306	OSTEOT W/WO CORRECT METATARSAL; 1ST METATARSAL	No pre-authorization is required for all providers.	N/A
28307	OSTEOT METATARSAL; 1ST METATARSAL W/AUTOGFT	No pre-authorization is required for all providers.	N/A
28308	OSTEOT W/WO CORRECT METATARSAL; NOT 1ST-EA	No pre-authorization is required for all providers.	N/A
28309	OSTEOT W/WO CORRECT METATARSAL; MX	No pre-authorization is required for all providers.	N/A
28310	OSTEOT-SHORTEN-CORRECT; PROX PHALANX 1ST TOE (SP)	No pre-authorization is required for all providers.	N/A
28312	OSTEOT SHORTEN-CORRECT; OTH PHALANGES-ANY TOE	No pre-authorization is required for all providers.	N/A
28313	RECON ANGULAR DEFORM TOE SOFT TISS PROC ONLY	No pre-authorization is required for all providers.	N/A
28315	SESAMOIDECTOMY FIRST TOE (SEPART PROC)	No pre-authorization is required for all providers.	N/A
28320	REPR NONUNION/MALUNION; TARSAL BONES	No pre-authorization is required for all providers.	N/A
28322	REPR NON/MALUNION; METATARSAL W/WO BONE GFT	No pre-authorization is required for all providers.	N/A
28340	RECON TOE MACRODACTYLY; SOFT TISS RESECT	No pre-authorization is required for all providers.	N/A
28341	RECON TOE MACRODACTYLY; REQUIRING BONE RESECT	No pre-authorization is required for all providers.	N/A
28344	RECON TOE; POLYDACTYLY	No pre-authorization is required for all providers.	N/A
28345	RECON TOE; SYNDACTYLY W/WO SKIN GFT EA WEB	No pre-authorization is required for all providers.	N/A
28360	RECON CLEFT FT	No pre-authorization is required for all providers.	N/A
28400	CLO TX CALCAN FX; WO MANIP	No pre-authorization is required for all providers.	N/A
28405	CLO TX CALCAN FX; W/MANIP	No pre-authorization is required for all providers.	N/A
28406	PERCUT SKELETAL FIXA CALCAN FX W/MANIP	No pre-authorization is required for all providers.	N/A
28415	OPEN TREATMENT CALCANEAL FRACTURE	No pre-authorization is required for all providers.	N/A
28420	OPEN TREATMENT CALCANEAL FRACTURE W BONE GRAFT	No pre-authorization is required for all providers.	N/A
28430	CLO TX TALUS FX; WO MANIP	No pre-authorization is required for all providers.	N/A
28435	CLO TX TALUS FX; W/MANIP	No pre-authorization is required for all providers.	N/A
28436	PERCUT SKELETAL FIXA TALUS FX W/MANIP	No pre-authorization is required for all providers.	N/A
28445	OPEN TREATMENT TALUS FRACTURE	No pre-authorization is required for all providers.	N/A
28446	OSTEOCHONDRAL TALUS AUTOGRFT	No pre-authorization is required for all providers.	N/A
28450	TX TARSAL BONE FX; WO MANIP EA	No pre-authorization is required for all providers.	N/A
28455	TX TARSAL BONE FX; W/MANIP EA	No pre-authorization is required for all providers.	N/A
28456	PERCUT SKELETAL FIX TARSAL BONE FX W/MANIP EA	No pre-authorization is required for all providers.	N/A
28465	OPEN TX TARSAL FRACTURE XCP TALUS & CALCANEUS EA	No pre-authorization is required for all providers.	N/A
28470	CLO TX METATARSAL FX; WO MANIP EA	No pre-authorization is required for all providers.	N/A
28475	CLO TX METATARSAL FX; W/MANIP EA	No pre-authorization is required for all providers.	N/A
28476	PERCUT SKELETAL FIXA METATARSAL FX W/MANIP EA	No pre-authorization is required for all providers.	N/A
28485	OPEN TREATMENT METATARSAL FRACTURE EACH	No pre-authorization is required for all providers.	N/A
28490	CLO TX FX GREAT TOE PHALANX/PHALANGES; WO MANIP	No pre-authorization is required for all providers.	N/A
28495	CLO TX FX GRT TOE PHALANX/PHALANGES; W/MANIP	No pre-authorization is required for all providers.	N/A
28496	PERCUT SKELETAL FIX FX GREAT TOE-PHALANX-W/MANIP	No pre-authorization is required for all providers.	N/A
28505	OPEN TX FRACTURE GREAT TOE/PHALANX/PHALANGES	No pre-authorization is required for all providers.	N/A
28510	CLO TX FX PHALANX OTHER THAN GREAT TOE; WO MANIP	No pre-authorization is required for all providers.	N/A
28515	CLO TX FX PHALANX NOT GREAT TOE; W/MANIP EA	No pre-authorization is required for all providers.	N/A
28525	OPEN TX FRACTURE PHALANX/PHALANGES NOT GREAT TOE	No pre-authorization is required for all providers.	N/A
28530	CLO TX SESAMOID FX	No pre-authorization is required for all providers.	N/A
28531	OPEN TX SESAMOID FX W/WO INT FIXA	No pre-authorization is required for all providers.	N/A
28540	CLO TX TARSAL BONE DISLOC-NOT TALOTARS; WO ANES	No pre-authorization is required for all providers.	N/A
28545	CLO TX TARSAL BONE DISLOC NOT TALOTARS; W/ANES	No pre-authorization is required for all providers.	N/A
28546	PERCUT FIX TARSAL DISLOC-NOT TALOTARS W/MANIP	No pre-authorization is required for all providers.	N/A
28555	OPEN TREATMENT TARSAL BONE DISLOCATION	No pre-authorization is required for all providers.	N/A

28570	CLO TX TALOTARSAL JT DISLOC; WO ANES	No pre-authorization is required for all providers.	N/A
28575	CLO TX TALOTARSAL JT DISLOC; REQUIRING ANES	No pre-authorization is required for all providers.	N/A
28576	PERCUT SKELETAL FIX TALOTARSAL JT DISLOC W/MANIP	No pre-authorization is required for all providers.	N/A
28585	OPEN TREATMENT TALOTARSAL JOINT DISLOCATION	No pre-authorization is required for all providers.	N/A
28600	CLO TX TARSOMETATARSAL JT DISLOC; WO ANES	No pre-authorization is required for all providers.	N/A
28605	CLO TX TARSOMETATARSAL JT DISLOC; REQUIRING ANES	No pre-authorization is required for all providers.	N/A
28606	PERCUT SKELETAL FIX TARSOMETAT JT DISLOC W/MANIP	No pre-authorization is required for all providers.	N/A
28615	OPEN TREATMENT TARSOMETATARSAL JOINT DISLOCATION	No pre-authorization is required for all providers.	N/A
28630	CLO TX METATARSOPHALANGEAL JT DISLOC; WO ANES	No pre-authorization is required for all providers.	N/A
28635	CLO TX METATARSOPHALANGEAL JT DISLOC; REQ ANES	No pre-authorization is required for all providers.	N/A
28636	PERCUT SKELET FIX METATARSOPHAL JT DISL W/MANIP	No pre-authorization is required for all providers.	N/A
28645	OPEN TX METATARSOPHALANGEAL JOINT DISLOCATION	No pre-authorization is required for all providers.	N/A
28660	CLO TX IP JT DISLOC; WO ANES	No pre-authorization is required for all providers.	N/A
28665	CLO TX IP JT DISLOC; REQUIRING ANES	No pre-authorization is required for all providers.	N/A
28666	PERCUT SKELETAL FIXA IP JT DISLOC W/MANIP	No pre-authorization is required for all providers.	N/A
28675	OPEN TREATMENT INTERPHALANGEAL JOINT DISLOCATION	No pre-authorization is required for all providers.	N/A
28705	ARTHRODESIS; PANTALAR	No pre-authorization is required for all providers.	N/A
28715	ARTHRODESIS; TRIPLE	No pre-authorization is required for all providers.	N/A
28725	ARTHRODESIS; SUBTALAR	No pre-authorization is required for all providers.	N/A
28730	ARTHRODESIS MIDTARS/TARSOMETAT MX/TRANSVERSE	No pre-authorization is required for all providers.	N/A
28735	ARTHRODESIS MIDTARS/TARSOMETAT MX; W/OSTEOT	No pre-authorization is required for all providers.	N/A
28737	ARTHRODESIS TENDON LENGTHEN/ADVANCE MIDTARSAL	No pre-authorization is required for all providers.	N/A
28740	ARTHRODESIS MIDTARSAL/TARSOMETATARSAL SNGL	No pre-authorization is required for all providers.	N/A
28750	ARTHRODESIS GREAT TOE; METATARSOPHALANGEAL JT	No pre-authorization is required for all providers.	N/A
28755	ARTHRODESIS GREAT TOE; IP JT	No pre-authorization is required for all providers.	N/A
28760	ARTHRODESIS EXTEN HALLUCIS TRANSF-GR TOE IP JT	No pre-authorization is required for all providers.	N/A
28800	AMPUTA FT; MIDTARSAL	No pre-authorization is required for all providers.	N/A
28805	AMPUTA FT; TRANSMETATARSAL	No pre-authorization is required for all providers.	N/A
28810	AMPUTA METATARSAL W/TOE SNGL	No pre-authorization is required for all providers.	N/A
28820	AMPUTA TOE; METATARSOPHALANGEAL JT	No pre-authorization is required for all providers.	N/A
28825	AMPUTA TOE; IP JT	No pre-authorization is required for all providers.	N/A
28890	HI ENRGY ESWT PLANTAR FASCIA	No pre-authorization is required for all providers.	N/A
28899	UNLISTED PROC FT/TOES	No pre-authorization is required for all providers.	N/A
29000	APPLIC HALO TYPE BODY CAST	No pre-authorization is required for all providers.	N/A
29010	APPLIC RISSER JACKET LOCALIZ BODY; ONLY	No pre-authorization is required for all providers.	N/A
29015	APPLIC RISSER JACKET LOCALIZ BODY; INCL HEAD	No pre-authorization is required for all providers.	N/A
29020	APPLIC TURNBUCKLE JACKET BODY; ONLY	This is no longer a valid code.	N/A
29025	APPLIC TURNBUCKLE JACKET BODY; INCL HEAD	This is no longer a valid code.	N/A
29035	APPLIC BODY CAST SHOULDER TO HIPS	No pre-authorization is required for all providers.	N/A
29040	APPLIC BODY CAST SHOULDR-HIPS; INCL HEAD-MINERVA	No pre-authorization is required for all providers.	N/A
29044	APPLIC BODY CAST SHOULDER TO HIPS; INCL 1 THIGH	No pre-authorization is required for all providers.	N/A
29046	APPLIC BODY CAST SHOULDER-HIPS; INCL BOTH THIGHS	No pre-authorization is required for all providers.	N/A
29049	APPLIC; PLASTER FIGURE-8	No pre-authorization is required for all providers.	N/A
29055	APPLIC; SHOULDER SPICA	No pre-authorization is required for all providers.	N/A
29058	APPLIC; PLASTER VELPEAU	No pre-authorization is required for all providers.	N/A
29065	APPLIC; SHOULDER TO HAND	No pre-authorization is required for all providers.	N/A
29075	APPLIC; ELBOW TO FINGER	No pre-authorization is required for all providers.	N/A
29085	APPLIC; HAND & LOWER FOREARM	No pre-authorization is required for all providers.	N/A
29086	APPLICATION OF FINGER CAST	No pre-authorization is required for all providers.	N/A
29105	APPLIC LONG ARM SPLINT	No pre-authorization is required for all providers.	N/A
29125	APPLIC SHORT ARM SPLINT; STATIC	No pre-authorization is required for all providers.	N/A
29126	APPLIC SHORT ARM SPLINT; DYNAMIC	No pre-authorization is required for all providers.	N/A
29130	APPLIC FINGER SPLINT; STATIC	No pre-authorization is required for all providers.	N/A
29131	APPLIC FINGER SPLINT; DYNAMIC	No pre-authorization is required for all providers.	N/A
29200	STRAPPING; THORAX	No pre-authorization is required for all providers.	N/A
29240	STRAPPING; SHOULDER	No pre-authorization is required for all providers.	N/A
29260	STRAPPING; ELBOW/WRIST	No pre-authorization is required for all providers.	N/A
29280	STRAPPING; HAND/FINGER	No pre-authorization is required for all providers.	N/A
29305	APPLIC HIP SPICA CAST; 1 LEG	No pre-authorization is required for all providers.	N/A
29325	APPLIC HIP SPICA CAST; 1-1/2 SPICA/BOTH LEGS	No pre-authorization is required for all providers.	N/A
29345	APPLIC LONG LEG CAST	No pre-authorization is required for all providers.	N/A
29355	APPLIC LONG LEG CAST; WALKER/AMBULATORY TYPE	No pre-authorization is required for all providers.	N/A
29358	APPLIC LONG LEG CAST BRACE	No pre-authorization is required for all providers.	N/A
29365	APPLIC CYLINDER CAST	No pre-authorization is required for all providers.	N/A
29405	APPLIC SHORT LEG CAST	No pre-authorization is required for all providers.	N/A
29425	APPLIC SHORT LEG CAST; WALKING/AMB TYPE	No pre-authorization is required for all providers.	N/A
29435	APPLIC PATELLAR TENDON BEARING CAST	No pre-authorization is required for all providers.	N/A
29440	ADD WALKER TO PREV APPLIC CAST	No pre-authorization is required for all providers.	N/A
29445	APPLIC RIGID TOT CONTACT LEG CAST	No pre-authorization is required for all providers.	N/A
29450	APPLIC CLUBFT CAST W/MOLDING/MANIP LONG/SHORT	No pre-authorization is required for all providers.	N/A
29505	APPLIC LONG LEG SPLINT	No pre-authorization is required for all providers.	N/A
29515	APPLIC SHORT LEG SPLINT	No pre-authorization is required for all providers.	N/A
29520	STRAPPING; HIP	No pre-authorization is required for all providers.	N/A
29530	STRAPPING; KNEE	No pre-authorization is required for all providers.	N/A
29540	STRAPPING; ANKLE AND/OR FOOT	No pre-authorization is required for all providers.	N/A
29550	STRAPPING; TOES	No pre-authorization is required for all providers.	N/A
29580	STRAPPING; UNNA BOOT	No pre-authorization is required for all providers.	N/A
29581	APPLY MULTLAY COMPRS LWR LEG	No pre-authorization is required for all providers.	N/A
29582	APPLY MULTLAY COMPRS UPR LEG	This is no longer a valid code.	N/A
29583	APPLY MULTLAY COMPRS UPR ARM	This is no longer a valid code.	N/A
29584	APPL MULTLAY COMPRS ARM/HAND	No pre-authorization is required for all providers.	N/A
29700	REMOV/BIVALVING; GAUNTLET BOOT BODY CAST	No pre-authorization is required for all providers.	N/A
29705	REMOV/BIVALVING; FULL ARM FULL LEG CAST	No pre-authorization is required for all providers.	N/A
29710	REMOV/BIVALV; SHOULDR/HIP SPICA MINERVA/RISSER	No pre-authorization is required for all providers.	N/A
29715	REMOV/BIVALVING; TURNBUCKLE JACKET	This is no longer a valid code.	N/A
29720	REPR SPICA BODY CAST/JACKET	No pre-authorization is required for all providers.	N/A
29730	WINDOWING CAST	No pre-authorization is required for all providers.	N/A
29740	WEDGING CAST	No pre-authorization is required for all providers.	N/A
29750	WEDGING CLUBFT CAST	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
29799	UNLISTED PROC CASTING/STRAPPING	No pre-authorization is required for all providers.	N/A
29800	ARTHROSCOPY-TMJ-DX W/WO SYNOVIAL BX (SEP PRO)	No pre-authorization is required for all providers.	N/A
29804	ARTHROSCOPY TEMPOROMANDIBULAR JT SURG	No pre-authorization is required for all providers.	N/A
29805	SHOULDER ARTHROSCOPY	No pre-authorization is required for all providers.	N/A
29806	SHOULDER ARTHROSCOPY	No pre-authorization is required for all providers.	N/A
29807	SHOULDER ARTHROSCOPY	No pre-authorization is required for all providers.	N/A
29819	ARTHROSCOPY SHOULDER SURG; W/REMOV LOOSE/FB	No pre-authorization is required for all providers.	N/A
29820	ARTHROSCOPY SHOULDER SURG; SYNOVECTOMY PART	No pre-authorization is required for all providers.	N/A
29821	ARTHROSCOPY SHOULDER SURG; SYNOVECTOMY COMPLT	No pre-authorization is required for all providers.	N/A
29822	ARTHROSCOPY SHOULDER SURG; DEBRID LTD	No pre-authorization is required for all providers.	N/A
29823	ARTHROSCOPY SHOULDER SURG; DEBRID EXTEN	No pre-authorization is required for all providers.	N/A
29824	SHOULDER ARTHROSCOPY	No pre-authorization is required for all providers.	N/A
29825	ARTHROSCOPY SHOULDER SURG; W/LYSIS ADHESIONS	No pre-authorization is required for all providers.	N/A
29826	SHOULDER ARTHROSCOPY/SURGERY	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29827	SCOPE SHLDR SURG; W/ROTOR CUFF REP	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29828	ARTHROSCOPY BICEPS TENODESIS	No pre-authorization is required for all providers.	N/A
29830	ARTHROSCOPY ELBOW DX W/WO SYNOVIAL BX (SEP PRO)	No pre-authorization is required for all providers.	N/A
29834	ARTHROSCOPY ELBOW SURG; W/REMOV LOOSE/FB	No pre-authorization is required for all providers.	N/A
29835	ARTHROSCOPY ELBOW SURG; SYNOVECTOMY PART	No pre-authorization is required for all providers.	N/A
29836	ARTHROSCOPY ELBOW SURG; SYNOVECTOMY COMPLT	No pre-authorization is required for all providers.	N/A
29837	ARTHROSCOPY ELBOW SURG; DEBRID LTD	No pre-authorization is required for all providers.	N/A
29838	ARTHROSCOPY ELBOW SURG; DEBRID EXTEN	No pre-authorization is required for all providers.	N/A

29840	ARTHROSCOPY WRIST DX W/WO SYNOVIAL BX (SEP PRO)	No pre-authorization is required for all providers.	N/A
29843	ARTHROSCOPY WRIST SURG; INFEC/LAVAGE & DRAINAGE	No pre-authorization is required for all providers.	N/A
29844	ARTHROSCOPY WRIST SURG; SYNOVECTOMY PART	No pre-authorization is required for all providers.	N/A
29845	ARTHROSCOPY WRIST SURG; SYNOVECTOMY COMPLT	No pre-authorization is required for all providers.	N/A
29846	ARTHROSCOPY WRIST SURG; EXC/REPR TRIANG FIBROCAR	No pre-authorization is required for all providers.	N/A
29847	ARTHROSCOPY WRIST SURG; INT FIX-FX/INSTABILITY	No pre-authorization is required for all providers.	N/A
29848	ENDO WRIST SURG-RELEAS TRANSVERSE CARPAL LIGAMNT	No pre-authorization is required for all providers.	N/A
29850	ARTHROSCOPICALLY AIDED TX FX KNEE; WO FIX	No pre-authorization is required for all providers.	N/A
29851	ARTHROSCOPICALLY AIDED TX FX KNEE; W/FIX	No pre-authorization is required for all providers.	N/A
29855	ARTHRS AID TIBIAL FRACTURE PROXIMAL UNICONDYLAR	No pre-authorization is required for all providers.	N/A
29856	ARTHRS AID TIBIAL FX PROX UNICONDYLAR BICONDYLAR	No pre-authorization is required for all providers.	N/A
29860	ARTHROSCOPY HIP DX W/WO SYNOVIAL BX (SEP PROC)	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29861	ARTHROSCOPY HIP SURG; W/REMOV LOOSE/FB	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29862	ARTHROSCOPY HIP SURG; DEBRID/SHAV ARTIC CARTIL	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29863	ARTHROSCOPY HIP SURG; W/SYNOVECTOMY	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29866	ARTHROSCOPY KNEE OSTEOCHONDRAL AGRFT MOSAICPLAST	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29867	ARTHROSCOPY KNEE SURG; OSTEOCHONDRAL ALLOGRAFT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29868	ARTHROSCOPY KNEE SURG; MENISCAL TPLNT MED/LAT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29870	ARTHROSCOPY KNEE DX W/WO SYNOVIAL BX (SEP PRO)	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29871	ARTHROSCOPY KNEE SURG; INFEC/LAVAGE & DRAINAGE	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29873	SCOPE KNEE SURGICAL; W/LAT RELEASE	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29874	ARTHROSCOPY KNEE SURG; REMOV LOOSE/FB	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29875	ARTHROSCOPY KNEE SURG; SYNOVECTOMY LTD (SEP PRO)	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29876	ARTHROSCOPY KNEE SURG; SYNOVECTOMY MAJOR	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29877	ARTHROSCOPY KNEE SURG; DEBRID/SHAV ARTIC CARTIL	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29879	ARTHROSCOPY KNEE SURG; ABRASION ARTHROPLASTY	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29880	KNEE ARTHROSCOPY/SURGERY	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29881	KNEE ARTHROSCOPY/SURGERY	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29882	ARTHROSCOPY KNEE SURG; W/MENISCUS REPR (MED/LAT)	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29883	ARTHROSCOPY KNEE SURG; W/MENISCUS REPR (MED & LAT)	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29884	ARTHROSCOPY KNEE SURG; W/LYSIS ADHES (SEP PRO)	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29885	ARTHROSCOPY KNEE SURG; DRILLING W/GFT W/WO FIX	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29886	ARTHROSCOPY KNEE SURG; DRILL-OSTEOCHOND LES	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29887	ARTHROSCOPY KNEE; DRILL-OSTEOCHOND LES W/FIXA	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29888	ARTHROSCOPICALLY AIDED ACL REPAIR/AUGMENT/RECON	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29889	ARTHROSCOPICALLY AIDED PCL REPAIR/AUGMENT/RECON	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29891	ARTHROSCOPY ANK SURG; EXC DEFEC TALUS & TIBIA	No pre-authorization is required for all providers.	N/A
29892	ARTHROSCOPICALLY AIDED REPR OSTEO LES-TAL/TIB FX	No pre-authorization is required for all providers.	N/A
29893	ENDOSCOPIC PLANTAR FASCIOTOMY	No pre-authorization is required for all providers.	N/A
29894	ARTHROSCOPY ANK SURG; W/REMOV LOOSE/FB	No pre-authorization is required for all providers.	N/A
29895	ARTHROSCOPY ANK SURG; SYNOVECTOMY PART	No pre-authorization is required for all providers.	N/A
29897	ARTHROSCOPY ANK SURG; DEBRID LTD	No pre-authorization is required for all providers.	N/A
29898	ARTHROSCOPY ANK SURG; DEBRID EXTEN	No pre-authorization is required for all providers.	N/A
29899	SCOPE ANKLE SURG; W/ANK ARTHRODESIS	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29900	METACARPOPHALENGEAL JOINT ARTHROSCOPY	No pre-authorization is required for all providers.	N/A
29901	METACARPOPHALENGEAL JOINT ARTHROSCOPY	No pre-authorization is required for all providers.	N/A
29902	METACARPOPHALENGEAL JOINT ARTHROSCOPY	No pre-authorization is required for all providers.	N/A
29904	SUBTALAR ARTHRO W/FB RMVL	No pre-authorization is required for all providers.	N/A
29905	SUBTALAR ARTHRO W/EXC	No pre-authorization is required for all providers.	N/A
29906	SUBTALAR ARTHRO W/DEB	No pre-authorization is required for all providers.	N/A
29907	SUBTALAR ARTHRO W/FUSION	No pre-authorization is required for all providers.	N/A
29914	HIP ARTHRO W/FEMOROPLASTY	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29915	HIP ARTHRO ACETABULOPLASTY	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29916	HIP ARTHRO W/LABRAL REPAIR	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
29999	UNLISTED ARTHROSCOPY PROCEDURE	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
30000	DRAINAGE ABSCESS/HEMATOMA-NASAL-INT APPROACH	No pre-authorization is required for all providers.	N/A
30020	DRAINAGE ABSCESS/HEMATOMA NASAL SEPTUM	No pre-authorization is required for all providers.	N/A
30100	BX INTRANASAL	No pre-authorization is required for all providers.	N/A
30110	EXC NASAL POLYP SIMPL	No pre-authorization is required for all providers.	N/A
30115	EXC NASAL POLYP EXTEN	No pre-authorization is required for all providers.	N/A
30117	EXC/DESTRCT INTRANASAL LES; INT APPROACH	No pre-authorization is required for all providers.	N/A
30118	EXC/DESTRCT INTRANASAL LES; EXT APPROACH	No pre-authorization is required for all providers.	N/A
30120	EXC/SURG PLANING SKIN NOSE RHINOPHYMA	Pre-authorization is required for all providers.	Prior to 09/01/2019
30124	EXC DERMOID CYST NOSE; SIMPL SKIN SUBQ	No pre-authorization is required for all providers.	N/A
30125	EXC DERMOID CYST NOSE; COMPLX UNDER BONE/CARTIL	No pre-authorization is required for all providers.	N/A
30130	EXC TURBINATE PART/COMPLT ANY METHD	No pre-authorization is required for all providers.	N/A
30140	SUBMUCOUS RESECT TURBINATE PART/COMPLT ANY METHD	No pre-authorization is required for all providers.	N/A
30150	RHINECTOMY; PART	No pre-authorization is required for all providers.	N/A
30160	RHINECTOMY; TOT	No pre-authorization is required for all providers.	N/A
30200	INJ INTO TURBINATE THERAP	No pre-authorization is required for all providers.	N/A
30210	DISPLACEMENT THERAP	No pre-authorization is required for all providers.	N/A
30220	INSRT NASAL SEPTAL PROSTH	No pre-authorization is required for all providers.	N/A
30300	REMOV FB INTRANASAL; OFFIC TYPE PROC	No pre-authorization is required for all providers.	N/A
30310	REMOV FB INTRANASAL; REQUIRING GEN ANES	No pre-authorization is required for all providers.	N/A
30320	REMOV FB INTRANASAL; BY LAT RHINOTOMY	No pre-authorization is required for all providers.	N/A
30400	RHINOPLASTY PRIM; LAT & ALAR CARTIL/ELEVAT TIP	Pre-authorization is required for all providers.	Prior to 09/01/2019
30410	RHINOPLASTY PRIM; COMPLT-EXT PARTS-ELEVAT TIP	Pre-authorization is required for all providers.	Prior to 09/01/2019
30420	RHINOPLASTY PRIMARY; INCL MAJOR SEPTAL REPR	Pre-authorization is required for all providers.	Prior to 09/01/2019
30430	RHINOPLASTY SECNDRY; MINOR REVIS	Pre-authorization is required for all providers.	Prior to 09/01/2019
30435	RHINOPLASTY SECNDRY; INTERMED REVIS	Pre-authorization is required for all providers.	Prior to 09/01/2019
30450	RHINOPLASTY SECNDRY; MAJOR REVIS	Pre-authorization is required for all providers.	Prior to 09/01/2019
30460	RHINOPLASTY-DEFORM CLEFT LIP; TIP ONLY	Pre-authorization is required for all providers.	Prior to 09/01/2019
30462	RHINOPLASTY-DEFORM CLEFT LIP; TIP/SEPTUM/OSTEOT	Pre-authorization is required for all providers.	Prior to 09/01/2019
30465	REPR NASAL VESTIBULAR STENOSIS 21.58	Pre-authorization is required for all providers.	Prior to 09/01/2019
30520	SEPTOPLASTY/SMR W/WO CARTIL SCORING/REPLAC W/GFT	Pre-authorization is required for all providers.	Prior to 09/01/2019
30540	REPR CHOANAL ATRESIA; INTRANASAL	No pre-authorization is required for all providers.	N/A
30545	REPR CHOANAL ATRESIA; TRANSPALATINE	No pre-authorization is required for all providers.	N/A
30560	LYSIS INTRANASAL SYNECHIA	No pre-authorization is required for all providers.	N/A
30580	REPR FISTULA; OROMAXILLARY	No pre-authorization is required for all providers.	N/A
30600	REPR FISTULA; ORONASAL	No pre-authorization is required for all providers.	N/A
30620	SEPTAL/OTHER INTRANASAL DERMATOPLASTY	Pre-authorization is required for all providers.	Prior to 09/01/2019
30630	REPR NASAL SEPTAL PERFORATIONS	Pre-authorization is required for all providers.	Prior to 09/01/2019
30801	CAUT MUCOSA TURBIN UNI-/BILAT (SEP PRO); SUPERF	No pre-authorization is required for all providers.	N/A
30802	CAUT MUCOS TURBIN UNI-/BILAT (SEP PRO); INTRAMUR	No pre-authorization is required for all providers.	N/A
30901	CONTRL NASAL HEMORR-ANT-SIMPL ANY METHD	No pre-authorization is required for all providers.	N/A
30903	CONTRL NASAL HEMORR-ANT-COMPLX ANY METHD	No pre-authorization is required for all providers.	N/A
30905	CONTRL NASAL HEMORR-POST-W/PACKS-CAUT; INIT	No pre-authorization is required for all providers.	N/A
30906	CONTRL NASAL HEMORR-POST-W/PACKS-CAUT; SUBSQ	No pre-authorization is required for all providers.	N/A
30915	LIG ART; ETHMO	No pre-authorization is required for all providers.	N/A
30920	LIG ART; INT MAXIL ART TRANSANTRAL	No pre-authorization is required for all providers.	N/A
30930	FX NASAL TURBINATE THERAP	No pre-authorization is required for all providers.	N/A
30999	UNLISTED PROC NOSE	No pre-authorization is required for all providers.	N/A
31000	LAVAGE BY CANNULATION; MAXIL SINUS	No pre-authorization is required for all providers.	N/A
31002	LAVAGE BY CANNULATION; SPHENOID SINUS	No pre-authorization is required for all providers.	N/A
31020	SINUSOTOMY MAXIL; INTRANASAL	No pre-authorization is required for all providers.	N/A
31030	SINUSOTOMY MAXIL; RAD WO REMOV ANTROCHOANAL POLYP	No pre-authorization is required for all providers.	N/A
31032	SINUSOTOMY MAXIL; RAD W/REMOV ANTROCHOANAL POLYPS	No pre-authorization is required for all providers.	N/A
31040	PTERYGOMAXILLARY FOSSA SURG ANY APPROACH	No pre-authorization is required for all providers.	N/A
31050	SINUSOTOMY SPHENOID W/WO BX	No pre-authorization is required for all providers.	N/A
31051	SINUSOTOMY SPHENOID W/WO BX; W/MUCOS STRIPPING	No pre-authorization is required for all providers.	N/A
31070	SINUSOTOMY FRONTAL; EXT SIMPL	No pre-authorization is required for all providers.	N/A
31075	SINUSOTOMY FRONTAL; TRANSORBITAL UNILAT	No pre-authorization is required for all providers.	N/A

31080	SINUSOTOMY FRONTAL; OBLIT-W/O FLAP-BROW INCS	No pre-authorization is required for all providers.	N/A
31081	SINUSOTOMY FRONTAL; OBLIT WO FLAP CORONAL INCS	No pre-authorization is required for all providers.	N/A
31084	SINUSOTOMY FRONTAL; OBLIT-W/FLAP-BROW INCS	No pre-authorization is required for all providers.	N/A
31085	SINUSOTOMY FRONTAL; OBLIT-W/FLAP-CORONAL INCS	No pre-authorization is required for all providers.	N/A
31086	SINUSOTOMY FRONT; NONOBLIT W/FLAP-BROW INCS	No pre-authorization is required for all providers.	N/A
31087	SINUSOTOMY FRONT; NONOBLIT W/FLAP-CORONAL INCS	No pre-authorization is required for all providers.	N/A
31090	SINUSOTOMY UNILAT 3/MORE PARANASAL SINUSES	No pre-authorization is required for all providers.	N/A
31200	ETHMO; INTRANASAL ANT	No pre-authorization is required for all providers.	N/A
31201	ETHMO; INTRANASAL TOT	No pre-authorization is required for all providers.	N/A
31205	ETHMO; EXTRANASAL TOT	No pre-authorization is required for all providers.	N/A
31225	MAXILLECTOMY; WO ORBITAL EXENTERATION	No pre-authorization is required for all providers.	N/A
31230	MAXILLECTOMY; W/ORBITAL EXENTERATION	No pre-authorization is required for all providers.	N/A
31231	NASAL ENDO DX UNILAT/BILAT (SEPART PROC)	No pre-authorization is required for all providers.	N/A
31233	NASAL/SINUS ENDOSCOPY DX MAXILLARY SINUSOSCOPY	No pre-authorization is required for all providers.	N/A
31235	NASAL/SINUS ENDOSCOPY DX SPHENOID SINUSOSCOPY	No pre-authorization is required for all providers.	N/A
31237	NASAL/SINUS ENDO SURG; W/BX/POLYPECT (SEP PROC)	No pre-authorization is required for all providers.	N/A
31238	NASAL/SINUS ENDO SURG; W/CONTRL EPISTAXIS	No pre-authorization is required for all providers.	N/A
31239	NASAL/SINUS ENDO SURG; W/DACRYOCYSTORHINOSTOMY	No pre-authorization is required for all providers.	N/A
31240	NASAL/SINUS ENDO SURG; W/CONCHA BULLOSA RESECT	No pre-authorization is required for all providers.	N/A
31241	NSL/SINS NDSC W/ARTERY LIG	No pre-authorization is required for all providers.	N/A
31253	NSL/SINS NDSC TOTAL	No pre-authorization is required for all providers.	N/A
31254	NSL/SINS NDSC W/PRTL ETHMDCT	No pre-authorization is required for all providers.	N/A
31255	NSL/SINS NDSC W/TOT ETHMDCT	No pre-authorization is required for all providers.	N/A
31256	NASAL/SINUS ENDO-OR-W/MAXIL ANTROSTOMY;	No pre-authorization is required for all providers.	N/A
31257	NSL/SINS NDSC TOT W/SPHENDT	No pre-authorization is required for all providers.	N/A
31259	NSL/SINS NDSC SPHN TISS RMVL	No pre-authorization is required for all providers.	N/A
31267	NASAL/SINUS ENDO-OR-W/MAXIL ANTROS; W/TISS REMOV	No pre-authorization is required for all providers.	N/A
31276	NSL/SINS NDSC FRNT TISS RMVL	No pre-authorization is required for all providers.	N/A
31287	NASAL/SINUS ENDO SURG W/SPHENOIDOTOMY	No pre-authorization is required for all providers.	N/A
31288	NASAL/SINUS ENDO W/SPHENOIDOT; REMOV TISS-SINUS	No pre-authorization is required for all providers.	N/A
31290	NASAL ENDO SURG REPR CSF LEAK; ETHMOID REGION	No pre-authorization is required for all providers.	N/A
31291	NASAL ENDO SURG REPR CSF LEAK; SPHENOID REGION	No pre-authorization is required for all providers.	N/A
31292	NASAL/SINUS NDSC SURG MEDIAL/INF ORB WALL DCMPRN	No pre-authorization is required for all providers.	N/A
31293	NASAL/SINUS NDSC SURG MEDIAL AND INF ORB WALL DCMPRN	No pre-authorization is required for all providers.	N/A
31294	NASAL/SINUS NDSC SURG W/OPTIC NERVE DCMPRN	No pre-authorization is required for all providers.	N/A
31295	NASAL/SINUS NDSC SURG W/DILATION MAXILLARY SINUS	No pre-authorization is required for all providers.	N/A
31296	NASAL/SINUS NDSC SURG W/DILATION FRONTAL SINUS	No pre-authorization is required for all providers.	N/A
31297	NASAL/SINUS NDSC SURG W/DILATION SPHENOID SINUS	No pre-authorization is required for all providers.	N/A
31298	NASAL/SINUS NDSC SURG W/DILATION FRNT AND SPHN SINUS	No pre-authorization is required for all providers.	N/A
31299	UNLISTED PROC ACCES SINUSES	No pre-authorization is required for all providers.	N/A
31300	REMOVAL OF LARYNX LESION	No pre-authorization is required for all providers.	N/A
31320	LARYNGOTOMY; DX	This is no longer a valid code.	N/A
31360	LARYNGECTOMY; TOT WO RADICAL NECK DISSECTION	No pre-authorization is required for all providers.	N/A
31365	LARYNGECTOMY; TOT W/RADICAL NECK DISSECTION	No pre-authorization is required for all providers.	N/A
31367	LARYNGECTOMY; SUBTL SUPRAGLOTTIC WO RAD NECK	No pre-authorization is required for all providers.	N/A
31368	LARYNGECTOMY; SUBTL SUPRAGLOTTIC W/RAD NECK	No pre-authorization is required for all providers.	N/A
31370	PART LARYNGECTOMY; HORIZONTAL	No pre-authorization is required for all providers.	N/A
31375	PART LARYNGECTOMY; LATEROVERTICAL	No pre-authorization is required for all providers.	N/A
31380	PART LARYNGECTOMY; ANTEROVERTICAL	No pre-authorization is required for all providers.	N/A
31382	PART LARYNGECTOMY; ANTERO-LATERO-VERTICAL	No pre-authorization is required for all providers.	N/A
31390	PHARYNGOLARYNGECTOMY W/RAD NECK WO RECON	No pre-authorization is required for all providers.	N/A
31395	PHARYNGOLARYNGECTOMY W/RAD NECK; W/RECON	No pre-authorization is required for all providers.	N/A
31400	ARYTENOIDECTOMY/ARYTENOIDOPEXY EXT APPROACH	No pre-authorization is required for all providers.	N/A
31420	EPIGLOTTIDECTOMY	No pre-authorization is required for all providers.	N/A
31500	INTUBATION ENDOTRACHEAL EMER PROC	No pre-authorization is required for all providers.	N/A
31502	TRACHEOTOMY TUBE CHANGE BEFOR ESTAB FISTULA TRAC	No pre-authorization is required for all providers.	N/A
31505	LARYNGOSCOPY INDIRECT (SEPART PROC); DX	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
31510	LARYNGOSCOPY INDIRECT (SEPART PROC); W/BX	No pre-authorization is required for all providers.	N/A
31511	LARYNGOSCOPY INDIRECT (SEPART PROC); W/REMOV FB	No pre-authorization is required for all providers.	N/A
31512	LARYNGOSCOPY INDIRECT (SEPART PROC); W/REMOV LES	No pre-authorization is required for all providers.	N/A
31513	LARYNGOSCOPY INDIREC (SEP PRO); W/VOCAL CORD INJ	No pre-authorization is required for all providers.	N/A
31515	LARYNGOSCOPY DIRECT W/WO TRACHEOSCOPY; ASPIRAT	No pre-authorization is required for all providers.	N/A
31520	LARYNGOSCOPY DIRECT W/WO TRACHEOSCOPY; DX NB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
31525	LARYNGOSCOPY DIRECT W/WO TRACHEOSCOPY; DX EX NB	No pre-authorization is required for all providers.	N/A
31526	LARYNGOSCOPY DIR W/WO TRACHEOSCPY; DX W/OR MICRO	No pre-authorization is required for all providers.	N/A
31527	LARYNGOSCOPY DIRECT; W/INSRT OBTURATOR	No pre-authorization is required for all providers.	N/A
31528	LARYNGOSCOPY DIR W/WO TRACHEOSCOPY; W/DILAT INIT	No pre-authorization is required for all providers.	N/A
31529	LARYNGOSCOPY DIR W/WO TRACHEOSCP; W/DILAT SUBSQT	No pre-authorization is required for all providers.	N/A
31530	LARYNGOSCOPY DIRECT OR W/FB REMOV	No pre-authorization is required for all providers.	N/A
31531	LARYNGOSCOPY DIRECT OR W/FB REMOV; W/OR MICRO	No pre-authorization is required for all providers.	N/A
31535	LARYNGOSCOPY DIRECT OR W/BX	No pre-authorization is required for all providers.	N/A
31536	LARYNGOSCOPY DIRECT OR W/BX; W/OPERATING MICRO	No pre-authorization is required for all providers.	N/A
31540	LARYNGOSCOPY DIR OR W/EXC TUMOR/STRIP VOCAL CORD	No pre-authorization is required for all providers.	N/A
31541	LARYNGOSCOPY DIR OR W/EXC TUMOR; W/OR MICRO	No pre-authorization is required for all providers.	N/A
31545	LARYN OP MIC REMV LES VC; RECNSTR W/LOC TISS FLP	No pre-authorization is required for all providers.	N/A
31546	LARYN OP MIC REMV LES VOCAL CORD; RECNSTR W/GFT	No pre-authorization is required for all providers.	N/A
31551	LARYNGOPLASTY LARYNGEAL STEN W/O STENT < 12 YRS	No pre-authorization is required for all providers.	N/A
31552	LARYNGOPLASTY LARYNGEAL STEN W/O STENT 12 YRS >	No pre-authorization is required for all providers.	N/A
31553	LARYNGOPLASTY LARYNGEAL STEN W/STENT < 12 YRS	No pre-authorization is required for all providers.	N/A
31554	LARYNGOPLASTY LARYNGEAL STEN W/STENT 12 YRS >	No pre-authorization is required for all providers.	N/A
31560	LARYNGOSCOPY DIRECT OR W/ARYTENOIDECTOMY	No pre-authorization is required for all providers.	N/A
31561	LARYNGOSCOPY DIR OR W/ARYTENOIDECT; W/OR MICRO	No pre-authorization is required for all providers.	N/A
31570	LARYNGOSCOPY DIR W/INJ INTO VOCAL CORDS; THERAP	No pre-authorization is required for all providers.	N/A
31571	LARYNGOSCP DIR W/INJ VOCAL CORDS THERAP; W/MICRO	No pre-authorization is required for all providers.	N/A
31572	LARYNGOSCOPY FLEXIBLE ABLATJ DESTJ LESION(S) UNI	No pre-authorization is required for all providers.	N/A
31573	LARYNGOSCOPY FLEXIBLE THERAPEUTIC INJECTION UNI	No pre-authorization is required for all providers.	N/A
31574	LARYNGOSCOPY FLEXIBLE W/INJECTION AGMNTJ UNI	No pre-authorization is required for all providers.	N/A
31575	DIAGNOSTIC LARYNGOSCOPY	No pre-authorization is required for all providers.	N/A
31576	LARYNGOSCOPY WITH BIOPSY	No pre-authorization is required for all providers.	N/A
31577	LARGSC W/RMVL FOREIGN BDY(S)	No pre-authorization is required for all providers.	N/A
31578	LARGSC W/REMOVAL LESION	No pre-authorization is required for all providers.	N/A
31579	LARYNGOSCOPY TELESCOPIC	No pre-authorization is required for all providers.	N/A
31580	LARYNGOPLASTY LARYNGEAL WEB	No pre-authorization is required for all providers.	N/A
31582	LARYNGOPLASTY; STENOSIS W/GFT INCL TRACHEOTOMY	This is no longer a valid code.	N/A
31584	LARYNGOPLASTY FX RDCTJ FIXJ	No pre-authorization is required for all providers.	N/A
31587	LARYNGOPLASTY CRICOID SPLIT	No pre-authorization is required for all providers.	N/A
31588	LARYNGOPLASTY NOS	This is no longer a valid code.	N/A
31590	LARYNGEAL REINNERVATION BY NEUROMUSCULAR PEDICLE	No pre-authorization is required for all providers.	N/A
31591	LARYNGOPLASTY MEDIALIZATION UNILATERAL	No pre-authorization is required for all providers.	N/A
31592	CRICOTRACHEAL RESECTION	No pre-authorization is required for all providers.	N/A
31595	SECT RECUR LARYNGEAL NERV THERAP (SEP PRO) UNILA	This is no longer a valid code.	N/A
31599	UNLISTED PROC LARYNX	No pre-authorization is required for all providers.	N/A
31600	TRACHEOSTOMY PLANNED (SEPART PROC)	No pre-authorization is required for all providers.	N/A
31601	TRACHEOSTOMY PLANNED (SEPART PROC); UNDER 2 YR	No pre-authorization is required for all providers.	N/A
31603	TRACHEOSTOMY EMER PROC; TRANSTRACHEAL	No pre-authorization is required for all providers.	N/A
31605	TRACHEOSTOMY EMER PROC; CRICOTHYROID MEMBRN	No pre-authorization is required for all providers.	N/A
31610	TRACHEOSTOMY FENESTRATION PROC W/SKIN FLAPS	No pre-authorization is required for all providers.	N/A
31611	SURGERY/SPEECH PROSTHESIS	No pre-authorization is required for all providers.	N/A
31612	TRACHEAL PUNCT-PERCUT-W/TRANSTRACH ASPIRAT/INJ	No pre-authorization is required for all providers.	N/A
31613	TRACHEOSTOMA REVIS; SIMPL WO FLAP ROTATION	No pre-authorization is required for all providers.	N/A
31614	TRACHEOSTOMA REVIS; COMPLX W/FLAP ROTATION	No pre-authorization is required for all providers.	N/A

31615	TRACHEOBRONCHOSCOPY THRU ESTAB TRACHEOSTOMY INCS	No pre-authorization is required for all providers.	N/A
31620	ENDOBONCHIAL US DUR BRONCHOSCOPY DX/TX INTERVEN	This is no longer a valid code.	N/A
31622	BRONCHOSCOPY W/WOUT FLUOROSCOPIC GUIDANCE	No pre-authorization is required for all providers.	N/A
31623	BRONCHOSCOPY; W/BRUSHING/PROTECTIVE BRUSHINGS	No pre-authorization is required for all providers.	N/A
31624	BRONCHOSCOPY; W/ BRONCH ALVEOLAR LAVAGE	No pre-authorization is required for all providers.	N/A
31625	BRONCHOSCOPY BRONCHIAL/ENDOBONCHIAL	No pre-authorization is required for all providers.	N/A
31626	BRONCHOSCOPY W/MARKERS	No pre-authorization is required for all providers.	N/A
31627	NAVIGATIONAL BRONCHOSCOPY	No pre-authorization is required for all providers.	N/A
31628	WITH TRANSBRONCHIAL LUNG BIOPSY(S), SINGLE LOBE	No pre-authorization is required for all providers.	N/A
31629	BRNCHSCPY NABX TRACH STEM&BRNCH	No pre-authorization is required for all providers.	N/A
31630	BRONCHOSCPY; W/TRACH/BRNCH DILAT/CLO REDUCT FX	No pre-authorization is required for all providers.	N/A
31631	BRONCHOSCOPY; W/TRACH DILAT PLCMT TRACHEAL STENT	No pre-authorization is required for all providers.	N/A
31632	BRNCHSCPY W/TBLB EA ADD LOBE	No pre-authorization is required for all providers.	N/A
31633	BRNCHSCPY W/TBNA BX EA ADD LOBE	No pre-authorization is required for all providers.	N/A
31634	BRONCH W/BALLOON OCCLUSION	No pre-authorization is required for all providers.	N/A
31635	BRONCHOSCOPY; W/REMOV FB	No pre-authorization is required for all providers.	N/A
31636	BRNCHSCPY RIGD/FLX;PLCMT BRNCH STNT INIT BRNCHUS	No pre-authorization is required for all providers.	N/A
31637	BRNCHSCPY RIGD/FLX; EA ADD MAJ BRONCHUS STNTD	No pre-authorization is required for all providers.	N/A
31638	BRNCHSCPY; REV TRACH/BRNCH STNT INSRT PREV SESS	No pre-authorization is required for all providers.	N/A
31640	BRONCHOSCOPY; W/EXC TUMOR	No pre-authorization is required for all providers.	N/A
31641	BRONCHOSCOPY; W/DESTRUCT TUMOR/RELIEF STENOSIS	No pre-authorization is required for all providers.	N/A
31643	BRONCHOSCOPY; W/CATH PLCMT-INTRACAV RAD APPLIC	No pre-authorization is required for all providers.	N/A
31645	BRNCHSC W/THER ASPIR 1ST	No pre-authorization is required for all providers.	N/A
31646	BRNCHSC W/THER ASPIR SBSQ	No pre-authorization is required for all providers.	N/A
31647	BRONCHIAL VALVE INIT INSERT	No pre-authorization is required for all providers.	N/A
31648	BRONCHIAL VALVE ADDL INSERT	No pre-authorization is required for all providers.	N/A
31649	BRONCHIAL VALVE REMOV INIT	No pre-authorization is required for all providers.	N/A
31651	BRONCHIAL VALVE REMOV ADDL	No pre-authorization is required for all providers.	N/A
31652	BRONCH EBUS SAMPLNG 1/2 NODE	No pre-authorization is required for all providers.	N/A
31653	BRONCH EBUS SAMPLNG 3/> NODE	No pre-authorization is required for all providers.	N/A
31654	BRONCH EBUS IVNTJ PERPH LES	No pre-authorization is required for all providers.	N/A
31660	BRONCH THERMOPLSTY 1 LOBE	No pre-authorization is required for all providers.	N/A
31661	BRONCH THERMOPLSTY 2/> LOBES	No pre-authorization is required for all providers.	N/A
31717	CATH W/BRONCHIAL BRUSH BX	No pre-authorization is required for all providers.	N/A
31720	CATH ASPIRAT (SEPART PROC); NASOTRACHEAL	No pre-authorization is required for all providers.	N/A
31725	CATH ASPIRAT (SEP PRO); TRACHEOBRONCH W/FIBERSCP	No pre-authorization is required for all providers.	N/A
31730	TRANSTRACH INTRO INDWELLING TUBE-O2 THERAP	No pre-authorization is required for all providers.	N/A
31750	TRACHEOPLASTY; CERV	No pre-authorization is required for all providers.	N/A
31755	TRACHEOPLASTY; TRACHEOPHARYNG FISTULIZATION	No pre-authorization is required for all providers.	N/A
31760	TRACHEOPLASTY; INTRATHORACIC	No pre-authorization is required for all providers.	N/A
31766	CARINAL RECON	No pre-authorization is required for all providers.	N/A
31770	BRONCHOPLASTY; GFT REPR	No pre-authorization is required for all providers.	N/A
31775	BRONCHOPLASTY; EXC STENOSIS & ANASTOM	No pre-authorization is required for all providers.	N/A
31780	EXC TRACHEAL STENOSIS & ANASTOM; CERV	No pre-authorization is required for all providers.	N/A
31781	EXC TRACHEAL STENOSIS & ANASTOM; CERVICOTHORACIC	No pre-authorization is required for all providers.	N/A
31785	EXC TRACHEAL TUMOR/CARCINOMA; CERV	No pre-authorization is required for all providers.	N/A
31786	EXC TRACHEAL TUMOR/CARCINOMA; THORACIC	No pre-authorization is required for all providers.	N/A
31800	SUTURE TRACHEAL WOUND/INJURY; CERV	No pre-authorization is required for all providers.	N/A
31805	SUTURE TRACHEAL WOUND/INJURY; INTRATHORACIC	No pre-authorization is required for all providers.	N/A
31820	SURG CLO TRACHEOSTOMY/FISTULA; WO PLASTIC REPR	No pre-authorization is required for all providers.	N/A
31825	SURG CLO TRACHEOSTOMY/FISTULA; W/PLASTIC REPR	No pre-authorization is required for all providers.	N/A
31830	REVIS TRACHEOSTOMY SCAR	No pre-authorization is required for all providers.	N/A
31899	UNLISTED PROC TRACHEA BRONCHI	No pre-authorization is required for all providers.	N/A
32035	THORACOSTOMY; W/RIB RESECT EMPYEMA	No pre-authorization is required for all providers.	N/A
32036	THORACOSTOMY; W/OPEN FLAP-DRAINAGE EMPYEMA	No pre-authorization is required for all providers.	N/A
32096	OPEN WEDGE/BX LUNG INFILTR	No pre-authorization is required for all providers.	N/A
32097	OPEN WEDGE/BX LUNG NODULE	No pre-authorization is required for all providers.	N/A
32098	OPEN BIOPSY OF LUNG PLEURA	No pre-authorization is required for all providers.	N/A
32100	EXPLORATION OF CHEST	No pre-authorization is required for all providers.	N/A
32110	EXPLORE/REPAIR CHEST	No pre-authorization is required for all providers.	N/A
32120	RE-EXPLORATION OF CHEST	No pre-authorization is required for all providers.	N/A
32124	EXPLORE CHEST FREE ADHESIONS	No pre-authorization is required for all providers.	N/A
32140	REMOVAL OF LUNG LESION(S)	No pre-authorization is required for all providers.	N/A
32141	REMOVE/TREAT LUNG LESIONS	No pre-authorization is required for all providers.	N/A
32150	REMOVAL OF LUNG LESION(S)	No pre-authorization is required for all providers.	N/A
32151	REMOVE LUNG FOREIGN BODY	No pre-authorization is required for all providers.	N/A
32160	OPEN CHEST HEART MASSAGE	No pre-authorization is required for all providers.	N/A
32200	PNEUMONOSTOMY W/OPEN DRAINAGE ABSCESS/CYST	No pre-authorization is required for all providers.	N/A
32201	PNEUMONOSTOMY; W/PERCUT DRAIN ABSCESS/CYST	This is no longer a valid code.	N/A
32215	PLEURAL SCARIFICATION REPEAT PNEUMOTHORAX	No pre-authorization is required for all providers.	N/A
32220	DECORTIC PULM (SEPART PROC); TOT	No pre-authorization is required for all providers.	N/A
32225	DECORTIC PULM (SEPART PROC); PART	No pre-authorization is required for all providers.	N/A
32310	PLEURECTOMY, PARIETAL (SEPART PROC)	No pre-authorization is required for all providers.	N/A
32320	DECORTIC & PARIETAL PLEURECTOMY	No pre-authorization is required for all providers.	N/A
32400	BX PLEURA; PERCUT NEEDLE	No pre-authorization is required for all providers.	N/A
32405	PERCUT BX LUNG/MEDIASTINUM	No pre-authorization is required for all providers.	N/A
32440	REMOVE LUNG PNEUMONECTOMY	No pre-authorization is required for all providers.	N/A
32442	SLEEVE PNEUMONECTOMY	No pre-authorization is required for all providers.	N/A
32445	REMOVAL OF LUNG EXTRAPLEURAL	No pre-authorization is required for all providers.	N/A
32480	PARTIAL REMOVAL OF LUNG	No pre-authorization is required for all providers.	N/A
32482	BILOBECTOMY	No pre-authorization is required for all providers.	N/A
32484	SEGMENTECTOMY	No pre-authorization is required for all providers.	N/A
32486	SLEEVE LOBECTOMY	No pre-authorization is required for all providers.	N/A
32488	COMPLETION PNEUMONECTOMY	No pre-authorization is required for all providers.	N/A
32491	LUNG VOLUME REDUCTION	No pre-authorization is required for all providers.	N/A
32501	RESECT & REPR BRONCH @ TIME LOBEC/SEGMENTECTOMY	No pre-authorization is required for all providers.	N/A
32503	RESCJ APICAL LNG TUM W/O CH WALL RCNSTJ	No pre-authorization is required for all providers.	N/A
32504	RESCJ APICAL LNG TUM W/CH WALL RCNSTJ	No pre-authorization is required for all providers.	N/A
32505	WEDGE RESECT OF LUNG INITIAL	No pre-authorization is required for all providers.	N/A
32506	WEDGE RESECT OF LUNG ADD-ON	No pre-authorization is required for all providers.	N/A
32507	WEDGE RESECT OF LUNG DIAG	No pre-authorization is required for all providers.	N/A
32540	EXTRAPLEURAL ENUCLEATION EMPYEMA	No pre-authorization is required for all providers.	N/A
32550	INSERT PLEURAL CATH	No pre-authorization is required for all providers.	N/A
32551	INSERTION OF CHEST TUBE	No pre-authorization is required for all providers.	N/A
32552	REMOVE LUNG CATHETER	No pre-authorization is required for all providers.	N/A
32553	INS MARK THOR FOR RT PERQ	No pre-authorization is required for all providers.	N/A
32554	ASPIRATE PLEURA W/O IMAGING	No pre-authorization is required for all providers.	N/A
32555	ASPIRATE PLEURA W/ IMAGING	No pre-authorization is required for all providers.	N/A
32556	INSERT CATH PLEURA W/O IMAGE	No pre-authorization is required for all providers.	N/A
32557	INSERT CATH PLEURA W/ IMAGE	No pre-authorization is required for all providers.	N/A
32560	TREAT LUNG LINING CHEMICALLY	No pre-authorization is required for all providers.	N/A
32561	LYSE CHEST FIBRIN INIT DAY	No pre-authorization is required for all providers.	N/A
32562	LYSE CHEST FIBRIN SUBQ DAY	No pre-authorization is required for all providers.	N/A
32567	THORACOSCOPY, SURGICAL	No pre-authorization is required for all providers.	N/A
32601	THORACOSCOPY DIAGNOSTIC	No pre-authorization is required for all providers.	N/A
32604	THORACOSCOPY DX (SEP PRO); PERICARDIAL SAC W/BX	No pre-authorization is required for all providers.	N/A
32606	THORACOSCOPY DX (SEP PRO); MEDIASTIN SPACE W/BX	No pre-authorization is required for all providers.	N/A
32607	THORACOSCOPY W/BX INFILTRATE	No pre-authorization is required for all providers.	N/A
32608	THORACOSCOPY W/BX NODULE	No pre-authorization is required for all providers.	N/A
32609	THORACOSCOPY W/BX PLEURA	No pre-authorization is required for all providers.	N/A
32650	THORACOSCOPY SURG; W/PLEURODESIS ANY METHD	No pre-authorization is required for all providers.	N/A

32651	THORACOSCOPY SURG; W/PART PULM DECORTIC	No pre-authorization is required for all providers.	N/A
32652	THORACOSCOPY SURG; W/TOT PULM DECORTIC/PNEUMOLYS	No pre-authorization is required for all providers.	N/A
32653	THORACOSCOPY SURG; W/REMOV INTRAPLEURAL FB	No pre-authorization is required for all providers.	N/A
32654	THORACOSCOPY SURG; W/CONTRL TRAUMATIC HEMORR	No pre-authorization is required for all providers.	N/A
32655	THORACOSCOPY RESECT BULLAE	No pre-authorization is required for all providers.	N/A
32656	THORACOSCOPY SURG; W/PARIETAL PLEURECTOMY	No pre-authorization is required for all providers.	N/A
32658	THORACOSCOPY SURG; W/REMOV CLOT/FB-PERICARD SAC	No pre-authorization is required for all providers.	N/A
32659	THORACOSCOPY SURG; W/CREAT PERICARD WINDOW	No pre-authorization is required for all providers.	N/A
32661	THORACOSCOPY SURG; W/EXC PERICARD CYST/TUMOR/MAS	No pre-authorization is required for all providers.	N/A
32662	THORACOSCOPY SURG; W/EXC MEDIASTIN CYST/TUMOR	No pre-authorization is required for all providers.	N/A
32663	THORACOSCOPY W/LOBECTOMY	No pre-authorization is required for all providers.	N/A
32664	THORACOSCOPY SURG; W/THORACIC SYMPATHECTOMY	No pre-authorization is required for all providers.	N/A
32665	THORACOSCOPY SURG; W/ESOPHAGOMYOTOMY	No pre-authorization is required for all providers.	N/A
32666	THORACOSCOPY W/WEDGE RESECT	No pre-authorization is required for all providers.	N/A
32667	THORACOSCOPY W/W RESECT ADDL	No pre-authorization is required for all providers.	N/A
32668	THORACOSCOPY W/W RESECT DIAG	No pre-authorization is required for all providers.	N/A
32669	THORACOSCOPY REMOVE SEGMENT	No pre-authorization is required for all providers.	N/A
32670	THORACOSCOPY BILOBECTOMY	No pre-authorization is required for all providers.	N/A
32671	THORACOSCOPY PNEUMONECTOMY	No pre-authorization is required for all providers.	N/A
32672	THORACOSCOPY FOR LVRS	No pre-authorization is required for all providers.	N/A
32673	THORACOSCOPY W/THYMUS RESECT	No pre-authorization is required for all providers.	N/A
32674	THORACOSCOPY LYMPH NODE EXC	No pre-authorization is required for all providers.	N/A
32701	THORAX STEREO RAD TARGETW/TX	No pre-authorization is required for all providers.	N/A
32800	REPR LUNG HERNIA THRU CHEST WALL	No pre-authorization is required for all providers.	N/A
32810	CLO CHEST WALL FOLLOWING OPEN FLAP DRAIN EMPYEMA	No pre-authorization is required for all providers.	N/A
32815	OPEN CLO MAJOR BRONCHIAL FISTULA	No pre-authorization is required for all providers.	N/A
32820	MAJOR RECON CHEST WALL	No pre-authorization is required for all providers.	N/A
32850	DONOR PNEUMONECTOMY W/PREP & MAINTENANCE ALLOGFT	This service is not covered by Superior HealthPlan.	N/A
32851	LUNG TRANSPL SNGL; WO CARDIOPULM BYPASS	Pre-authorization is required for all providers.	Prior to 09/01/2019
32852	LUNG TRANSPL SNGL; W/CARDIOPULM BYPASS	Pre-authorization is required for all providers.	Prior to 09/01/2019
32853	LUNG TRANSPL DBL; WO CARDIOPULM BYPASS	Pre-authorization is required for all providers.	Prior to 09/01/2019
32854	LUNG TRANSPL DBL; W/CARDIOPULM BYPASS	Pre-authorization is required for all providers.	Prior to 09/01/2019
32855	BACKBENCH STD PREP CADVR DONR LUNG ALLOGFT; UNI	This service is not covered by Superior HealthPlan.	N/A
32856	BACKBENCH STD PREP CADVR DONR LUNG ALLOGFT; BIL	This service is not covered by Superior HealthPlan.	N/A
32900	RESECT RIBS EXTRAPLEURAL ALL STAGES	No pre-authorization is required for all providers.	N/A
32905	THORACOPLASTY SCHEDE TYPE/EXTRAPLEURAL	No pre-authorization is required for all providers.	N/A
32906	THORACOPLASTY; W/CLO BRONCHOPLEURAL FISTULA	No pre-authorization is required for all providers.	N/A
32940	PNEUMOLYSIS EXTRAPERIOSTEAL INCL FILL/PACK PROC	No pre-authorization is required for all providers.	N/A
32960	PNEUMOTHORAX THERAP-INTRAPLEURAL INJ AIR	No pre-authorization is required for all providers.	N/A
32994	ABLATE PULM TUMOR PERQ CRYBL	No pre-authorization is required for all providers.	N/A
32997	TOTAL LUNG LAVAGE (UNILATERAL)	No pre-authorization is required for all providers.	N/A
32998	ABLATE PULM TUMOR PERQ RF	This service is not covered by Superior HealthPlan.	N/A
32999	UNLISTED PROC LUNGS & PLEURA	No pre-authorization is required for all providers.	N/A
33010	PERICARDIOCENTESIS; INIT	No pre-authorization is required for all providers.	N/A
33011	PERICARDIOCENTESIS; SUBSQ	No pre-authorization is required for all providers.	N/A
33015	TUBE PERICARDIOSTOMY	No pre-authorization is required for all providers.	N/A
33016	PERICARDIOCENTESIS W/IMG GUIDANCE WHEN PERFORMED	No pre-authorization is required for all providers.	N/A
33017	PERQ PRCRD DRG 6YR+ W/O CONGENITAL CAR ANOMALY	No pre-authorization is required for all providers.	N/A
33018	PERQ PRCRD DRG 0-5YR/ANY AGE W/CGEN CAR ANOMALY	No pre-authorization is required for all providers.	N/A
33019	PERQ PERICARDIAL DRG W/INSJ NDWELLG CATH W/CT	No pre-authorization is required for all providers.	N/A
33020	PERICARDIOTOMY REMOV CLOT/FB	No pre-authorization is required for all providers.	N/A
33025	CREATION PERICARDIAL WINDOW/PART RESECT DRAIN	No pre-authorization is required for all providers.	N/A
33030	PERICARDIOTOMY SUBTL/COMPLT; WO CP BYPASS	No pre-authorization is required for all providers.	N/A
33031	PERICARDIOTOMY SUBTL/COMPLT; W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33050	RESECT HEART SAC LESION	No pre-authorization is required for all providers.	N/A
33120	EXC INTRACARDIAC TUMOR RESECT W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33130	RESECT EXT CARDIAC TUMOR	No pre-authorization is required for all providers.	N/A
33140	TRANSMYOCARDIAL LASER REVASCLARIZATION BY THORACOTOMY	No pre-authorization is required for all providers.	N/A
33141	TMR-THORACOTOMY; DUR OP CARD PROC 7.41	No pre-authorization is required for all providers.	N/A
33201	INSRT PERM PACEMAKER; BY XIPHOID APPROACH	No pre-authorization is required for all providers.	N/A
33202	INSERTION OF EPICARDIAL ELECTRODE(S)	No pre-authorization is required for all providers.	N/A
33203	ENDOSCOPIC APPROACH (EG, THORACOSCOPY, PERICARDIOSCOPY)	No pre-authorization is required for all providers.	N/A
33206	INSERT HEART PM ATRIAL	No pre-authorization is required for all providers.	N/A
33207	INSERT HEART PM VENTRICULAR	No pre-authorization is required for all providers.	N/A
33208	INSRT HEART PM ATRIAL & VENT	No pre-authorization is required for all providers.	N/A
33210	INSRT/REPLAC TEMP ONE CHMBR ELECT/CATH (SEP PRO)	No pre-authorization is required for all providers.	N/A
33211	INSRT/REPLAC TEMP DUAL CHAMB ELECTROD (SEP PRO)	No pre-authorization is required for all providers.	N/A
33212	INSERT PULSE GEN SNGL LEAD	No pre-authorization is required for all providers.	N/A
33213	INSERT PULSE GEN DUAL LEADS	No pre-authorization is required for all providers.	N/A
33214	UPGRADE IMPLNT PACEMAKER SYST SNGL TO DUAL	No pre-authorization is required for all providers.	N/A
33215	REPOSITION PACING-DEFIB LEAD	No pre-authorization is required for all providers.	N/A
33216	INSERT 1 ELECTRODE PM-DEFIB	No pre-authorization is required for all providers.	N/A
33217	INSERT 2 ELECTRODE PM-DEFIB	No pre-authorization is required for all providers.	N/A
33218	REPAIR LEAD PACE-DEFIB ONE	No pre-authorization is required for all providers.	N/A
33220	REPAIR LEAD PACE-DEFIB DUAL	No pre-authorization is required for all providers.	N/A
33221	INSERT PULSE GEN MULT LEADS	No pre-authorization is required for all providers.	N/A
33222	RELOCATION POCKET PACEMAKER	No pre-authorization is required for all providers.	N/A
33223	RELOCATE POCKET FOR DEFIB	No pre-authorization is required for all providers.	N/A
33224	INSERT PACING LEAD & CONNECT	No pre-authorization is required for all providers.	N/A
33225	L VENTRIC PACING LEAD ADD-ON	No pre-authorization is required for all providers.	N/A
33226	REPOSITION L VENTRIC LEAD	No pre-authorization is required for all providers.	N/A
33227	REMOVE&REPLACE PM GEN SNGL	No pre-authorization is required for all providers.	N/A
33228	REMOV&REPLC PM GEN DUAL LEAD	No pre-authorization is required for all providers.	N/A
33229	REMOV&REPLC PM GEN MULT LEADS	No pre-authorization is required for all providers.	N/A
33230	INSRT PULSE GEN W/DUAL LEADS	No pre-authorization is required for all providers.	N/A
33231	INSRT PULSE GEN W/MULT LEADS	No pre-authorization is required for all providers.	N/A
33233	REMOVAL OF PM GENERATOR	No pre-authorization is required for all providers.	N/A
33234	REMOV TRANSVEN PACEMKR ELECTRODE(S); 1 LEAD SYST	No pre-authorization is required for all providers.	N/A
33235	REMOV TRANSVEN PACEMKR ELECTRODE(S); DUAL LEAD	No pre-authorization is required for all providers.	N/A
33236	REMOV PERM EPICARD PACEMKR-THORACOT; 1 LEAD SYST	No pre-authorization is required for all providers.	N/A
33237	REMOV PERM EPICARD PACEMKR-THORACOT; DUAL LEAD	No pre-authorization is required for all providers.	N/A
33238	REMOV PERM TRANSVENOUS ELECTRODE-THORACOTOMY	No pre-authorization is required for all providers.	N/A
33240	INSRT PULSE GEN W/SINGL LEAD	No pre-authorization is required for all providers.	N/A
33241	REMOVE PULSE GENERATOR	No pre-authorization is required for all providers.	N/A
33243	REMOVE ELTRD/THORACOTOMY	No pre-authorization is required for all providers.	N/A
33244	REMOVE ELCTRD TRANSVENOUSLY	No pre-authorization is required for all providers.	N/A
33249	INSJ/RPLCMT DEFIB W/LEAD(S)	No pre-authorization is required for all providers.	N/A
33250	OR ABLAT SUPRAVENT ARRHYTH FOCUS; WO CP BYPASS	No pre-authorization is required for all providers.	N/A
33251	OR ABLATION SUPRAVENT ARRHYTH FOCUS; W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33254	OPERATIVE TISSUE ABLATION AND RECONSTRUCTION OF ATRIA	No pre-authorization is required for all providers.	N/A
33255	OPERATIVE TISSUE ABLATION AND RECONSTRUCTION OF ATRIA	No pre-authorization is required for all providers.	N/A
33256	WITH CARDIOPULMONARY BYPASS	No pre-authorization is required for all providers.	N/A
33257	ABLATE ATRIA LMTD ADD-ON	No pre-authorization is required for all providers.	N/A
33258	ABLATE ATRIA X10SV ADD-ON	No pre-authorization is required for all providers.	N/A
33259	ABLATE ATRIA W/BYPASS ADD-ON	No pre-authorization is required for all providers.	N/A
33261	OPER ABLATION VENT ARRHYTH FOCUS W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33262	RMVL & REPLC PULSE GEN 1 LEAD	No pre-authorization is required for all providers.	N/A
33263	RMVL & RPLCMT DFB GEN 2 LEAD	No pre-authorization is required for all providers.	N/A
33264	RMVL & RPLCMT DFB GEN MLT LD	No pre-authorization is required for all providers.	N/A
33265	ENDOSCOPY, SURGICAL OPERATIVE TISSUE ABLATION	No pre-authorization is required for all providers.	N/A
33266	OPERATIVE TISSUE ABLATION AND RECONSTRUCTION OF ATRIA	No pre-authorization is required for all providers.	N/A

33270	INS/REP SUBQ DEFIBRILLATOR	This service is not covered by Superior HealthPlan.	N/A
33271	INSJ SUBQ IMPLTBL DFB ELCTRD	This service is not covered by Superior HealthPlan.	N/A
33272	RMVL OF SUBQ DEFIBRILLATOR	This service is not covered by Superior HealthPlan.	N/A
33273	REPOS PREV IMPLTBL SUBQ DFB	This service is not covered by Superior HealthPlan.	N/A
33274	TCAT INSJ/RPL PERM LEADLESS PACEMAKER RV W/IMG	This service is not covered by Superior HealthPlan.	N/A
33275	TCAT REMOVAL PERM LEADLESS PM RIGHT VENTR W/IMG	This service is not covered by Superior HealthPlan.	N/A
33282	IMPLANTATION OF PATIENT-ACTIVATED CARDIAC EVENT RECORDER	This is no longer a valid code.	N/A
33284	REMOVAL OF AN IMPLANTABLE, PATIENT-ACTIVATED CARDIAC EVENT RECORDER	This is no longer a valid code.	N/A
33285	INSERTION SUBQ CARDIAC RHYTHM MONITOR W/PRGRMG	No pre-authorization is required for all providers.	N/A
33286	REMOVAL SUBCUTANEOUS CARDIAC RHYTHM MONITOR	No pre-authorization is required for all providers.	N/A
33289	TCAT IMPL WRLS P-ART PRS SNR L-T HEMODYN MNTR	This service is not covered by Superior HealthPlan.	N/A
33300	REPR CARDIAC WOUND; WO BYPASS	No pre-authorization is required for all providers.	N/A
33305	REPR CARDIAC WOUND; W/CARDIOPULMONARY BYPASS	No pre-authorization is required for all providers.	N/A
33310	CARDIOTOMY EXPL WITHOUT BYPASS	No pre-authorization is required for all providers.	N/A
33315	CARDIOTOMY EXPLOR; W/CARDIOPULMONARY BYPASS	No pre-authorization is required for all providers.	N/A
33320	SUTURE REPR AORTA/GRT VESSELS; WO SHUNT/BYPASS	No pre-authorization is required for all providers.	N/A
33321	SUTURE REPR AORTA/GRT VESSELS; W/SHUNT BYPASS	No pre-authorization is required for all providers.	N/A
33322	SUTURE REPR AORTA/GRT VESSELS; W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33330	INSRT GFT AORTA/GRT VESSELS; WO SHUNT/BYPASS	No pre-authorization is required for all providers.	N/A
33332	INSRT GFT AORTA/GRT VESSELS; W/SHUNT BYPASS	This is no longer a valid code.	N/A
33335	INSRT GFT AORTA/GRT VESSELS; W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33340	PERQ CLSR TCAT L ATR APNDGE W/ENDOCARDIAL IMPLNT	No pre-authorization is required for all providers.	N/A
33361	REPLACE AORTIC VALVE PERQ	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
33362	REPLACE AORTIC VALVE OPEN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
33363	REPLACE AORTIC VALVE OPEN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
33364	REPLACE AORTIC VALVE OPEN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
33365	REPLACE AORTIC VALVE OPEN	No pre-authorization is required for all providers.	N/A
33366	TRCATH REPLACE AORTIC VALVE	No pre-authorization is required for all providers.	N/A
33367	REPLACE AORTIC VALVE W/BYP	No pre-authorization is required for all providers.	N/A
33368	REPLACE AORTIC VALVE W/BYP	No pre-authorization is required for all providers.	N/A
33369	REPLACE AORTIC VALVE W/BYP	No pre-authorization is required for all providers.	N/A
33390	VALVULOPLASTY AORTIC VALVE OPEN CARD BYP SIMPLE	No pre-authorization is required for all providers.	N/A
33391	VALVULOPLASTY AORTIC VALVE OPEN CARD BYP COMPLEX	No pre-authorization is required for all providers.	N/A
33400	VALVULOPLASTY AORTIC VALV; OPEN W/CP BYPASS	This is no longer a valid code.	N/A
33401	VALVULOPLASTY AORTIC VALV; OPEN W/INFLOW OCCLUD	This is no longer a valid code.	N/A
33403	VALVULOPLASTY AORTIC; USING DILAT W/CP BYPASS	This is no longer a valid code.	N/A
33404	CONSTRUCTION APICAL-AORTIC CONDUIT	No pre-authorization is required for all providers.	N/A
33405	REPLACEMENT AORTIC VALVE OPN	No pre-authorization is required for all providers.	N/A
33406	REPLACEMENT AORTIC VALVE OPN	No pre-authorization is required for all providers.	N/A
33410	REPLACEMENT AORTIC VALVE OPN	No pre-authorization is required for all providers.	N/A
33411	REPLACEMENT OF AORTIC VALVE	No pre-authorization is required for all providers.	N/A
33412	REPLAC AORTIC VALV; W/TRANSVENT AORTIC ANNULUS	No pre-authorization is required for all providers.	N/A
33413	REPLAC AORTIC VALV; TRANSLOCAT AUTOLOG PULM VALV	No pre-authorization is required for all providers.	N/A
33414	REPR LT VENT OUTFLM OBSTRUC-PATCH ENLARGE TRACT	No pre-authorization is required for all providers.	N/A
33415	RESECT/INCS SUBVALVULAR TISS-AORTIC STENOSIS	No pre-authorization is required for all providers.	N/A
33416	VENTRICULOMYOTOMY-IDIOPATHIC SUBAORTIC STENOSIS	No pre-authorization is required for all providers.	N/A
33417	AORTOPLASTY SUPRAVALVULAR STENOSIS	No pre-authorization is required for all providers.	N/A
33418	REPAIR TCAT MITRAL VALVE	This service is not covered by Superior HealthPlan.	N/A
33419	REPAIR TCAT MITRAL VALVE	This service is not covered by Superior HealthPlan.	N/A
33420	VALVOTOMY MITRAL VALV; CLO HEART	No pre-authorization is required for all providers.	N/A
33422	VALVOTOMY MITRAL VALV; OPEN HEART W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33425	VALVULOPLASTY-MITRAL W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33426	VALVULOPLASTY-MITRAL W/CP BYPASS; W/PROSTH RING	No pre-authorization is required for all providers.	N/A
33427	VALVULOPLASTY-MITRAL W/CP BYPASS; RAD RECON	No pre-authorization is required for all providers.	N/A
33430	REPLAC MITRAL VALV W/CARDIOPULMONARY BYPASS	No pre-authorization is required for all providers.	N/A
33440	RPLCMT AORTIC VALVE BY TLCJ AUTOL PULM VALVE	No pre-authorization is required for all providers.	N/A
33460	VALVECTOMY TRICUSPID VALV; W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33463	VALVULOPLASTY TRICUSPID VALV; WO RING INSRT	No pre-authorization is required for all providers.	N/A
33464	VALVULOPLASTY TRICUSPID VALV; W/RING INSRT	No pre-authorization is required for all providers.	N/A
33465	REPLAC TRICUSPID VALV W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33468	TRICUSPID VALV REPOSIT & PLICAT EPSTEIN ANOMALY	No pre-authorization is required for all providers.	N/A
33470	VALVOTOMY PULM VALV; CLO HEART; TRANSVENTRICULAR	No pre-authorization is required for all providers.	N/A
33471	VALVOTOMY PULM VALV CLO HEART; VIA PULM ART	This service is not covered by Superior HealthPlan.	N/A
33472	VALVOTOMY PULM VALV; OPEN HEART; W/INFLOW OCCLUD	This is no longer a valid code.	N/A
33474	VALVOTOMY PULM VALV OPEN HEART; W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33475	REPLAC PULM VALV	No pre-authorization is required for all providers.	N/A
33476	RT VENTRIC RESECT-INFUNDIB STENOSIS-W/WO COMMISS	No pre-authorization is required for all providers.	N/A
33477	IMPLANT TCAT PULM VLV PERQ	No pre-authorization is required for all providers.	N/A
33478	OUTFLOW TRACT AUGMEN W/WO COMMISSUROTOMY	No pre-authorization is required for all providers.	N/A
33496	REPR PROSTH VALV DYSFUNCT W/CP BYPASS (SEP PROC)	No pre-authorization is required for all providers.	N/A
33500	REPR CORONARY AV CHAMBER FISTULA; W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33501	REPR CORONARY AV CHAMBER FISTULA; WO CP BYPASS	No pre-authorization is required for all providers.	N/A
33502	REPR ANOMALOUS CORONARY ART; LIG	No pre-authorization is required for all providers.	N/A
33503	ANOMALOUS CORONARY ART; GFT WO CP BYPASS	No pre-authorization is required for all providers.	N/A
33504	ANOMALOUS CORONARY ART; GFT W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33505	REPR ANOMALOUS CORON ART; CONSTRUC INTRAPULM ART	No pre-authorization is required for all providers.	N/A
33506	REPR ANOMALOUS CORON ART; TRNSLOC PULM ART-AORTA	No pre-authorization is required for all providers.	N/A
33507	RPR ANOM AORTIC ORIGIN C ART UNROOFING/TLCJ	No pre-authorization is required for all providers.	N/A
33508	ENDO VIDEO-ASSTD HARV VEINS CA BYPS	No pre-authorization is required for all providers.	N/A
33510	CORON ART BYPASS-VEIN ONLY; 1 CORON VENOUS GFT	No pre-authorization is required for all providers.	N/A
33511	CORON ART BYPASS-VEIN ONLY; 2 CORON VENOUS GFT	No pre-authorization is required for all providers.	N/A
33512	CORON ART BYPASS-VEIN ONLY; 3 CORON VENOUS GFT	No pre-authorization is required for all providers.	N/A
33513	CORON ART BYPASS-VEIN ONLY; 4 CORON VENOUS GFT	No pre-authorization is required for all providers.	N/A
33514	CORON ART BYPASS-VEIN ONLY; 5 CORON VENOUS GFT	No pre-authorization is required for all providers.	N/A
33516	CORON ART BYPASS-VEIN ONLY; 6/MORE VENOUS GFT	No pre-authorization is required for all providers.	N/A
33517	CORONARY ARTERY BYP W VEIN &ARTERY GRAFT 1 VEIN	No pre-authorization is required for all providers.	N/A
33518	CORONARY ARTERY BYP W VEIN &ARTERY GRAFT 2 VEIN	No pre-authorization is required for all providers.	N/A
33519	CORONARY ARTERY BYP W VEIN &ARTERY GRAFT 3 VEIN	No pre-authorization is required for all providers.	N/A
33521	CORONARY ARTERY BYP W VEIN &ARTERY GRAFT 4 VEIN	No pre-authorization is required for all providers.	N/A
33522	CORONARY ARTERY BYP W VEIN &ARTERY GRAFT 5 VEIN	No pre-authorization is required for all providers.	N/A
33523	CORONARY ARTERY BYP W VEIN &ARTERY GRAFT 6 VEIN	No pre-authorization is required for all providers.	N/A
33530	REOPERAT CAB/VALVE PROC > 1 MO AFTER ORIG OR	No pre-authorization is required for all providers.	N/A
33533	CORONARY ART BYPASS W/ART GFT; 1 ART GFT	No pre-authorization is required for all providers.	N/A
33534	CORON ART BYPASS W/ART GFT; 2 CORON ART GFT	No pre-authorization is required for all providers.	N/A
33535	CORON ART BYPASS W/ART GFT; 3 CORON ART GFT	No pre-authorization is required for all providers.	N/A
33536	CORON ART BYPASS W/ART GFT; 4/MORE CORON ART GFT	No pre-authorization is required for all providers.	N/A
33542	MYOCARDIAL RESECT	No pre-authorization is required for all providers.	N/A
33545	REPR POSTINFARCT VENT SEPTAL DEFECT W/WO RESECT	No pre-authorization is required for all providers.	N/A
33548	SURG VENTR RSTRJ PX W/PROSTC PATCH PFRMD	No pre-authorization is required for all providers.	N/A
33572	CORONARY ENDARTERECT-OP-PERFMD W/CABG-EA VESSEL	No pre-authorization is required for all providers.	N/A
33600	CLO ATRIOVENTRICULAR VALV-SUTURE/PATCH	No pre-authorization is required for all providers.	N/A
33602	CLO SEMILUNAR VALV-SUTURE/PATCH	No pre-authorization is required for all providers.	N/A
33606	ANASTOM PULM ART TO AORTA	No pre-authorization is required for all providers.	N/A
33608	REPR COMPLX CARDIAC ANOMALY NOT PULM ATRESIA	No pre-authorization is required for all providers.	N/A
33610	REPR COMPLX CARD ANOMAL-SURG ENLARGE SEPTL DEFEC	No pre-authorization is required for all providers.	N/A
33611	REPR DBL OUTLET RT VENT W/INTRA VENT TUNNEL REPR	No pre-authorization is required for all providers.	N/A
33612	REPR DBL OUTLET RT VENT; W/REPR RT OUTFLO OBSTRUC	No pre-authorization is required for all providers.	N/A
33615	REPR CARD ANOMAL-CLO ATRIAL SEPTL DEFEC & ANASTO	No pre-authorization is required for all providers.	N/A
33617	REPR COMPLX CARDIAL ANOMALIES-MODIF FONTAN PROC	No pre-authorization is required for all providers.	N/A
33619	REPR 1 VENT W/AORTIC OBSTRUC & ARCH HYPOPLASIA	No pre-authorization is required for all providers.	N/A
33620	APPLY R&L PULM ART BANDS	No pre-authorization is required for all providers.	N/A

33621	TRANSTHOR CATH FOR STENT	No pre-authorization is required for all providers.	N/A
33622	REDO COMPL CARDIAC ANOMALY	No pre-authorization is required for all providers.	N/A
33641	REPR ATRIAL SEPTAL DEFECT SECUNDUM W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33645	DIRECT/PATCH CLO-SINUS VENOSUS-W/WO PULM DRAIN	No pre-authorization is required for all providers.	N/A
33647	REPR ATRIAL & VENTRIC SEPTAL DEFECT W/DIRECT CLO	No pre-authorization is required for all providers.	N/A
33660	REPR INCOMPL/PART ATRIOVENT CANAL W/WO VALV REPR	No pre-authorization is required for all providers.	N/A
33665	REPR INTERMED/TRANSIT ATRIOVENT CANAL W/WO VALV	No pre-authorization is required for all providers.	N/A
33670	REPR COMPLT ATRIOVENT CANAL W/WO PROSTH VALV	No pre-authorization is required for all providers.	N/A
33675	CLOSURE OF MULTIPLE VENTRICULAR SEPTAL DEFECTS	No pre-authorization is required for all providers.	N/A
33676	WITH PULMONARY VALVOTOMY OR INFUNDIBULAR RESECTION	No pre-authorization is required for all providers.	N/A
33677	WITH REMOVAL OF PULMONARY ARTERY BAND	No pre-authorization is required for all providers.	N/A
33681	CLOSURE SINGLE VENTRICULAR SEPTAL DEFECT W ITH OR WITHOUT PATCH	No pre-authorization is required for all providers.	N/A
33684	CLO VENT SEPTAL DEFECT W/WO PATCH; W/PULM VALVOT	No pre-authorization is required for all providers.	N/A
33688	CLO VSD W/WO PATCH; W/REMOV PULM ART BAND	No pre-authorization is required for all providers.	N/A
33690	BANDING PULM ART	No pre-authorization is required for all providers.	N/A
33692	COMPLT REPR TETRALOGY FALLOT WO PULM ATRESIA	No pre-authorization is required for all providers.	N/A
33694	COMPLT REPR TETRALOGY WO PULM ATRES; W/PATCH	No pre-authorization is required for all providers.	N/A
33697	COMPLT REPR TETRALOGY FALLOT W/PULM ATRESIA	No pre-authorization is required for all providers.	N/A
33702	REPR SINUS VALSALVA FISTULA W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33710	REPR SINUS FISTULA W/BYPASS; W/REPR SEPTAL DEFEC	No pre-authorization is required for all providers.	N/A
33720	REPR SINUS VALSALVA ANEURY W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33722	CLO AORTICO-LT VENTRICULAR TUNNEL	No pre-authorization is required for all providers.	N/A
33724	REPAIR OF ISOLATED PATIAL ANOMALOUS PULMONARY VENOUS RETURN	No pre-authorization is required for all providers.	N/A
33726	REPAIR OF PULMONARY VENOUS STENOSIS	No pre-authorization is required for all providers.	N/A
33730	COMPLT REPR ANOMALOUS VENOUS RETURN	No pre-authorization is required for all providers.	N/A
33732	REPR COR TRIARIATUM/SUPRAVALVULAR MITRAL RING	No pre-authorization is required for all providers.	N/A
33735	ATRIAL SEPTECTOMY/SEPTOSTOMY; CLO HEART	No pre-authorization is required for all providers.	N/A
33736	ATRIAL SEPTECT/SEPTOST; OPEN HEART W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33737	ATRIAL SEPTEC/SEPTOS; OPEN HEART W/INFLOW OCCLUD	No pre-authorization is required for all providers.	N/A
33750	SHUNT; SUBCLAVIAN PULM ART	No pre-authorization is required for all providers.	N/A
33755	SHUNT; ASCENDING AORTA PULM ART	No pre-authorization is required for all providers.	N/A
33762	SHUNT; DESCENDING AORTA PULM ART	No pre-authorization is required for all providers.	N/A
33764	SHUNT; CENTRAL W/PROSTH GFT	No pre-authorization is required for all providers.	N/A
33766	SHUNT; SUPER VENA CAVA-PULM ART-FLOW TO 1 LUNG	No pre-authorization is required for all providers.	N/A
33767	SHUNT; SUPER VENA CAVA-PULM ART FLOW-BOTH LUNGS	No pre-authorization is required for all providers.	N/A
33768	ANAST CAVOPULM 2ND SUPRIOR V/C	No pre-authorization is required for all providers.	N/A
33770	REPR TRANSPOSIT GRT ART; WO SURG ENLARG SEPTAL	No pre-authorization is required for all providers.	N/A
33771	REPR TRANSPOSIT GRT ART; W/SURG ENLARG SEPTL DEF	No pre-authorization is required for all providers.	N/A
33774	REPR TRANSPOSIT GR ART-ATRIAL BAFFLE W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33775	REPR TRANSPOSIT W/CP BYPASS; W/REMOV PULM BAND	No pre-authorization is required for all providers.	N/A
33776	REPR TRANSPOSIT GR ART; W/CLO VENT SEPTAL DEFECT	No pre-authorization is required for all providers.	N/A
33777	REPR TRANSPOSIT GRT ART; W/REPR SUBPULM OBSTRUC	No pre-authorization is required for all providers.	N/A
33778	REPR TRANSPOSIT GRT ART AORTIC PULM RECON	No pre-authorization is required for all providers.	N/A
33779	REPR TRANSPOSIT-AORTIC PULM RECON; W/REMOV BAND	No pre-authorization is required for all providers.	N/A
33780	REPR TRANSPOSIT-AORTIC PULM RECON; W/CLO SEPTAL	No pre-authorization is required for all providers.	N/A
33781	REPR TRANSPOSIT-AORTIC PULM; W/REPR SUBPULM OBST	No pre-authorization is required for all providers.	N/A
33782	NIKAIDOH PROC	No pre-authorization is required for all providers.	N/A
33783	NIKAIDOH PROC W/OSTIA IMPLT	No pre-authorization is required for all providers.	N/A
33786	TOT REPR TRUNCUS ARTERIOSUS	No pre-authorization is required for all providers.	N/A
33788	REIMPLANTATION AN ANOMALOUS PULM ART	No pre-authorization is required for all providers.	N/A
33800	AORTIC SUSPEN-TRACHEAL DECOMP (SEPART PROC)	No pre-authorization is required for all providers.	N/A
33802	DIVISION ABERRANT VESSEL	No pre-authorization is required for all providers.	N/A
33803	DIVISION ABERRANT VESSEL; W/REANASTOMOSIS	No pre-authorization is required for all providers.	N/A
33813	OBLIT AORTOPULM SEPTAL DEFECT; WO CP BYPASS	No pre-authorization is required for all providers.	N/A
33814	OBLIT AORTOPULM SEPTAL DEFECT; W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33820	REPR PATENT DUCTUS ARTERIOSUS; LIG	No pre-authorization is required for all providers.	N/A
33822	REPR PATENT DUCTUS ARTERIOSUS; DIVIS < 18 YR	No pre-authorization is required for all providers.	N/A
33824	REPR PATENT DUCTUS ARTERIOSUS; DIVIS 18YR & OLDR	No pre-authorization is required for all providers.	N/A
33840	EXC COARCTATION AORTA; W/DIRECT ANASTOM	No pre-authorization is required for all providers.	N/A
33845	EXC COARCTATION AORTA W/WO PATENT DUCTUS; W/GFT	No pre-authorization is required for all providers.	N/A
33851	EXC COARCTAT AORTA; REPR W/LT SUBCLAV/PROSTH MAT	No pre-authorization is required for all providers.	N/A
33852	REPR HYPOPLASTIC/INTERRUP AORTIC ARCH; WO CP BYP	No pre-authorization is required for all providers.	N/A
33853	REPR HYPOPLASTIC AORTIC ARCH W/MAT; W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33858	AS-AORT GRF W/CARD BYP F/AORTIC DISSECTION	No pre-authorization is required for all providers.	N/A
33859	AS-AORT GRF W/CARD BYP F/AORTIC DS OTH/THN DSJ	No pre-authorization is required for all providers.	N/A
33860	ASCENDING AORTIC GRAFT	No pre-authorization is required for all providers.	N/A
33863	ASCENDING AORTIC GRAFT	No pre-authorization is required for all providers.	N/A
33864	ASCENDING AORTIC GRAFT	No pre-authorization is required for all providers.	N/A
33866	AORTIC HEMIARCH GRAFT W/ISOL AND CTRL ARCH VESSELS	No pre-authorization is required for all providers.	N/A
33870	TRANSVERSE ARCH GFT W/CARDIOPULMONARY BYPASS	No pre-authorization is required for all providers.	N/A
33871	TRANSVRS A-ARCH GRF W/CARD BYP PRFD HYPOTHERMIA	No pre-authorization is required for all providers.	N/A
33875	DESCENDING THORACIC AORTA GFT W/WO BYPASS	No pre-authorization is required for all providers.	N/A
33877	REPR THORACOABD AORTIC ANEURY W/GFT W/WO BYPASS	No pre-authorization is required for all providers.	N/A
33880	EVASC RPR DTA COVERAGE ART ORIGIN 1ST ENDOPROSTH	No pre-authorization is required for all providers.	N/A
33881	EVASC RPR DTA EXP COVERAGE W/O ART ORIGIN	No pre-authorization is required for all providers.	N/A
33883	PLMT PROX XTN PROSTH EVASC RPR DTA 1ST XTN	No pre-authorization is required for all providers.	N/A
33884	PLMT PROX XTN PROSTH EVASC RPR DTA EA PROX XTN	No pre-authorization is required for all providers.	N/A
33886	PLMT DSTL XTN PROSTH DLYD AFTER EVASC RPR DTA	No pre-authorization is required for all providers.	N/A
33889	OPN SUBCLA CRTD ART TRPOS NCK INC ULAT	No pre-authorization is required for all providers.	N/A
33891	BYP GRF W/DTA RPR NCK INC	No pre-authorization is required for all providers.	N/A
33910	PULM ART EMBOLECTOMY; W/CARDIOPULMONARY BYPASS	No pre-authorization is required for all providers.	N/A
33915	PULM ART EMBOLECTOMY; WO CP BYPASS	No pre-authorization is required for all providers.	N/A
33916	PULM ENDARTERECTOMY W/WO EMBOLECTOMY W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33917	REPR PULM ART STENOSIS-RECON W/PATCH/GFT	No pre-authorization is required for all providers.	N/A
33920	REPR PULM ATRESIA-CONSTRUCT/REPLAC CONDUIT	No pre-authorization is required for all providers.	N/A
33922	TRANSECT PULM ART W/CP BYPASS	No pre-authorization is required for all providers.	N/A
33924	LIG & TAKEDOWN SYST-TO-PULM ART SHUNT	No pre-authorization is required for all providers.	N/A
33925	RPR P-ART ARBORIZJ ANOMAL UNIFCLIZJ W/O CARD BYP	No pre-authorization is required for all providers.	N/A
33926	RPR P-ART ARBORIZJ ANOMAL UNIFCLIZJ W/CARD BYP	No pre-authorization is required for all providers.	N/A
33927	IMPLTJ TOT RPLCMT HRT SYS	No pre-authorization is required for all providers.	N/A
33928	RMVL & RPLCMT TOT HRT SYS	No pre-authorization is required for all providers.	N/A
33929	RMVL RPLCMT HRT SYS F/TRNSPL	No pre-authorization is required for all providers.	N/A
33930	DONOR CARDIEC-PNEUMONEC W/PREP & MAINTEN-ALLOGFT	This service is not covered by Superior HealthPlan.	N/A
33933	BACKBENCH STD PREP CADVER DONOR HRT/LUNG ALLOGFT	This service is not covered by Superior HealthPlan.	N/A
33935	HEART-LUNG TRANSPL W/RECIPIENT CARDIECT-PNEUMONE	Pre-authorization is required for all providers.	Prior to 09/01/2019
33940	DONOR CARDIECT W/PREP & MAINTENANCE-ALLOGFT	This service is not covered by Superior HealthPlan.	N/A
33944	BACKBENCH STD PREP CADVER DONOR HEART ALLOGFT	This service is not covered by Superior HealthPlan.	N/A
33945	HEART TRANSPL W/WO RECIPIENT CARDIECTOMY	Pre-authorization is required for all providers.	Prior to 09/01/2019
33946	ECMO/ECLS INITIATION VENOUS	No pre-authorization is required for all providers.	N/A
33947	ECMO/ECLS INITIATION ARTERY	No pre-authorization is required for all providers.	N/A
33948	ECMO/ECLS DAILY MGMT-VENOUS	No pre-authorization is required for all providers.	N/A
33949	ECMO/ECLS DAILY MGMT ARTERY	No pre-authorization is required for all providers.	N/A
33951	ECMO/ECLS INSJ PRPH CANNULA	No pre-authorization is required for all providers.	N/A
33952	ECMO/ECLS INSJ PRPH CANNULA	No pre-authorization is required for all providers.	N/A
33953	ECMO/ECLS INSJ PRPH CANNULA	No pre-authorization is required for all providers.	N/A
33954	ECMO/ECLS INSJ PRPH CANNULA	No pre-authorization is required for all providers.	N/A
33955	ECMO/ECLS INSJ CTR CANNULA	No pre-authorization is required for all providers.	N/A
33956	ECMO/ECLS INSJ CTR CANNULA	No pre-authorization is required for all providers.	N/A
33957	ECMO/ECLS REPOS PERPH CNULA	No pre-authorization is required for all providers.	N/A
33958	ECMO/ECLS REPOS PERPH CNULA	No pre-authorization is required for all providers.	N/A
33959	ECMO/ECLS REPOS PERPH CNULA	No pre-authorization is required for all providers.	N/A

33960	EXTERNAL CIRCULATION ASSIST	This is no longer a valid code.	N/A
33961	EXTERNAL CIRCULATION ASSIST	This is no longer a valid code.	N/A
33962	ECMO/ECLS REPOS PERPH CNULA	No pre-authorization is required for all providers.	N/A
33963	ECMO/ECLS REPOS PERPH CNULA	No pre-authorization is required for all providers.	N/A
33964	ECMO/ECLS REPOS PERPH CNULA	No pre-authorization is required for all providers.	N/A
33965	ECMO/ECLS RMVL PERPH CANNULA	No pre-authorization is required for all providers.	N/A
33966	ECMO/ECLS RMVL PRPH CANNULA	No pre-authorization is required for all providers.	N/A
33967	PERCUTANEOUS INSERTION OF INTRA-AORTIC BALLOON	No pre-authorization is required for all providers.	N/A
33968	REMOVAL OF INTRA-AORTIC BALLOON ASSIST DEVICE, PERCUTANEOUS	No pre-authorization is required for all providers.	N/A
33969	ECMO/ECLS RMVL PERPH CANNULA	No pre-authorization is required for all providers.	N/A
33970	INSRT INTRA-AORTIC BALLOON ASST DEVICE-FEM OPEN	No pre-authorization is required for all providers.	N/A
33971	REMOV INTRA-AORTIC BALLOON ASSIST DEVIC-REPR FEM	No pre-authorization is required for all providers.	N/A
33973	INSRT INTRA-AORT BALOON ASSIST DEVIC-ASCENT AORT	No pre-authorization is required for all providers.	N/A
33974	REMOV INTRA-AORTIC BALLOON DEVICE W/REPR AORTA	No pre-authorization is required for all providers.	N/A
33975	IMPLNT VENTRIC ASSIST DEVICE; 1 VENTRICLE SUPPRT	No pre-authorization is required for all providers.	N/A
33976	IMPLNT VENTRIC ASSIST DEVICE; BIVENTRIC SUPPORT	No pre-authorization is required for all providers.	N/A
33977	REMOV VENTRIC ASSIST DEVICE; 1 VENTRICLE SUPPORT	No pre-authorization is required for all providers.	N/A
33978	REMOV VENTRIC ASSIST DEVICE; BIVENTRICUL SUPPORT	No pre-authorization is required for all providers.	N/A
33979	INSERTATION OF INTRACORPORAL VENTRICULAR ASSIST DEVICE.	No pre-authorization is required for all providers.	N/A
33980	REMOVAL OF INTRACORPORAL VENTRICULAR ASSIST DEVICE	No pre-authorization is required for all providers.	N/A
33981	REPLACE VAD PUMP EXT	No pre-authorization is required for all providers.	N/A
33982	REPLACE VAD INTRA W/O BP	No pre-authorization is required for all providers.	N/A
33983	REPLACE VAD INTRA W/BP	No pre-authorization is required for all providers.	N/A
33984	ECMO/ECLS RMVL PRPH CANNULA	No pre-authorization is required for all providers.	N/A
33985	ECMO/ECLS RMVL CTR CANNULA	No pre-authorization is required for all providers.	N/A
33986	ECMO/ECLS RMVL CTR CANNULA	No pre-authorization is required for all providers.	N/A
33987	ARTERY EXPOS/GRAFT ARTERY	No pre-authorization is required for all providers.	N/A
33988	INSERTION OF LEFT HEART VENT	No pre-authorization is required for all providers.	N/A
33989	REMOVAL OF LEFT HEART VENT	No pre-authorization is required for all providers.	N/A
33990	INSERT VAD ARTERY ACCESS	Pre-authorization is required for all providers.	Prior to 09/01/2019
33991	INSERT VAD ART&VEIN ACCESS	Pre-authorization is required for all providers.	Prior to 09/01/2019
33992	REMOVE VAD DIFFERENT SESSION	Pre-authorization is required for all providers.	Prior to 09/01/2019
33993	REPOSITION VAD DIFF SESSION	Pre-authorization is required for all providers.	Prior to 09/01/2019
33999	UNLISTED PROC CARDIAC SURG	No pre-authorization is required for all providers.	N/A
34001	EMBOLECT/THROMBEC; CAROTID ART BY NECK INCS	No pre-authorization is required for all providers.	N/A
34051	EMBOLECT/THROMBEC; INNOMINATE BY THORACIC INCS	No pre-authorization is required for all providers.	N/A
34101	EMBOLECT/THROMBEC; AXILRY/BRACHIAL ART-ARM INCS	No pre-authorization is required for all providers.	N/A
34111	EMBOLECT/THROMBEC; RADIAL/ULNAR ART BY ARM INCS	No pre-authorization is required for all providers.	N/A
34151	EMBOLECT/THROMBEC; RENAL/CELIAC ART BY ABD INCS	No pre-authorization is required for all providers.	N/A
34201	EMBOLECT/THROMBEC; FEMPOP ART BY LEG INCS	No pre-authorization is required for all providers.	N/A
34203	EMBOLECT/THROMBEC; POP-TIBIO-PER ART BY LEG INCS	No pre-authorization is required for all providers.	N/A
34401	THROMBEC DIRECT OR W/CATH; VENA CAVA BY ABD INCS	No pre-authorization is required for all providers.	N/A
34421	THROMBEC DIRECT OR W/CATH; VENA CAVA BY LEG INCS	No pre-authorization is required for all providers.	N/A
34451	THROMBEC; VENA CAVA BY ABD & LEG INCS	No pre-authorization is required for all providers.	N/A
34471	THROMBEC DIREC OR W/CATH; SUBCLAV VEIN NECK INCS	No pre-authorization is required for all providers.	N/A
34490	THROMBEC; AXILRY & SUBCLAV BY ARM INCS	No pre-authorization is required for all providers.	N/A
34501	VALVULOPLASTY FEMORAL VEIN	No pre-authorization is required for all providers.	N/A
34502	RECON VENA CAVA ANY METHD	No pre-authorization is required for all providers.	N/A
34510	VENOUS VALVE TRANSPOSITION ANY VEIN DONOR	No pre-authorization is required for all providers.	N/A
34520	CROSS-OVER VEIN GFT TO VENOUS SYST	No pre-authorization is required for all providers.	N/A
34530	SAPHENOPLOPLITEAL VEIN ANASTOM	No pre-authorization is required for all providers.	N/A
34701	EVASC RPR A-AO NDGFT	No pre-authorization is required for all providers.	N/A
34702	EVASC RPR A-AO NDGFT RPT	No pre-authorization is required for all providers.	N/A
34703	EVASC RPR A-UNILAC NDGFT	No pre-authorization is required for all providers.	N/A
34704	EVASC RPR A-UNILAC NDGFT RPT	No pre-authorization is required for all providers.	N/A
34705	EVAC RPR A-BILIAC NDGFT	No pre-authorization is required for all providers.	N/A
34706	EVASC RPR A-BILIAC RPT	No pre-authorization is required for all providers.	N/A
34707	EVASC RPR ILIO-ILIAC NDGFT	No pre-authorization is required for all providers.	N/A
34708	EVASC RPR ILIO-ILIAC RPT	No pre-authorization is required for all providers.	N/A
34709	PLMT XTN PROSTH EVASC RPR	No pre-authorization is required for all providers.	N/A
34710	DLYD PLMT XTN PROSTH 1ST VSL	No pre-authorization is required for all providers.	N/A
34711	DLYD PLMT XTN PROSTH EA ADDL	No pre-authorization is required for all providers.	N/A
34712	TCAT DLVR ENHNCED FIXJ DEV	No pre-authorization is required for all providers.	N/A
34713	PERQ ACCESS & CLSR FEM ART	No pre-authorization is required for all providers.	N/A
34714	OPN FEM ART EXPOS CNDT CRTJ	No pre-authorization is required for all providers.	N/A
34715	OPN AX/SUBCLA ART EXPOS	No pre-authorization is required for all providers.	N/A
34716	OPN AX/SUBCLA ART EXPOS CNDT	No pre-authorization is required for all providers.	N/A
34717	EVASC RPR ILIAC ART TM OF A-ILIAC ART NDGFT UNI	No pre-authorization is required for all providers.	N/A
34718	EVASC RPR ILIAC ART N/A A-ILIAC ART NDGFT UNI	No pre-authorization is required for all providers.	N/A
34800	ENDO REPR ABD ANEUR; W/PROSTH TUBE 31.96	This is no longer a valid code.	N/A
34802	ENDO REPR AO ANEUR; W/BIFUR PROS 35.27	This is no longer a valid code.	N/A
34803	ENDOVASC REPR AAA; BIFURCAT PROS 2 DOCK LIMBS	This is no longer a valid code.	N/A
34804	ENDO REPR AO ANEUR; W/UNIBODY PROST 35.27	This is no longer a valid code.	N/A
34805	ENDO REP AAA AORTO-UNILAC/UNIFEM	This is no longer a valid code.	N/A
34806	ANEURYSM PRESS SENSOR ADD-ON	This is no longer a valid code.	N/A
34808	ENDOVASC PLCMT ILIAC ART OCCLU DEV 6.07	No pre-authorization is required for all providers.	N/A
34812	OPN FEM ART EXPOS	No pre-authorization is required for all providers.	N/A
34813	PLCMT FEM PROS GFT DUR ANEUR REPR 7.06	No pre-authorization is required for all providers.	N/A
34820	OPN ILIAC ART EXPOS	No pre-authorization is required for all providers.	N/A
34825	PLCMT EXT PROS REP AORTC ANEUR;INIT	This is no longer a valid code.	N/A
34826	PLCMT EXT PROS REP AORTC ANEUR; ADD	This is no longer a valid code.	N/A
34830	OP REPR AO ANEUR/TRAUMA; TUBE PROS 49.74	No pre-authorization is required for all providers.	N/A
34831	OP REPR AO ANEUR; AO-BI-ILIAC PROS 53.77	No pre-authorization is required for all providers.	N/A
34832	OP REPR AO ANEUR; AORTO-BIFEM PROS 53.77	No pre-authorization is required for all providers.	N/A
34833	OPN ILAC ART EXPOS CNDT CRTJ	No pre-authorization is required for all providers.	N/A
34834	OPN BRACH ART EXPOS	No pre-authorization is required for all providers.	N/A
34839	PLNNING PT SPEC FENEST GRAFT	No pre-authorization is required for all providers.	N/A
34841	ENDOVASC VISC AORTA 1 GRAFT	No pre-authorization is required for all providers.	N/A
34842	ENDOVASC VISC AORTA 2 GRAFT	No pre-authorization is required for all providers.	N/A
34843	ENDOVASC VISC AORTA 3 GRAFT	No pre-authorization is required for all providers.	N/A
34844	ENDOVASC VISC AORTA 4 GRAFT	No pre-authorization is required for all providers.	N/A
34845	VISC & INFRAREN ABD 1 PROSTH	No pre-authorization is required for all providers.	N/A
34846	VISC & INFRAREN ABD 2 PROSTH	No pre-authorization is required for all providers.	N/A
34847	VISC & INFRAREN ABD 3 PROSTH	No pre-authorization is required for all providers.	N/A
34848	VISC & INFRAREN ABD 4+ PROST	No pre-authorization is required for all providers.	N/A
34900	ENDOVASC ILIAC REPR W/GRAFT	This is no longer a valid code.	N/A
35001	DIREC REPR ANEUR; ANEUR/OCCLUD CAROTID/SUBCLAV	No pre-authorization is required for all providers.	N/A
35002	DIREC REPR ANEUR; RUPTD ANEURY-NECK INCS	No pre-authorization is required for all providers.	N/A
35005	DIREC REPR ANEUR; ANEURY/OCCLUD VERTEBRAL ART	No pre-authorization is required for all providers.	N/A
35011	DIREC REPR; ANEURY AXILRY-BRACH ART BY ARM INCS	No pre-authorization is required for all providers.	N/A
35013	DIREC REPR; RUPT ANEURY AX-BRACH ART BY ARM INCS	No pre-authorization is required for all providers.	N/A
35021	DIREC REPR; ANEUR INNOM/SUBCLAV-THORACIC INCS	No pre-authorization is required for all providers.	N/A
35022	DIREC REPR; RUPT ANEURY INNOMIN ART-THORAC INCS	No pre-authorization is required for all providers.	N/A
35045	DIREC REPR; ANEURY/OCCLUD RADIAL/ULNAR ART	No pre-authorization is required for all providers.	N/A
35081	DIREC REPR; ANEURY/FALSE ANEURY/OCCLUD ABD AORTA	No pre-authorization is required for all providers.	N/A
35082	DIREC REPR ANEURY; RUPT ANEURY ABD AORTA	No pre-authorization is required for all providers.	N/A
35091	DIREC REPR; ANEURY ABD AORTA INVOLV VISCRL VESSL	No pre-authorization is required for all providers.	N/A
35092	DIREC REPR; RUPT ANEURY ABD AORTA W/VISCRL VESSL	No pre-authorization is required for all providers.	N/A
35102	DIREC REPR; ANEURY ABD AORTA INVOLV ILIAC VESSL	No pre-authorization is required for all providers.	N/A
35103	DIREC REPR; RUPT ANEURY ABD AORTA W/ILIAC VESSL	No pre-authorization is required for all providers.	N/A
35111	DIREC REPR; ANEURY/FLSE ANEUR/OCCLUD SPLENIC ART	No pre-authorization is required for all providers.	N/A

35112	DIREC REPR ANEURY; RUPT ANEURY SPLENIC ART	No pre-authorization is required for all providers.	N/A
35121	DIREC REPR; ANEURY HEPATIC/CELIAC/RENAL/MES ART	No pre-authorization is required for all providers.	N/A
35122	DIREC REPR; RUPT ANEURY HEPATIC/CELIAC/RENAL ART	No pre-authorization is required for all providers.	N/A
35131	DIREC REPR; ANEURY/FALSE ANEURY/OCCLUD ILIAC ART	No pre-authorization is required for all providers.	N/A
35132	DIREC REPR ANEURY; RUPT ANEURY ILIAC ART	No pre-authorization is required for all providers.	N/A
35141	DIREC REPR; ANEURY/FLSE ANEURY/OCCLU COMMON FEM A	No pre-authorization is required for all providers.	N/A
35142	DIREC REPR ANEURY; RUPT ANEURY COMMON FEM ART	No pre-authorization is required for all providers.	N/A
35151	DIREC REPR; ANEURY/FALSE ANEURY/OCCLUD POP ART	No pre-authorization is required for all providers.	N/A
35152	DIREC REPR ANEURY; RUPT ANEURY POP ART	No pre-authorization is required for all providers.	N/A
35180	REPR CONGEN AV FISTULA; HEAD & NECK	No pre-authorization is required for all providers.	N/A
35182	REPR CONGEN AV FISTULA; THORAX & ABD	No pre-authorization is required for all providers.	N/A
35184	REPR CONGEN AV FISTULA; EXTREM	No pre-authorization is required for all providers.	N/A
35188	REPR ACQUIRED/TRAUMATIC AV FISTULA; HEAD & NECK	No pre-authorization is required for all providers.	N/A
35189	REPR ACQUIRED/TRAUMATIC AV FISTULA; THORAX & ABD	No pre-authorization is required for all providers.	N/A
35190	REPR ACQUIRED/TRAUMATIC AV FISTULA; EXTREM	No pre-authorization is required for all providers.	N/A
35201	REPR BLD VESSEL DIRECT; NECK	No pre-authorization is required for all providers.	N/A
35206	REPR BLD VESSEL DIRECT; UPPER EXTREM	No pre-authorization is required for all providers.	N/A
35207	REPR BLD VESSEL DIRECT; HAND-FINGER	No pre-authorization is required for all providers.	N/A
35211	REPR BLD VESSEL DIRECT; INTRATHORACIC W/BYPASS	No pre-authorization is required for all providers.	N/A
35216	REPR BLD VESSEL DIRECT; INTRATHORACIC WO BYPASS	No pre-authorization is required for all providers.	N/A
35221	REPR BLD VESSEL DIRECT; INTRA-ABD	No pre-authorization is required for all providers.	N/A
35226	REPR BLD VESSEL DIRECT; LOWER EXTREM	No pre-authorization is required for all providers.	N/A
35231	REPR BLD VESSEL W/VEIN GFT; NECK	No pre-authorization is required for all providers.	N/A
35236	REPR BLD VESSEL W/VEIN GFT; UPPER EXTREM	No pre-authorization is required for all providers.	N/A
35241	REPR BLD VESS W/VEIN GFT; INTRATHORACIC W/BYPASS	No pre-authorization is required for all providers.	N/A
35246	REPR BLD VESS W/VEIN GFT; INTRATHORAC WO BYPASS	No pre-authorization is required for all providers.	N/A
35251	REPR BLD VESSEL W/VEIN GFT; INTRA-ABD	No pre-authorization is required for all providers.	N/A
35256	REPR BLD VESSEL W/VEIN GFT; LOWER EXTREM	No pre-authorization is required for all providers.	N/A
35261	REPR BLD VESSEL W/GFT OTHER THAN VEIN; NECK	No pre-authorization is required for all providers.	N/A
35266	REPR BLD VESS W/GFT OTHER THAN VEIN; UPPR EXTREM	No pre-authorization is required for all providers.	N/A
35271	REPR BLD VESS W/GFT NOT VEIN; INTRATHORAC W/BYPS	No pre-authorization is required for all providers.	N/A
35276	REPR BLD VESS W/GFT NOT VEIN; INTRATHOR WO BYPAS	No pre-authorization is required for all providers.	N/A
35281	REPR BLD VESSEL W/GFT OTHER THAN VEIN; INTRA-ABD	No pre-authorization is required for all providers.	N/A
35286	REPR BLD VESS W/GFT OTHER THAN VEIN; LOWR EXTREM	No pre-authorization is required for all providers.	N/A
35301	THROMBOENDARTERECTOMY INCL PATCH GRAFT IF PERF.CAROTID.VERTEBRAL.SUBCL	No pre-authorization is required for all providers.	N/A
35302	SUPERFICIAL FEMORAL ARTERY	No pre-authorization is required for all providers.	N/A
35303	POPLITEAL ARTERY	No pre-authorization is required for all providers.	N/A
35304	TIBIOPERONEAL TRUNK ARTERY	No pre-authorization is required for all providers.	N/A
35305	TIBIAL OR PERONEAL ARTERY, INITIAL VESSEL	No pre-authorization is required for all providers.	N/A
35306	EACH ADDITIONAL TIBIAL OR PERONEAL ARTERY	No pre-authorization is required for all providers.	N/A
35311	THROMBOENDARTERECT; SUBCLAV/INNOMIN-THORAC INCS	No pre-authorization is required for all providers.	N/A
35321	THROMBOENDARTERECT W/WO GFT; AXILRY-BRACHIAL	No pre-authorization is required for all providers.	N/A
35331	THROMBOENDARTERECTOMY W/WO PATCH GFT; ABD AORTA	No pre-authorization is required for all providers.	N/A
35341	THROMBOENDARTERECT; MESENTERIC/CELIAC/RENAL	No pre-authorization is required for all providers.	N/A
35351	THROMBOENDARTERECTOMY W/WO PATCH GFT; ILIAC	No pre-authorization is required for all providers.	N/A
35355	THROMBOENDARTERECT W/WO PATCH GFT; ILIOFEMORAL	No pre-authorization is required for all providers.	N/A
35361	THROMBOENDARTERECT W/WO GFT; COMBO AORTOILIAC	No pre-authorization is required for all providers.	N/A
35363	THROMBOENDARTERECTOMY; COMBO AORTOILIOFEMORAL	No pre-authorization is required for all providers.	N/A
35371	THROMBOENDARTERECT W/WO GFT; COMMON FEMORAL	No pre-authorization is required for all providers.	N/A
35372	THROMBOENDARTERECT W/WO PATCH GFT; DEEP FEMORAL	No pre-authorization is required for all providers.	N/A
35390	REOPERAT CAROTID THROMBOENDARTERECT > 1 MO-ORIG	No pre-authorization is required for all providers.	N/A
35400	ANGIOSCOPY (NON-CORONARY) DURING THERAP INTRVNTN	No pre-authorization is required for all providers.	N/A
35450	TRANSLUMNL BALLOON ANGIOPL OPEN; RENAL/VISC ART	This is no longer a valid code.	N/A
35452	TRANSLUMINAL BALLOON ANGIOPLASTY OPEN; AORTIC	This is no longer a valid code.	N/A
35458	TRNSLM BALLOON ANGPLST-OPEN; BRACHCEPH/BRNCH-EA	This is no longer a valid code.	N/A
35460	TRANSLUMINAL BALLOON ANGIOPLASTY OPEN; VENOUS	This is no longer a valid code.	N/A
35471	TRANSLUMINAL BALLOON ANGIOPL PERCUT; RENAL ART	This is no longer a valid code.	N/A
35472	TRANSLUMINAL BALLOON ANGIOPLASTY PERCUT; AORTIC	This is no longer a valid code.	N/A
35475	TRNSLM BLOON ANGPLST-PERC; BRACHCEPHAL/BRNCH-EA	This is no longer a valid code.	N/A
35476	TRANSLUMINAL BALLOON ANGIOPLASTY PERCUT; VENOUS	This is no longer a valid code.	N/A
35500	HARVEST UP EXTREM VEIN-LOW EXTREM BYPASS PROC	No pre-authorization is required for all providers.	N/A
35501	BYPASS GRAFT W/VEIN, COMMON CAROTID-IPSI LATERAL INTERNAL CAROTID	No pre-authorization is required for all providers.	N/A
35506	BYPASS GRFT W/OTHR THN VEIN, COMM CAROTID-IPSI LATERAL INTERNAL CAROTID	No pre-authorization is required for all providers.	N/A
35508	BYPASS GFT W/VEIN; CAROTID-VERTEBRAL	No pre-authorization is required for all providers.	N/A
35509	BYPASS GRAFT WITH VEIN, CAROTID-CONTRALATERAL CAROTID	No pre-authorization is required for all providers.	N/A
35510	BYPASS GRAFT W/VEIN CAROTID-BRACH	No pre-authorization is required for all providers.	N/A
35511	BYPASS GFT W/VEIN; SUBCLAVIAN-SUBCLAVIAN	No pre-authorization is required for all providers.	N/A
35512	BYPS GRAFT W/VEIN SUBCLAVIAN-BRACH	No pre-authorization is required for all providers.	N/A
35515	BYPASS GFT W/VEIN; SUBCLAVIAN-VERTEBRAL	No pre-authorization is required for all providers.	N/A
35516	BYPASS GFT W/VEIN; SUBCLAVIAN-AXILRY	No pre-authorization is required for all providers.	N/A
35518	BYPASS GFT W/VEIN; AXILRY-AXILRY	No pre-authorization is required for all providers.	N/A
35521	BYPASS GFT W/VEIN; AXILRY-FEMORAL	No pre-authorization is required for all providers.	N/A
35522	BYPASS GRAFT W/VEIN AX-BRACHIAL	No pre-authorization is required for all providers.	N/A
35523	ARTERY BYPASS GRAFT	No pre-authorization is required for all providers.	N/A
35525	BYPASS GRAFT W/VEIN BRACH-BRACH	No pre-authorization is required for all providers.	N/A
35526	ARTERY BYPASS GRAFT	No pre-authorization is required for all providers.	N/A
35531	BYPASS GFT W/VEIN; AORTOCELIAC/AORTOMESENTERIC	No pre-authorization is required for all providers.	N/A
35533	BYPASS GFT W/VEIN; AXILRY-FEMORAL-FEMORAL	No pre-authorization is required for all providers.	N/A
35535	ARTERY BYPASS GRAFT	No pre-authorization is required for all providers.	N/A
35536	BYPASS GFT W/VEIN; SPLENORENAL	No pre-authorization is required for all providers.	N/A
35537	AORTOILIAC	No pre-authorization is required for all providers.	N/A
35538	AORTOBIA-ILIAC	No pre-authorization is required for all providers.	N/A
35539	AORTOFEMORAL	No pre-authorization is required for all providers.	N/A
35540	AORTOBIFEMORAL	No pre-authorization is required for all providers.	N/A
35556	BYPASS GFT W/VEIN; FEMORAL-POP	No pre-authorization is required for all providers.	N/A
35558	BYPASS GFT W/VEIN; FEMORAL-FEMORAL	No pre-authorization is required for all providers.	N/A
35560	BYPASS GFT W/VEIN; AORTORENAL	No pre-authorization is required for all providers.	N/A
35563	BYPASS GFT W/VEIN; ILIOILIAC	No pre-authorization is required for all providers.	N/A
35565	BYPASS GFT W/VEIN; ILIOFEMORAL	No pre-authorization is required for all providers.	N/A
35566	BYPASS GFT W/VEIN; FEM-ANT TIB/POST TIB/DISTAL	No pre-authorization is required for all providers.	N/A
35570	ARTERY BYPASS GRAFT	No pre-authorization is required for all providers.	N/A
35571	BYPASS GFT W/VEIN; POP-TIBI-PERONEAL ART/DISTAL	No pre-authorization is required for all providers.	N/A
35572	HARV FEMPOP VEIN 1 SEG VASC REC NSTR	No pre-authorization is required for all providers.	N/A
35583	IN-SITU VEIN BYPASS; FEMORAL-POP	No pre-authorization is required for all providers.	N/A
35585	IN-SITU VEIN BYPASS; FEM-ANT TIB/POST TIB/PERONL	No pre-authorization is required for all providers.	N/A
35587	IN-SITU VEIN BYPASS; POP-TIBIAL/PERONEAL	No pre-authorization is required for all providers.	N/A
35600	HARVEST UPPER EXTREMITY ART 1 SEGMENT FOR CABG	No pre-authorization is required for all providers.	N/A
35601	BYPASS GRFT W/OTHR THN VEIN, COMMON CAROTID-IPSI LATERAL INTERNAL CAROTID	No pre-authorization is required for all providers.	N/A
35606	BYPASS GFT W/OTHER THAN VEIN; CAROTID-SUBCLAVIAN	No pre-authorization is required for all providers.	N/A
35612	BYPASS GFT W/OTHER THAN VEIN; SUBCLAVIAN-SUBCLAV	No pre-authorization is required for all providers.	N/A
35616	BYPASS GFT W/OTHER THAN VEIN; SUBCLAVIAN-AXILRY	No pre-authorization is required for all providers.	N/A
35621	BYPASS GFT W/OTHER THAN VEIN; AXILRY-FEMORAL	No pre-authorization is required for all providers.	N/A
35623	BYPASS GFT W/OTHER THAN VEIN; AX-POP-TIBIAL	No pre-authorization is required for all providers.	N/A
35626	ARTERY BYPASS GRAFT	No pre-authorization is required for all providers.	N/A
35631	BYPASS GFT NOT VEIN; AORTOCELIAC/AORTOMESENTERIC	No pre-authorization is required for all providers.	N/A
35632	ARTERY BYPASS GRAFT	No pre-authorization is required for all providers.	N/A
35633	ARTERY BYPASS GRAFT	No pre-authorization is required for all providers.	N/A
35634	ARTERY BYPASS GRAFT	No pre-authorization is required for all providers.	N/A
35636	BYPASS GFT W/OTHER THAN VEIN; SPLENORENAL	No pre-authorization is required for all providers.	N/A
35637	ARTERY BYPASS GRAFT	No pre-authorization is required for all providers.	N/A
35638	ARTERY BYPASS GRAFT	No pre-authorization is required for all providers.	N/A

35642	BYPASS GFT W/OTHER THAN VEIN; CAROTID-VERTEBRAL	No pre-authorization is required for all providers.	N/A
35645	BYPASS GFT W/OTHER THAN VEIN; SUBCLAV-VERTEBRAL	No pre-authorization is required for all providers.	N/A
35646	BYPASS GFT W/OTHER THAN VEIN; AORTOFEM/BIFEM	No pre-authorization is required for all providers.	N/A
35647	AORTOFEMORAL BYPASS GRAFT	No pre-authorization is required for all providers.	N/A
35650	BYPASS GFT W/OTHER THAN VEIN; AXILRY-AXILRY	No pre-authorization is required for all providers.	N/A
35654	BYPASS GFT W/OTHER THAN VEIN; AXILRY-FEM-FEM	No pre-authorization is required for all providers.	N/A
35656	BYPASS GFT W/OTHER THAN VEIN; FEMORAL-POP	No pre-authorization is required for all providers.	N/A
35661	BYPASS GFT W/OTHER THAN VEIN; FEMORAL-FEMORAL	No pre-authorization is required for all providers.	N/A
35663	BYPASS GFT W/OTHER THAN VEIN; ILIOILIAC	No pre-authorization is required for all providers.	N/A
35665	BYPASS GFT W/OTHER THAN VEIN; ILIOFEMORAL	No pre-authorization is required for all providers.	N/A
35666	BYPASS GFT NOT VEIN; FEM-ANT TIB/POST TIB/PERONL	No pre-authorization is required for all providers.	N/A
35671	BYPASS GFT W/OTHER THAN VEIN; POP-TIB-/PERONEAL	No pre-authorization is required for all providers.	N/A
35681	BYPASS GFT; COMPOSITE PROSTH VEIN	No pre-authorization is required for all providers.	N/A
35682	BYPASS GFT; AUTOG COMPOSITE-2 SEGMT 2 LOCATIONS	No pre-authorization is required for all providers.	N/A
35683	BYPASS GFT; AUTOG COMPOSITE-3/> SEGMT 2/> LOCATN	No pre-authorization is required for all providers.	N/A
35685	BYPASS GRAFT PATENCY/VEIN PATCH	No pre-authorization is required for all providers.	N/A
35686	BYPASS GRAFT PATENCY/AV FISTULA	No pre-authorization is required for all providers.	N/A
35691	TRANSPOSIT &/OR REIMPLNT; VERTEB TO CAROTID ART	No pre-authorization is required for all providers.	N/A
35693	TRANSPOSIT &/OR REIMPLNT; VERTEB TO SUBCLAV ART	No pre-authorization is required for all providers.	N/A
35694	TRANSPOSIT &/OR REIMPLNT; SUBCLAV TO CAROTID ART	No pre-authorization is required for all providers.	N/A
35695	TRANSPOSIT &/OR REIMPLNT; CAROTID TO SUBCLAV ART	No pre-authorization is required for all providers.	N/A
35697	REIMPL ART INFRARENL AORTC PROS EA	No pre-authorization is required for all providers.	N/A
35700	REOPERAT FEM-POP/FEM-ANT TIB > 1 MO AFTR ORIG OR	No pre-authorization is required for all providers.	N/A
35701	EXPLORATION N/FLWD SURG NECK ARTERY	No pre-authorization is required for all providers.	N/A
35702	EXPLORATION N/FLWD SURG UPPER EXTREMITY ARTERY	No pre-authorization is required for all providers.	N/A
35703	EXPLORATION N/FLWD SURG LOWER EXTREMITY ARTERY	No pre-authorization is required for all providers.	N/A
35721	EXPLOR W/WO LYSIS ART; FEMORAL ART	No pre-authorization is required for all providers.	N/A
35741	EXPLOR W/WO LYSIS ART; POP ART	No pre-authorization is required for all providers.	N/A
35761	EXPLOR W/WO LYSIS ART; OTHER VESSELS	No pre-authorization is required for all providers.	N/A
35800	EXPLOR POSTOP HEMORR THROMBOSIS/INFEC; NECK	No pre-authorization is required for all providers.	N/A
35820	EXPLOR POSTOP HEMORR THROMBOSIS/INFEC; CHEST	No pre-authorization is required for all providers.	N/A
35840	EXPLOR POSTOP HEMORR THROMBOSIS/INFEC; ABD	No pre-authorization is required for all providers.	N/A
35860	EXPLOR POSTOP HEMORR/THROMBOSIS/INFEC; EXTREM	No pre-authorization is required for all providers.	N/A
35870	REPR GFT-ENTERIC FISTULA	No pre-authorization is required for all providers.	N/A
35875	THROMBECTOMY ART/VENOUS GFT;	No pre-authorization is required for all providers.	N/A
35876	THROMBECTOMY ART/VENOUS GFT; W/REVIS GFT	No pre-authorization is required for all providers.	N/A
35879	REVISION LOWER EXTREMITY ARTERIAL BYPASS W/O THROMBECTOMY OPEN	No pre-authorization is required for all providers.	N/A
35881	REVISION LOWER EXTREMITY ARTERIAL BYPASS W/SEGMENTAL VEIN	No pre-authorization is required for all providers.	N/A
35883	REVISION, FEMORAL ANASTOMOSIS	No pre-authorization is required for all providers.	N/A
35884	WITH AUTOGENOUS VEIN PATCH GRAFT	No pre-authorization is required for all providers.	N/A
35901	EXC INFEC GFT; NECK	No pre-authorization is required for all providers.	N/A
35903	EXC INFEC GFT; EXTREM	No pre-authorization is required for all providers.	N/A
35905	EXC INFEC GFT; THORAX	No pre-authorization is required for all providers.	N/A
35907	EXC INFEC GFT; ABD	No pre-authorization is required for all providers.	N/A
36000	INTRO NEEDLE/INTRACATHETER VEIN	No pre-authorization is required for all providers.	N/A
36002	PSEUDOANEURYSM INJECTION	No pre-authorization is required for all providers.	N/A
36005	INJ PROC CONTRAST VENOGRAPHY	No pre-authorization is required for all providers.	N/A
36010	INTRO CATH SUPER/INFERIOR VENA CAVA	No pre-authorization is required for all providers.	N/A
36011	SELECT CATH PLCMT VENOUS SYST; 1ST ORDER BRANCH	No pre-authorization is required for all providers.	N/A
36012	SELECT CATH PLCMT VENOUS; 2ND ORDER/MORE SELECT	No pre-authorization is required for all providers.	N/A
36013	INTRO CATH RT HEART/MAIN PULM ART	No pre-authorization is required for all providers.	N/A
36014	SELECT CATH PLCMT LT/RT PULM ART	No pre-authorization is required for all providers.	N/A
36015	SELECT CATH PLCMT SEGMT/SUBSEGMENTAL PULM ART	No pre-authorization is required for all providers.	N/A
36100	INTRO NEEDLE/INTRACATH CAROTID/VERTEB ART	No pre-authorization is required for all providers.	N/A
36120	INTRO NEEDLE/INTRACATH; RETROGRADE BRACHIAL ART	This is no longer a valid code.	N/A
36140	INTRO NDL ICATH UPRL/XTR ART	No pre-authorization is required for all providers.	N/A
36147	ACCESS AV DIAL GRFT FOR EVAL	This is no longer a valid code.	N/A
36148	ACCESS AV DIAL GRFT FOR PROC	This is no longer a valid code.	N/A
36160	INTRO NEEDLE/INTRACATHETER AORTIC TRANSLUMBAR	No pre-authorization is required for all providers.	N/A
36200	PLACE CATHETER IN AORTA	No pre-authorization is required for all providers.	N/A
36208	THAW PRESERVED STEM CELLS	No pre-authorization is required for all providers.	N/A
36215	SELECT CATH PLCMT ART SYST; EA 1ST ORDER THORAC	No pre-authorization is required for all providers.	N/A
36216	SELECT CATH PLCMT ART SYST; INIT 2ND ORDER THORA	No pre-authorization is required for all providers.	N/A
36217	SELECT CATH PLCMT ART SYST; INIT 3RD ORDER THORA	No pre-authorization is required for all providers.	N/A
36218	SELECT CATH PLCMT ART; ADD 2ND & 3RD & BEYOND	No pre-authorization is required for all providers.	N/A
36221	PLACE CATH THORACIC AORTA	No pre-authorization is required for all providers.	N/A
36222	PLACE CATH CAROTID/INOM ART	No pre-authorization is required for all providers.	N/A
36223	PLACE CATH CAROTID/INOM ART	No pre-authorization is required for all providers.	N/A
36224	PLACE CATH CAROTD ART	No pre-authorization is required for all providers.	N/A
36225	PLACE CATH SUBCLAVIAN ART	No pre-authorization is required for all providers.	N/A
36226	PLACE CATH VERTEBRAL ART	No pre-authorization is required for all providers.	N/A
36227	PLACE CATH XTRNL CAROTID	No pre-authorization is required for all providers.	N/A
36228	PLACE CATH INTRACRANIAL ART	No pre-authorization is required for all providers.	N/A
36245	INS CATH ABD/L-EXT ART 1ST	No pre-authorization is required for all providers.	N/A
36246	INS CATH ABD/L-EXT ART 2ND	No pre-authorization is required for all providers.	N/A
36247	INS CATH ABD/L-EXT ART 3RD	No pre-authorization is required for all providers.	N/A
36248	INS CATH ABD/L-EXT ART ADDL	No pre-authorization is required for all providers.	N/A
36251	INS CATH REN ART 1ST UNILAT	No pre-authorization is required for all providers.	N/A
36252	INS CATH REN ART 1ST BILAT	No pre-authorization is required for all providers.	N/A
36253	INS CATH REN ART 2ND+ UNILAT	No pre-authorization is required for all providers.	N/A
36254	INS CATH REN ART 2ND+ BILAT	No pre-authorization is required for all providers.	N/A
36260	INSRT IMPLNT INTRA-ART INFUSION PUMP	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
36261	REVIS IMPLNT INTRA-ART INFUSION PUMP	No pre-authorization is required for all providers.	N/A
36262	REMOV IMPLNT INTRA-ART INFUSION PUMP	No pre-authorization is required for all providers.	N/A
36299	UNLISTED PROC VASCULAR INJ	No pre-authorization is required for all providers.	N/A
36400	BL DRAW < 3 YRS FEM/JUGULAR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
36405	BL DRAW <3 YRS SCALP VEIN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
36406	BL DRAW <3 YRS OTHER VEIN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
36410	NON-ROUTINE BL DRAW 3/> YRS	No pre-authorization is required for all providers.	N/A
36415	COLLECTION VENOUS BLD VENIPUNCTURE	This service is not covered by Superior HealthPlan.	N/A
36416	COLLECTON CAPILLARY BLOOD SPECIMEN	This service is not covered by Superior HealthPlan.	N/A
36420	VENIPUNCTURE CUTDOWN; UNDER AGE 1 YR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
36425	VENIPUNCTURE CUTDOWN; AGE 1/OVER	No pre-authorization is required for all providers.	N/A
36430	TRANSFUSION BLD/BLD COMPONENTS	No pre-authorization is required for all providers.	N/A
36440	PUSH TRANSFUSION BLD 2 YR/UNDER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
36450	EXCHG TRANSFUSION BLD; NB	No pre-authorization is required for all providers.	N/A
36455	EXCHG TRANSFUSION BLD; OTHER THAN NB	No pre-authorization is required for all providers.	N/A
36456	PRTL EXCHANGE TRANSFUSE BLOOD/PLSM/CRYST NEWBORN	No pre-authorization is required for all providers.	N/A
36460	TRANSFUSION INTRAUTERINE FETAL	No pre-authorization is required for all providers.	N/A
36465	NJX NONCMPND SCLRSNT 1 VEIN	Pre-authorization is required for all providers.	Prior to 09/01/2019
36466	NJX NONCMPND SCLRSNT MLT VN	Pre-authorization is required for all providers.	Prior to 09/01/2019
36468	NJX SCLRSNT SPIDER VEINS	This service is not covered by Superior HealthPlan.	N/A
36469	SNGL/MX INJ SCLEROSING SOLUT-SPIDER VEINS; FACE	This is no longer a valid code.	N/A
36470	NJX SCLRSNT 1 INCMPTNT VEIN	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
36471	NJX SCLRSNT MLT INCMPTNT VN	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
36473	ENDOVEN ABLTJ INCMPTNT VEIN MCHNCHEM 1ST VEIN	No pre-authorization is required for all providers.	N/A
36474	ENDOVEN ABLTJ INCMPTNT VEIN MCHNCHEM SBQS VEINS	No pre-authorization is required for all providers.	N/A
36475	ENDOVENUS ABLAT TX INCOMPETENT VEIN EXT RF; 1 VN	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
36476	ENDOVENOUS RF VEIN ADD-ON	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
36478	ENDOVEN ABLAT TX INCMPTNT VEIN EXT LASR;1 VEIN	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
36479	ENDOVENOUS LASER VEIN ADDON	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019

36481	PERCUT PORTAL VEIN CATH BY ANY METHD	No pre-authorization is required for all providers.	N/A
36482	ENDOVEN THER CHEM ADHES 1ST	This service is not covered by Superior HealthPlan.	N/A
36483	ENDOVEN THER CHEM ADHES SBSQ	This service is not covered by Superior HealthPlan.	N/A
36500	VENOUS CATH SELECT ORGAN BLD SAMPL	No pre-authorization is required for all providers.	N/A
36510	CATH UMBILICAL VEIN DX/THERAP NB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
36511	TX APHERES; WHITE BLD CELLS	No pre-authorization is required for all providers.	N/A
36512	THERAPEUTIC APHERESIS; RBCS	No pre-authorization is required for all providers.	N/A
36513	THERAPEUTIC APHERESIS; PLATELETS	No pre-authorization is required for all providers.	N/A
36514	THERAPEUTIC APHERES; PLASMA PHERES	No pre-authorization is required for all providers.	N/A
36515	TX APHERES; W/IMMUOADSORPT&REINFUS	This is no longer a valid code.	N/A
36516	APHERESIS IMMUNOADS SLCTV	No pre-authorization is required for all providers.	N/A
36522	PHOTOPHERESIS EXTRACORPoreal	No pre-authorization is required for all providers.	N/A
36555	INSRT NON-TUNNL CNTRL CVC <5 YR	No pre-authorization is required for all providers.	N/A
36556	INSRT NON-TUNNL CNTRL CVC 5/>	No pre-authorization is required for all providers.	N/A
36557	INSRT TUNNL CVC NO PORT/PUMP <5 YR	No pre-authorization is required for all providers.	N/A
36558	INSRT TUNNL CVC NO PORT/PUMP 5 YR/>	No pre-authorization is required for all providers.	N/A
36560	INSRT TUNNL CNTRL CVAD PORT <5 YR	No pre-authorization is required for all providers.	N/A
36561	INSRT TUNNL CNTRL CVAD PORT 5 YR/>	No pre-authorization is required for all providers.	N/A
36563	INSRT TUNNL CNTRL CVAD W/SUBQ PUMP	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
36565	INSRT TUNL CVAD 2 CATH-SITE NO PORT	No pre-authorization is required for all providers.	N/A
36566	INSRT TUNNL CVAD 2 CATH-2 SITE PORT	No pre-authorization is required for all providers.	N/A
36568	INSERTION PICC W/O IMG GDN < 5 YR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
36569	INSERTION PICC W/O IMG GDN 5 YR/>	No pre-authorization is required for all providers.	N/A
36570	INSRT PERIPH INSRT CVAD W/PORT <5YR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
36571	INSRT PERIPH INSRT CVAD PORT 5YR/>	No pre-authorization is required for all providers.	N/A
36572	INSERTION PICC W/RS AND I < 5 YR	No pre-authorization is required for all providers.	N/A
36573	INSERTION PICC W/RS AND I 5 YR/>	No pre-authorization is required for all providers.	N/A
36575	REP CV ACSS CATH W/O PORT/PUMP	No pre-authorization is required for all providers.	N/A
36576	REP CVAD W/PORT/PUMP CNTRL/PERIPH	No pre-authorization is required for all providers.	N/A
36578	REPL CATH ONLY CVAD SUBQ PORT/PUMP	No pre-authorization is required for all providers.	N/A
36580	REPL NON-TUNNLD CVC W/O PORT/PUMP	No pre-authorization is required for all providers.	N/A
36581	REPL TUNNLD CNTRL CVC W/O PORT/PUMP	No pre-authorization is required for all providers.	N/A
36582	REPL TUNNLD CNTRL CVAD W/SUBQ PORT	No pre-authorization is required for all providers.	N/A
36583	REPL TUNNLD CNTRL CVAD W/SUBQ PUMP	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
36584	COMPLETE REPLACEMENT PICC R S AND I	No pre-authorization is required for all providers.	N/A
36585	REPL PERIPH INSRT CVAD W/SUBQ PORT	No pre-authorization is required for all providers.	N/A
36589	REMV TUNNLD CVC W/O SUBQ PORT/PUMP	No pre-authorization is required for all providers.	N/A
36590	REMV TUNNLD CVAD W/SUBQ PORT/PUMP	No pre-authorization is required for all providers.	N/A
36591	DRAW BLOOD OFF VENOUS DEVICE	No pre-authorization is required for all providers.	N/A
36592	COLLECT BLOOD FROM PICC	This service is not covered by Superior HealthPlan.	N/A
36593	DECLOT VASCULAR DEVICE	No pre-authorization is required for all providers.	N/A
36595	MECH REMV PERICATH MATL SEP ACSS	No pre-authorization is required for all providers.	N/A
36596	MECH REMV INTRALUMNL OBST MATL-LUMN	No pre-authorization is required for all providers.	N/A
36597	REPSTN PREV PLCD CVC FLUORO GUID	No pre-authorization is required for all providers.	N/A
36598	CNTRST NJX RAD EVAL CTR VAD FLUOR IMG&REPR	No pre-authorization is required for all providers.	N/A
36600	ART PUNCT WITHDRAWAL BLD DX	No pre-authorization is required for all providers.	N/A
36620	ART CATH/CANNULAT-SAMPL MONITOR (SEP PROC); PERQ	No pre-authorization is required for all providers.	N/A
36625	ART CATH/CANNULAT-SAMPL/MONITOR (SEP PROC); CUTDN	No pre-authorization is required for all providers.	N/A
36640	ART CATH PROLONGED INFUSION THERAP CUTDOWN	No pre-authorization is required for all providers.	N/A
36660	CATHETERIZATION UMBILICAL NEWBORN ART DX/THERAPY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
36680	PLCMT NEEDLE INTRAOSSEOUS INFUSION	No pre-authorization is required for all providers.	N/A
36800	INSRT CANNULA (SEPART PROC); VEIN-VEIN	No pre-authorization is required for all providers.	N/A
36810	INSRT CANNULA (SEPART PROC); AV-EXT	No pre-authorization is required for all providers.	N/A
36815	INSRT CANNULA (SEPART PROC); AV-EXT REVIS/CLO	No pre-authorization is required for all providers.	N/A
36818	AV ANASTOM OPEN; UP ARM CEPHALIC VEIN TRNSPSTN	No pre-authorization is required for all providers.	N/A
36819	ARTERIOVENOUS ANASTOMOSIS, OPEN BY BASILIC VEIN TRANSPORTATION	No pre-authorization is required for all providers.	N/A
36820	INSERTION OF CANNULA	No pre-authorization is required for all providers.	N/A
36821	AV ANASTOM DIRECT ANY SITE (SEPART PROC)	No pre-authorization is required for all providers.	N/A
36822	INSRT CANNULA PROLONG EXTRACORP CIRC (SEP PROC)	This is no longer a valid code.	N/A
36823	INSRT ART & VEN CANNULA(S)-EXTRACORP CIRC-CHEMO	No pre-authorization is required for all providers.	N/A
36825	CREATE AV FISTULA (SEPART PROC); AUTOG GFT	No pre-authorization is required for all providers.	N/A
36830	CREAT AV FIST SEP PROC; NONAUTOGEN	No pre-authorization is required for all providers.	N/A
36831	THROMBECT AV FIST WO REVIS-AUTOG/NONAUTOG GFT	No pre-authorization is required for all providers.	N/A
36832	REVIS-AV FIST AUTOG/NONAUTOG DIALYSIS GFT (SP)	No pre-authorization is required for all providers.	N/A
36833	REVIS AV FIST; W/THROMBECT-AUTOG/NONAUTOG GFT	No pre-authorization is required for all providers.	N/A
36835	INSRT THOMAS SHUNT (SEPART PROC)	No pre-authorization is required for all providers.	N/A
36838	DRIL UPPER EXT HEMODIALYSIS ACCESS	No pre-authorization is required for all providers.	N/A
36860	EXT CANNULA DECLOT (SP); WO BALLOON CATH	No pre-authorization is required for all providers.	N/A
36861	EXT CANNULA DECLOT (SEPART PROC); W/BALLOON CATH	No pre-authorization is required for all providers.	N/A
36870	THROMBECT PERC AVF-AUTO/NONAUTO 36.23	This is no longer a valid code.	N/A
36901	INTRO CATH DIALYSIS CIRCUIT DX ANGRPH FLUOR S&I	No pre-authorization is required for all providers.	N/A
36902	INTRO CATH DIALYSIS CIRCUIT W/TRLUML BALO ANGIOP	No pre-authorization is required for all providers.	N/A
36903	INTRO CATH DIALYSIS CIRCUIT W/TCAT PLMT IV STENT	No pre-authorization is required for all providers.	N/A
36904	PERQ THRMBC/NFS DIALYSIS CIRCUIT IMG DX ANGRPH	No pre-authorization is required for all providers.	N/A
36905	PERQ THRMBC/NFS DIAL CIRCUIT TRLUML BALO ANGIOP	No pre-authorization is required for all providers.	N/A
36906	PERQ THRMBC/NFS DIAL CIRCUIT TCAT PLMT IV STENT	No pre-authorization is required for all providers.	N/A
36907	TRLUML BALO ANGIOP CTR DIALYSIS SEG W/IMG S&I	No pre-authorization is required for all providers.	N/A
36908	STENT PLMT CTR DIALYSIS SEG	No pre-authorization is required for all providers.	N/A
36909	DIALYSIS CIRCUIT VASC EMBOLI OCCLS EVASC IMG S&I	No pre-authorization is required for all providers.	N/A
37140	VENOUS ANASTOMOSIS OPEN; PORTOCAVAL	No pre-authorization is required for all providers.	N/A
37145	VENOUS ANASTOMOSIS OPEN; RENOPORTAL	No pre-authorization is required for all providers.	N/A
37160	VENUS ANASTOM OPEN; CAVAL-MESNTRIC	No pre-authorization is required for all providers.	N/A
37180	VENUS ANASTOM OPEN; SPLENORENL PROX	No pre-authorization is required for all providers.	N/A
37181	VENUS ANASTOM OPEN; SPLENORENL DIST	No pre-authorization is required for all providers.	N/A
37182	INSRT TRNS INTRAHEP PORTOSYS SHNT	No pre-authorization is required for all providers.	N/A
37183	REV TRNS INTRAHEP PORTOSYS SHNT	No pre-authorization is required for all providers.	N/A
37184	PRIM ART M-THRMBC 1ST VSL	No pre-authorization is required for all providers.	N/A
37185	PRIM ART M-THRMBC SBSQ VSL	No pre-authorization is required for all providers.	N/A
37186	SEC ART THROMBECTOMY ADD-ON	No pre-authorization is required for all providers.	N/A
37187	PRQ TRLUML MCHNL THRMBC VEIN	No pre-authorization is required for all providers.	N/A
37188	PRQ TRLUML MCHNL THRMBC VEIN REPEAT TX	No pre-authorization is required for all providers.	N/A
37191	INS ENDOVAS VENA CAVA FILTR	No pre-authorization is required for all providers.	N/A
37192	REDO ENDOVAS VENA CAVA FILTR	No pre-authorization is required for all providers.	N/A
37193	REM ENDOVAS VENA CAVA FILTER	No pre-authorization is required for all providers.	N/A
37195	THROMBOLYSIS CEREBRAL BY IV INFUS	No pre-authorization is required for all providers.	N/A
37197	REMOVE INTRVAS FOREIGN BODY	No pre-authorization is required for all providers.	N/A
37200	TRANSCATH BX	No pre-authorization is required for all providers.	N/A
37202	TRANSCATH THERAP INFUSION NOT THROMBOLYSIS	This is no longer a valid code.	N/A
37204	TRANSCATH OCCLUD/EMBOLIZAT-PERCUT-NON CNS/HEAD	This is no longer a valid code.	N/A
37205	TRANSCATH IV STENT PERCUT	This is no longer a valid code.	N/A
37206	TRANSCATH IV STENT/PERC ADD	This is no longer a valid code.	N/A
37207	TRANSCATH IV STENT OPEN	This is no longer a valid code.	N/A
37208	TRANSCATH IV STENT/OPEN ADD	This is no longer a valid code.	N/A
37210	UTERINE FIBROID EMBOLIZATION	This is no longer a valid code.	N/A
37211	THROMBOLYTIC ART THERAPY	No pre-authorization is required for all providers.	N/A
37212	THROMBOLYTIC VENOUS THERAPY	No pre-authorization is required for all providers.	N/A
37213	THROMBLYTIC ART/VEN THERAPY	No pre-authorization is required for all providers.	N/A
37214	CESSJ THERAPY CATH REMOVAL	No pre-authorization is required for all providers.	N/A
37215	TRANSCATH STENT CCA W/EPS	No pre-authorization is required for all providers.	N/A
37216	TRANSCATH STENT CCA W/O EPS	No pre-authorization is required for all providers.	N/A
37217	STENT PLACEMT RETRO CAROTID	No pre-authorization is required for all providers.	N/A

37218	STENT PLACEMT ANTE CAROTID	No pre-authorization is required for all providers.	N/A
37220	ILIAC REVASC	No pre-authorization is required for all providers.	N/A
37221	ILIAC REVASC W/STENT	No pre-authorization is required for all providers.	N/A
37222	ILIAC REVASC ADD-ON	No pre-authorization is required for all providers.	N/A
37223	ILIAC REVASC W/STENT ADD-ON	No pre-authorization is required for all providers.	N/A
37224	FEM/POPL REVAS W/TLA	No pre-authorization is required for all providers.	N/A
37225	FEM/POPL REVAS W/ATHER	No pre-authorization is required for all providers.	N/A
37226	FEM/POPL REVASC W/STENT	No pre-authorization is required for all providers.	N/A
37227	FEM/POPL REVASC STNT & ATHE	No pre-authorization is required for all providers.	N/A
37228	TIB/PER REVASC W/TLA	No pre-authorization is required for all providers.	N/A
37229	TIB/PER REVASC W/ATHER	No pre-authorization is required for all providers.	N/A
37230	TIB/PER REVASC W/STENT	No pre-authorization is required for all providers.	N/A
37231	TIB/PER REVASC STENT & ATHE	No pre-authorization is required for all providers.	N/A
37232	TIB/PER REVASC ADD-ON	No pre-authorization is required for all providers.	N/A
37233	TIBPER REVASC W/ATHER ADD-O	No pre-authorization is required for all providers.	N/A
37234	REVSC OPN/PRQ TIB/PERO STEN	No pre-authorization is required for all providers.	N/A
37235	TIB/PER REVASC STNT & ATHER	No pre-authorization is required for all providers.	N/A
37236	OPEN/PERQ PLACE STENT 1ST	No pre-authorization is required for all providers.	N/A
37237	OPEN/PERQ PLACE STENT EA ADD	No pre-authorization is required for all providers.	N/A
37238	OPEN/PERQ PLACE STENT SAME	No pre-authorization is required for all providers.	N/A
37239	OPEN/PERQ PLACE STENT EA ADD	No pre-authorization is required for all providers.	N/A
37241	VASC EMBOLIZE/OCCLUDE VENOUS	No pre-authorization is required for all providers.	N/A
37242	VASC EMBOLIZE/OCCLUDE ARTERY	No pre-authorization is required for all providers.	N/A
37243	VASC EMBOLIZE/OCCLUDE ORGAN	No pre-authorization is required for all providers.	N/A
37244	VASC EMBOLIZE/OCCLUDE BLEED	No pre-authorization is required for all providers.	N/A
37246	TRLML BALO ANGIOP OPEN/PERQ IMG S&I 1ST ART	No pre-authorization is required for all providers.	N/A
37247	TRLML BALO ANGIOP OPEN/PERQ IMG S&I EA ADDL ART	No pre-authorization is required for all providers.	N/A
37248	TRLML BALO ANGIOP OPEN/PERQ W/IMG S&I 1ST VEIN	No pre-authorization is required for all providers.	N/A
37249	TRLML BALO ANGIOP OPEN/PERQ W/IMG S&I ADDL VEIN	No pre-authorization is required for all providers.	N/A
37250	INTRAVASC US (NOT CORN) DURING THERAP; INITIAL	This is no longer a valid code.	N/A
37251	INTRAVASC US (NOT CORN) DURING THERAP; EA ADD	This is no longer a valid code.	N/A
37252	INTRVASC US NONCORONARY 1ST	No pre-authorization is required for all providers.	N/A
37253	INTRVASC US NONCORONARY ADDL	No pre-authorization is required for all providers.	N/A
37500	VASC ENDO SURG LIG PERFORATOR VNS	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
37501	UNLISTED VASCULAR ENDOSCOPY PROC	No pre-authorization is required for all providers.	N/A
37565	LIG INT JUGULAR VEIN	No pre-authorization is required for all providers.	N/A
37600	LIG; EXT CAROTID ART	No pre-authorization is required for all providers.	N/A
37605	LIG; INT/COMMON CAROTID ART	No pre-authorization is required for all providers.	N/A
37606	LIG; INT/COMMON CAROTID ART W/GRADUAL OCCLUD	No pre-authorization is required for all providers.	N/A
37607	LIG/BANDING ANGIO ACCESS AV FISTULA	No pre-authorization is required for all providers.	N/A
37609	LIG/BX TEMPORAL ART	No pre-authorization is required for all providers.	N/A
37615	LIG MAJOR ART; NECK	No pre-authorization is required for all providers.	N/A
37616	LIG MAJOR ART; CHEST	No pre-authorization is required for all providers.	N/A
37617	LIG MAJOR ART; ABD	No pre-authorization is required for all providers.	N/A
37618	LIG MAJOR ART; EXTREM	No pre-authorization is required for all providers.	N/A
37619	LIGATION OF INF VENA CAVA	No pre-authorization is required for all providers.	N/A
37650	REVISION OF MAJOR VEIN	No pre-authorization is required for all providers.	N/A
37660	REVISION OF MAJOR VEIN	No pre-authorization is required for all providers.	N/A
37700	LIG & DIVIS LONG SAPHENOUS VEIN @ SAPHENOFEMORAL	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
37718	LIG DIV&STRIPPING SHORT SAPHENOUS VEIN	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
37722	LIG DIV&STRIP LONG SAPH SAPHFEM JUNCT KNE/BELW	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
37735	LIG & STRIP LONG/SHORT SAPHENOUS W/RAD EXC ULCER	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
37760	LIG PERFORATR VNS SUBFASCL RADL OPN	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
37761	LIGATE LEG VEINS OPEN	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
37765	STAB PHLEBECT VV 1 EXT 10-20 INCI	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
37766	STAB PHLEBECT VV 1 EXT >20 INCI	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
37780	LIG SHORT SAPHENOUS VEIN @ SAPHENOPOP (SEP PRO)	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
37785	LIG & EXC VARICOSE VN CLUSTR 1 LEG	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
37788	PENILE REVASCULARIZATION ART W/WO VEIN GFT	This service is not covered by Superior HealthPlan.	N/A
37790	PENILE VENOUS OCCLUD PROC	This service is not covered by Superior HealthPlan.	N/A
37799	UNLISTED PROC VASCULAR SURG	No pre-authorization is required for all providers.	N/A
38100	SPLENECTOMY; TOT (SEPART PROC)	No pre-authorization is required for all providers.	N/A
38101	SPLENECTOMY; PART (SEPART PROC)	No pre-authorization is required for all providers.	N/A
38102	SPLENECTOMY; TOT EN BLOC EXTEN DZ W/OTH PROC	No pre-authorization is required for all providers.	N/A
38115	REPR RUPT SPLEEN W/WO PART SPLENECTOMY	No pre-authorization is required for all providers.	N/A
38120	LAPAROSCOPY, SURGICAL, SPLENECTOMY	No pre-authorization is required for all providers.	N/A
38129	UNLISTED LAPAROSCOPY PROCEDURE, SPLEEN	No pre-authorization is required for all providers.	N/A
38200	INJ PROC SPLENOPTOGRAPHY	No pre-authorization is required for all providers.	N/A
38204	MGMT RECIP HEM PRGNTR CELL DONR S&A	This service is not covered by Superior HealthPlan.	N/A
38205	BLD-DRIV PRGNTR CELL HRV TPLNT;ALLO	This service is not covered by Superior HealthPlan.	N/A
38206	BLD-DRV PRGNTR CELL HRV TPLNT;AUTOL	Pre-authorization is required for all providers.	Prior to 09/01/2019
38207	TPLNT PREP HEM PRGNTR CELL;CRY&STOR	This service is not covered by Superior HealthPlan.	N/A
38208	TPLNT PREP HEM PRG CELLTHW NO WASH	This service is not covered by Superior HealthPlan.	N/A
38209	WASH HARVEST STEM CELLS	This service is not covered by Superior HealthPlan.	N/A
38210	TPLNT PREP HEM PRGNTR CELL; T-CELL	This service is not covered by Superior HealthPlan.	N/A
38211	TPLNT PREP HEM PRGNTR CELL;TUM DPLT	This service is not covered by Superior HealthPlan.	N/A
38212	TPLNT PREP HEM PRGNTR CELL;RBC REMV	This service is not covered by Superior HealthPlan.	N/A
38213	TPLNT PREP PRGNTR CELL; PLATLT DPLT	This service is not covered by Superior HealthPlan.	N/A
38214	TPLNT PREP PRGNTR CELL; PLAS DPLT	This service is not covered by Superior HealthPlan.	N/A
38215	TPLNT PREP PRGNTR CELL; CONC PLAS	This service is not covered by Superior HealthPlan.	N/A
38220	DX BONE MARROW ASPIRATIONS	No pre-authorization is required for all providers.	N/A
38221	DX BONE MARROW BIOPSIES	No pre-authorization is required for all providers.	N/A
38222	DX BONE MARROW BX & ASPIR	No pre-authorization is required for all providers.	N/A
38230	BONE MARROW HARVEST ALLOGEN	Pre-authorization is required for all providers.	Prior to 09/01/2019
38232	BONE MARROW HARVEST AUTOLOG	Pre-authorization is required for all providers.	Prior to 09/01/2019
38240	TRANSPLT ALLO HCT/DONOR	Pre-authorization is required for all providers.	Prior to 09/01/2019
38241	TRANSPLT AUTOL HCT/DONOR	Pre-authorization is required for all providers.	Prior to 09/01/2019
38242	TRANSPLT ALLO LYMPHOCYTES	Pre-authorization is required for all providers.	Prior to 09/01/2019
38243	TRANSPLJ HEMATOPOIETIC BOOST	Pre-authorization is required for all providers.	Prior to 09/01/2019
38300	DRAINAGE LYMPH NODE ABSCESS/LYMPHADENITIS; SIMPL	No pre-authorization is required for all providers.	N/A
38305	DRAINAGE LYMPH NODE ABSCESS/LYMPHADENITIS; EXTEN	No pre-authorization is required for all providers.	N/A
38308	LYMPHANGIOTOMY/OTHER OR ON LYMPHATIC CHANNELS	No pre-authorization is required for all providers.	N/A
38380	SUTURE &/OR LIG THORACIC DUCT; CERV APPROACH	No pre-authorization is required for all providers.	N/A
38381	SUTURE &/OR LIG THORACIC DUCT; THORACIC APPROACH	No pre-authorization is required for all providers.	N/A
38382	SUTURE &/OR LIG THORACIC DUCT; ABD APPROACH	No pre-authorization is required for all providers.	N/A
38500	BX/EXC LYMPH NODE; SUPERF (SEPART PROC)	No pre-authorization is required for all providers.	N/A
38505	BX/EXC LYMPH NODE; BY NEEDLE SUPERF	No pre-authorization is required for all providers.	N/A
38510	BX/EXC LYMPH NODE; DEEP CERV NODE	No pre-authorization is required for all providers.	N/A
38520	BX/EXC LYMPH NODE; DEEP CERV NODE W/EXC FAT PAD	No pre-authorization is required for all providers.	N/A
38525	BX/EXC LYMPH NODE; DEEP AXILRY NODE	No pre-authorization is required for all providers.	N/A
38530	BX/EXC LYMPH NODE; INT MAMMARY NODE (SEP PRO)	No pre-authorization is required for all providers.	N/A
38531	OPEN BIOPSY/EXCISION INGUINOFEMORAL NODES	No pre-authorization is required for all providers.	N/A
38542	DISSECTION DEEP JUGULAR NODE	No pre-authorization is required for all providers.	N/A
38550	EXC CYSTIC HYGROMA AXIL/CERV; WO NEUROVAS DISSEC	No pre-authorization is required for all providers.	N/A
38555	EXC CYSTIC HYGROMA AXIL/CERV; W/NEUROVAS DISSEC	No pre-authorization is required for all providers.	N/A
38562	LTD LYMPHADENECTOMY (SEPART PROC); PELVIC	No pre-authorization is required for all providers.	N/A
38564	LTD LYMPHADENECT (SEPART PROC); RETROPERITONEAL	No pre-authorization is required for all providers.	N/A
38570	LAPAROSCOPY, SURGICAL	No pre-authorization is required for all providers.	N/A
38571	LAPAROSCOPY W/BILAT TOTAL PELVIC LYMPHADENECTOMY	No pre-authorization is required for all providers.	N/A
38572	LAPAROSCOPY WITH BILAT TOTAL PELVIC LYMPHADENECTOMY	No pre-authorization is required for all providers.	N/A
38573	LAPS PELVIC LYMPHADEC	No pre-authorization is required for all providers.	N/A

38589	UNLISTED LAPAROSCOPY PROCEDURE, LYMPHATIC SYSTEM	No pre-authorization is required for all providers.	N/A
38700	SUPRAHYOID LYMPHADENECTOMY	No pre-authorization is required for all providers.	N/A
38720	CERV LYMPHADENECTOMY (COMPLETE)	No pre-authorization is required for all providers.	N/A
38724	CERV LYMPHADENECTOMY (MODIFIED RAD NECK DISECT)	No pre-authorization is required for all providers.	N/A
38740	AXILRY LYMPHADENECTOMY; SUPERF	No pre-authorization is required for all providers.	N/A
38745	AXILRY LYMPHADENECTOMY; COMPLT	No pre-authorization is required for all providers.	N/A
38746	REMOVE THORACIC LYMPH NODES	No pre-authorization is required for all providers.	N/A
38747	ABD LYMPHADENECTOMY REGIONAL INCL NODES	No pre-authorization is required for all providers.	N/A
38760	REMOVE GROIN LYMPH NODES	No pre-authorization is required for all providers.	N/A
38765	INGUINOFEM LYMPHADENECTMY W/PELV LYMPH (SEP PRO)	No pre-authorization is required for all providers.	N/A
38770	PELVIC LYMPHADENECTOMY W/EXT ILIAC (SEPART PROC)	No pre-authorization is required for all providers.	N/A
38780	RETROPERITONEAL TRANSABD LYMPHADNECT (SEP PRO)	No pre-authorization is required for all providers.	N/A
38790	INJ PROC; LYMPHANGIOGRAPHY	No pre-authorization is required for all providers.	N/A
38792	RA TRACER ID OF SENTINL NODE	No pre-authorization is required for all providers.	N/A
38794	CANNULATION THORACIC DUCT	No pre-authorization is required for all providers.	N/A
38900	IO MAP OF SENT LYMPH NODE	No pre-authorization is required for all providers.	N/A
38999	UNLISTED PROC HEMIC/LYMPHATIC SYST	No pre-authorization is required for all providers.	N/A
39000	MEDIASTINOTOMY W/EXPLOR/RAIN/REMOV FB/BX; CERV	No pre-authorization is required for all providers.	N/A
39010	MEDIASTINOTOMY W/EXPLOR/RAIN/BX; TRANSTHORACIC	No pre-authorization is required for all providers.	N/A
39200	RESECT MEDIASTINAL CYST	No pre-authorization is required for all providers.	N/A
39220	RESECT MEDIASTINAL TUMOR	No pre-authorization is required for all providers.	N/A
39400	MEDIASTINOSCOPY INCL BIOPSY	This is no longer a valid code.	N/A
39401	MEDIASTINOSCPY W/MEDSTNL BX	No pre-authorization is required for all providers.	N/A
39402	MEDIASTINOSCPY W/LMPH NOD BX	No pre-authorization is required for all providers.	N/A
39499	UNLISTED PROC MEDIASTINUM	No pre-authorization is required for all providers.	N/A
39501	REPR LACERATION DIAPHRAGM ANY APPROACH	No pre-authorization is required for all providers.	N/A
39503	REPR NEONAT DIAPHRAGMATIC HERNIA W/WO CHEST TUBE	No pre-authorization is required for all providers.	N/A
39540	REPR DIAPHRAGMATIC HERNIA-TRAUMATIC; ACUTE	No pre-authorization is required for all providers.	N/A
39541	REPR DIAPHRAGMATIC HERNIA-TRAUMATIC; CHRONIC	No pre-authorization is required for all providers.	N/A
39545	IMBRICATION DIAPHRAGM-EVENTRATION; PARALYTIC/NON	No pre-authorization is required for all providers.	N/A
39560	RESECTION DIAPHRAGM W/SINPLE REPAIR	No pre-authorization is required for all providers.	N/A
39561	RESECTION DIAPHRAGM W/COMPLEX REPAIR	No pre-authorization is required for all providers.	N/A
39599	UNLISTED PROC DIAPHRAGM	No pre-authorization is required for all providers.	N/A
40490	BX LIP	No pre-authorization is required for all providers.	N/A
40500	VERMILIONECTOMY W/MUCOS ADVANCEMENT	No pre-authorization is required for all providers.	N/A
40510	EXC LIP; TRANSVERSE WEDGE EXC W/PRIM CLO	No pre-authorization is required for all providers.	N/A
40520	EXC LIP; V-EXC W/PRIM DIRECT LINEAR CLO	No pre-authorization is required for all providers.	N/A
40525	EXC LIP; FULL THICK RECON W/LOCAL FLAP	No pre-authorization is required for all providers.	N/A
40527	EXC LIP; FULL THICK RECON W/CROSS LIP FLAP	No pre-authorization is required for all providers.	N/A
40530	RESECT LIP MORE THAN 1-FOURTH WO RECON	No pre-authorization is required for all providers.	N/A
40650	REPR LIP FULL THICK; VERMILION ONLY	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
40652	REPR LIP FULL THICK; UP TO HALF VERTICAL HEIGHT	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
40654	REPR LIP FULL THICK; > 1/2 VERTICAL HT/COMPLX	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
40700	PLASTIC REPR CLEFT LIP/NASAL DEFORM; PRIM UNILAT	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
40701	PLASTIC REPR CLEFT LIP; PRIM BILAT-1 STAGE PROC	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
40702	PLASTIC REPR CLEFT LIP; PRIM BILAT-1 OF 2 STAGES	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
40720	PLASTIC REPR CLEFT LIP; SECNDRY-RECREAT & RECLO	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
40761	PLASTIC REPR CLEFT LIP; W/CROSS LIP PEDICLE FLAP	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
40799	UNLISTED PROC LIPS	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
40800	DRAIN ABSCESS/CYST VESTIBULE MOUTH; SIMPL	No pre-authorization is required for all providers.	N/A
40801	DRAIN ABSCESS/CYST VESTIBULE MOUTH; COMPLIC	No pre-authorization is required for all providers.	N/A
40804	REMOV EMBEDDED FB VESTIBULE MOUTH; SIMPL	No pre-authorization is required for all providers.	N/A
40805	REMOV EMBEDDED FB VESTIBULE MOUTH; COMPLIC	No pre-authorization is required for all providers.	N/A
40806	INCS LABIAL FRENUM	No pre-authorization is required for all providers.	N/A
40808	BX VESTIBULE MOUTH	No pre-authorization is required for all providers.	N/A
40810	EXC LES-MUCOS/SUBMUCOSA-VESTIBULE MOUTH; WO REPR	No pre-authorization is required for all providers.	N/A
40812	EXC LES-MUCOS/SUBMUCOSA-MOUTH; W/SIMPL REPR	No pre-authorization is required for all providers.	N/A
40814	EXC LES-MUCOS/SUBMUCOSA-MOUTH; W/COMPLX REPR	No pre-authorization is required for all providers.	N/A
40816	EXC LES-VESTIBULE-MOUTH; COMPLX W/EXC MUSCL	No pre-authorization is required for all providers.	N/A
40818	EXC MUCOS VESTIBULE MOUTH AS DONOR GFT	No pre-authorization is required for all providers.	N/A
40819	EXC FRENUM LABIAL/BUCCAL	No pre-authorization is required for all providers.	N/A
40820	DESTRCT LES/SCAR VESTIBULE MOUTH-PHYSICAL METHD	No pre-authorization is required for all providers.	N/A
40830	CLO LACERATION VESTIBULE MOUTH; 2.5 CM/LESS	No pre-authorization is required for all providers.	N/A
40831	CLO LACERATION VESTIBULE MOUTH; > 2.5 CM/COMPLX	No pre-authorization is required for all providers.	N/A
40840	VESTIBULOPLASTY; ANT	No pre-authorization is required for all providers.	N/A
40842	VESTIBULOPLASTY; POST UNILAT	No pre-authorization is required for all providers.	N/A
40843	VESTIBULOPLASTY; POST BILAT	No pre-authorization is required for all providers.	N/A
40844	VESTIBULOPLASTY; ENTIRE ARCH	No pre-authorization is required for all providers.	N/A
40845	VESTIBULOPLASTY; COMPLX	No pre-authorization is required for all providers.	N/A
40899	UNLISTED PROC VESTIBULE MOUTH	No pre-authorization is required for all providers.	N/A
41000	INTRAORAL I&D ABSCESS/CYST TONGUE/MOUTH; LINGUAL	No pre-authorization is required for all providers.	N/A
41005	INTRAORAL I&D ABSCESS TONGUE/MOUTH; SUBLINGUAL	No pre-authorization is required for all providers.	N/A
41006	INTRAORAL I&D ABSCESS; SUBLINGUAL SUPRAMYLOHYOID	No pre-authorization is required for all providers.	N/A
41007	INTRAORAL I&D ABSCESS/CYST; SUBMENTAL SPACE	No pre-authorization is required for all providers.	N/A
41008	INTRAORAL I&D ABSCESS/CYST; SUBMANDIBULAR SPACE	No pre-authorization is required for all providers.	N/A
41009	INTRAORAL I&D ABSCESS/CYST; MASTICATOR SPACE	No pre-authorization is required for all providers.	N/A
41010	INCS LINGUAL FRENUM	No pre-authorization is required for all providers.	N/A
41015	EXTRAORAL I&D ABSCESS FLOOR MOUTH; SUBLINGUAL	No pre-authorization is required for all providers.	N/A
41016	EXTRAORAL I&D ABSCESS FLOOR MOUTH; SUBMENTAL	No pre-authorization is required for all providers.	N/A
41017	EXTRAORAL I&D ABSCESS FLOOR MOUTH; SUBMANDIBULAR	No pre-authorization is required for all providers.	N/A
41018	EXTRAORAL I&D ABSCESS MOUTH; MASTICATOR SPACE	No pre-authorization is required for all providers.	N/A
41019	PLACE NEEDLES H&N FOR RT	This service is not covered by Superior HealthPlan.	N/A
41100	BX TONGUE; ANT TWO-THIRDS	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
41105	BX TONGUE; POST ONE-THIRD	No pre-authorization is required for all providers.	N/A
41108	BX FLOOR MOUTH	No pre-authorization is required for all providers.	N/A
41110	EXC LES TONGUE WO CLO	No pre-authorization is required for all providers.	N/A
41112	EXC LES TONGUE W/CLO; ANT TWO-THIRDS	No pre-authorization is required for all providers.	N/A
41113	EXC LES TONGUE W/CLO; POST ONE-THIRD	No pre-authorization is required for all providers.	N/A
41114	EXC LES TONGUE W/CLO; W/LOCAL TONGUE FLAP	No pre-authorization is required for all providers.	N/A
41115	EXC LINGUAL FRENUM	No pre-authorization is required for all providers.	N/A
41116	EXC LES FLOOR MOUTH	No pre-authorization is required for all providers.	N/A
41120	GLOSSECTOMY; < ONE-HALF TONGUE	No pre-authorization is required for all providers.	N/A
41130	GLOSSECTOMY; HEMIGLOSSECTOMY	No pre-authorization is required for all providers.	N/A
41135	GLOSSECTOMY; PART W/UNILAT RADICAL NECK DISSECT	No pre-authorization is required for all providers.	N/A
41140	GLOSSECTOMY; COMPLT/TOT W/WO TRACH WO RAD NCEK	No pre-authorization is required for all providers.	N/A
41145	GLOSSECTOMY; COMPLT/TOT W/UNILAT RADICAL NECK	No pre-authorization is required for all providers.	N/A
41150	GLOSSECTOMY; COMPOSITE WO RADICAL NECK DISSECT	No pre-authorization is required for all providers.	N/A
41153	GLOSSECTOMY; COMPOSITE W/SUPRAHYOID NECK DISSECT	No pre-authorization is required for all providers.	N/A
41155	GLOSSECTOMY; COMPOSITE & RADICAL NECK DISSECTION	No pre-authorization is required for all providers.	N/A
41250	REPR LACERATION 2.5 CM/LESS; ANT 2/3 TONGUE	No pre-authorization is required for all providers.	N/A
41251	REPR LACERATION 2.5 CM/LESS; POST 1/3 TONGUE	No pre-authorization is required for all providers.	N/A
41252	REPR LACERAT TONGUE/FLOOR MOUTH > 2.6 CM/COMPLX	No pre-authorization is required for all providers.	N/A
41500	FIXA TONGUE MECH OTHER THAN SUTURE	This is no longer a valid code.	N/A
41510	SUTURE TONGUE TO LIP MICROGNATHIA	No pre-authorization is required for all providers.	N/A
41512	TONGUE SUSPENSION	This service is not covered by Superior HealthPlan.	N/A
41520	FRENOPLASTY	No pre-authorization is required for all providers.	N/A
41530	TONGUE BASE VOL REDUCTION	This service is not covered by Superior HealthPlan.	N/A
41599	UNLISTED PROC TONGUE FLOOR MOUTH	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
41800	DRAINAGE ABSCESS/CYST FROM DENTOALVEOLAR STRUCT	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
41805	REMOV EMBED FB-DENTOALVEOLAR STRUCT; SOFT TISS	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
41806	REMOV EMBEDDED FB-DENTOALVEOLAR STRUCT; BONE	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019

41820	GINGIVECTOMY EXC GINGIVA EA QUADRANT	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
41821	OPERCULECTOMY EXC PERICORONAL TISS	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
41822	EXC FIBROUS TUBEROSITIES DENTOALVEOLAR STRUCT	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
41823	EXC OSSEOUS TUBEROSITIES DENTOALVEOLAR STRUCT	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
41825	EXC LES/TUMOR DENTOALVEOLAR STRUCT; WO REPR	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
41826	EXC LES/TUMOR DENTOALVEOLAR STRUCT; W/SIMPL REPR	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
41827	EXC LES DENTOALVEOLAR STRUCT; W/COMPLX REPR	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
41828	EXC HYPERPLASTIC ALVEOLAR MUCOS EA QUADRANT	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
41830	ALVEOLECTOMY INCL CURET OSTEITIS/SEQUESTRECTOMY	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
41850	DESTRCT LES DENTOALVEOLAR STRUCT	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
41870	PERIODONTAL MUCOS GFT	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
41872	GINGIVOPLASTY EA QUADRANT	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
41874	ALVEOLOPLASTY EA QUADRANT	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
41899	UNLISTED PROC DENTOALVEOLAR STRUCT	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
42000	DRAINAGE ABSCESS PALATE UVULA	No pre-authorization is required for all providers.	N/A
42100	BX PALATE UVULA	No pre-authorization is required for all providers.	N/A
42104	EXC LES PALATE UVULA; WO CLO	No pre-authorization is required for all providers.	N/A
42106	EXC LES PALATE UVULA; W/SIMPL PRIM CLO	No pre-authorization is required for all providers.	N/A
42107	EXC LES PALATE UVULA; W/LOCAL FLAP CLO	No pre-authorization is required for all providers.	N/A
42120	RESECT PALATE/EXTEN RESECT LES	No pre-authorization is required for all providers.	N/A
42140	UVULECTOMY EXC UVULA	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
42145	PALATOPHARYNGOPLASTY	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
42160	DESTRCT LES PALATE/UVULA	No pre-authorization is required for all providers.	N/A
42180	REPR LACERATION PALATE; UP TO 2 CM	No pre-authorization is required for all providers.	N/A
42182	REPR LACERATION PALATE; OVER 2 CM/COMPLX	No pre-authorization is required for all providers.	N/A
42200	PALATOPLASTY-CLEFT PALATE SOFT &/OR HARD PALATE	Pre-authorization is required for all providers.	Prior to 09/01/2019
42205	PALATOPLASTY-CLEFT PALATE; SOFT TISS ONLY	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
42210	PALATOPLASTY CLEFT PALATE; W/BONE GFT-ALVEOLAR	Pre-authorization required for all providers.	Prior to 09/01/2019
42215	PALATOPLASTY CLEFT PALATE; MAJOR REVIS	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
42220	PALATOPLASTY CLEFT PALATE; SECNDRY LENGTHENING	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
42225	PALATOPLASTY CLEFT PALATE; ATTACH PHARYNGEAL FLP	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
42226	LENGTHENING PALATE & PHARYNGEAL FLAP	No pre-authorization is required for all providers.	N/A
42227	LENGTHENING PALATE W/ISLAND FLAP	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
42235	REPR ANT PALATE INCL VOMER FLAP	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
42260	REPR NASOLABIAL FISTULA	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
42280	MAXIL IMPRESSION PALATAL PROSTH	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
42281	INSRT PIN-RETAINED PALATAL PROSTH	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
42299	UNLISTED PROC PALATE UVULA	Pre-authorization is required in all locations except Urgent Care and Emergency Room.	Prior to 09/01/2019
42300	DRAINAGE ABSCESS; PAROTID SIMPL	No pre-authorization is required for all providers.	N/A
42305	DRAINAGE ABSCESS; PAROTID COMPLIC	No pre-authorization is required for all providers.	N/A
42310	DRAINAGE ABSCESS; SUBMAXIL/SUBLINGUAL INTRAORAL	No pre-authorization is required for all providers.	N/A
42320	DRAINAGE ABSCESS; SUBMAXILLARY EXT	No pre-authorization is required for all providers.	N/A
42330	SIALOLITHOTOMY; SUBMANDIBULAR UNCOMP INTRAORAL	No pre-authorization is required for all providers.	N/A
42335	SIALOLITHOTOMY; SUBMANDIBULAR COMPLIC INTRAORAL	No pre-authorization is required for all providers.	N/A
42340	SIALOLITHOTOMY; PAROTID/COMPLIC INTRAORAL	No pre-authorization is required for all providers.	N/A
42400	BX SALIVARY GLAND; NEEDLE	No pre-authorization is required for all providers.	N/A
42405	BX SALIVARY GLAND; INCS	No pre-authorization is required for all providers.	N/A
42408	EXC SUBLINGUAL SALIVARY CYST	No pre-authorization is required for all providers.	N/A
42409	MARSUPIALIZATION SUBLINGUAL SALIVARY CYST	No pre-authorization is required for all providers.	N/A
42410	EXC PAROTID TUMOR; LAT LOBE WO NERVE DISSECTION	No pre-authorization is required for all providers.	N/A
42415	EXC PAROTID TUMOR; LAT LOBE W/DISSECTION NERVE	No pre-authorization is required for all providers.	N/A
42420	EXC PAROTID TUMOR; TOT W/DISSECT & PRESERV NERVE	No pre-authorization is required for all providers.	N/A
42425	EXC PAROTID TUMOR; TOT W/SACRIFICE FACIAL NERVE	No pre-authorization is required for all providers.	N/A
42426	EXC PAROTID TUMOR; TOT W/UNILAT RAD NECK DISSECT	No pre-authorization is required for all providers.	N/A
42440	EXC SUBMANDIBULAR GLAND	No pre-authorization is required for all providers.	N/A
42450	EXC SUBLINGUAL GLAND	No pre-authorization is required for all providers.	N/A
42500	PLASTIC REPR SALIVARY DUCT; PRIM/SIMPL	No pre-authorization is required for all providers.	N/A
42505	PLASTIC REPR SALIVARY DUCT; SECNDRY/COMPLIC	No pre-authorization is required for all providers.	N/A
42507	PAROTID DUCT DIVERSION BILAT	No pre-authorization is required for all providers.	N/A
42508	PAROTID DIVERSION BILAT; W/EXC 1 SUBMANDIB GLAND	This is no longer a valid code.	N/A
42509	PAROTID DIVERSION BILAT; W/EXC BOTH GLANDS	No pre-authorization is required for all providers.	N/A
42510	PAROTID DIVERSION BILAT; W/LIG SUBMANDIB DUCTS	No pre-authorization is required for all providers.	N/A
42550	INJ PROC SIALOGRAPHY	No pre-authorization is required for all providers.	N/A
42600	CLO SALIVARY FISTULA	No pre-authorization is required for all providers.	N/A
42650	DILAT SALIVARY DUCT	No pre-authorization is required for all providers.	N/A
42660	DILAT & CATH SALIVARY DUCT W/WO INJ	No pre-authorization is required for all providers.	N/A
42665	LIG SALIVARY DUCT INTRAORAL	No pre-authorization is required for all providers.	N/A
42699	UNLISTED PROC SALIVARY GLANDS/DUCTS	No pre-authorization is required for all providers.	N/A
42700	I&D ABSCESS; PERITONSILLAR	No pre-authorization is required for all providers.	N/A
42720	I&D ABSCESS; RETROPHARYNGEAL INTRAORAL APPROACH	No pre-authorization is required for all providers.	N/A
42725	I&D ABSCESS; RETROPHARYNGEAL EXT APPROACH	No pre-authorization is required for all providers.	N/A
42800	BX; OROPHARYNX	No pre-authorization is required for all providers.	N/A
42802	BX; HYPOPHARYNX	This is no longer a valid code.	N/A
42804	BX; NASOPHARYNX VISIBLE LES SIMPL	No pre-authorization is required for all providers.	N/A
42806	BX; NASOPHARYNX SURVEY-UNKNOWN PRIM LES	No pre-authorization is required for all providers.	N/A
42808	EXC/DESTRCT LES PHARYNX ANY METHD	No pre-authorization is required for all providers.	N/A
42809	REMOV FB FROM PHARYNX	No pre-authorization is required for all providers.	N/A
42810	EXC BRANCHIAL CLEFT CYST-CONFINED TO SKIN/SUBQ	No pre-authorization is required for all providers.	N/A
42815	EXC BRANCHIAL CLEFT CYST-BENEATH SUBQ INTO PHARY	No pre-authorization is required for all providers.	N/A
42820	TONSILLECTOMY & ADENOIDECTOMY; UNDER AGE 12	No pre-authorization is required for all providers.	N/A
42821	TONSILLECTOMY & ADENOIDECTOMY; AGE 12/OVER	No pre-authorization is required for all providers.	N/A
42825	TONSILLECTOMY PRIM/SECNDRY; UNDER AGE 12	No pre-authorization is required for all providers.	N/A
42826	TONSILLECTOMY PRIM/SECNDRY; AGE 12/OVER	No pre-authorization is required for all providers.	N/A
42830	ADENOIDECTOMY PRIM; UNDER AGE 12	No pre-authorization is required for all providers.	N/A
42831	ADENOIDECTOMY PRIM; AGE 12/OVER	No pre-authorization is required for all providers.	N/A
42835	ADENOIDECTOMY SECNDRY; UNDER AGE 12	No pre-authorization is required for all providers.	N/A
42836	ADENOIDECTOMY SECNDRY; AGE 12/OVER	No pre-authorization is required for all providers.	N/A
42842	RADICAL RESECT TONSIL/TONSILLAR PILLARS; WO CLO	No pre-authorization is required for all providers.	N/A
42844	RADICAL RESECT TONSIL/PILLARS; CLO W/LOCAL FLAP	No pre-authorization is required for all providers.	N/A
42845	RADICAL RESECT TONSIL/PILLARS; CLO W/OTHER FLAP	No pre-authorization is required for all providers.	N/A
42860	EXC TONSIL TAGS	No pre-authorization is required for all providers.	N/A
42870	EXC/DESTRCT LINGUAL TONSIL ANY METHD (SEP PRO)	No pre-authorization is required for all providers.	N/A
42890	LTD PHARYNGECTOMY	No pre-authorization is required for all providers.	N/A
42892	RESECT LAT PHARYNGEAL WALL DIRECT CLO BY ADVANCE	No pre-authorization is required for all providers.	N/A
42894	RESECT PHARYNGEAL WALL W/CLO W/MYOCUTANEOUS FLAP	No pre-authorization is required for all providers.	N/A
42900	SUTURE PHARYNX WOUND/INJURY	No pre-authorization is required for all providers.	N/A
42950	PHARYNGOPLASTY	No pre-authorization is required for all providers.	N/A
42953	PHARYNGOESOPHAGEAL REPR	No pre-authorization is required for all providers.	N/A
42955	PHARYNGOSTOMY	No pre-authorization is required for all providers.	N/A
42960	CONTRL OROPHARYNG HEMORR PRIM/SECNDRY; SIMPL	No pre-authorization is required for all providers.	N/A
42961	CONTRL OROPHARYNG HEMORR; COMPLIC W/HOSPITALIZAT	No pre-authorization is required for all providers.	N/A
42962	CONTRL OROPHARYNG HEMORR; W/SECNDRY SURG INTERV	No pre-authorization is required for all providers.	N/A
42970	CONTRL NASOPHARYNG HEMORR; SIMPL W/PACKS/CAUTERY	No pre-authorization is required for all providers.	N/A
42971	CONTRL NASOPHARYNG HEMORR; COMPLIC W/HOSPITALIZ	No pre-authorization is required for all providers.	N/A
42972	CONTRL NASOPHARYNG HEMORR; W/SECNDRY SURG INTERV	No pre-authorization is required for all providers.	N/A
42999	UNLISTED PROC PHARYNX/ADENOIDS/TONSILS	No pre-authorization is required for all providers.	N/A
43020	ESOPHAGOTOMY CERV APPROACH; W/REMOV FB	No pre-authorization is required for all providers.	N/A
43030	CRICOPHARYNGEAL MYOTOMY	No pre-authorization is required for all providers.	N/A
43045	ESOPHAGOTOMY THORACIC APPROACH, W/REMOV FB	No pre-authorization is required for all providers.	N/A
43100	EXC LES ESOPHAGUS W/PRIMARY REPR; CERV	No pre-authorization is required for all providers.	N/A
43101	EXC LES ESOPHAGUS W/PRIMARY REPR; THORACIC/ABD	No pre-authorization is required for all providers.	N/A
43107	TOT ESOPHAGECT WO THORCTMY; W/PHARYNGOGASTROST	No pre-authorization is required for all providers.	N/A

43108	TOT ESOPHAGECT WO THORCTMY; W/INTRPOS/SB RECON	No pre-authorization is required for all providers.	N/A
43112	ESPHG TOT W/THRCM	No pre-authorization is required for all providers.	N/A
43113	TOT ESOPHAGECT W/THORCTMY; W/INTRPOS/SB RECON	No pre-authorization is required for all providers.	N/A
43116	PART ESOPHAGECT-CERV-W/GFT/MICROVAS ANAS/RECON	No pre-authorization is required for all providers.	N/A
43117	PART ESOPHAGECT W/THOR, ABD INCS; W/ESOPHGASTRST	No pre-authorization is required for all providers.	N/A
43118	PART ESOPHAGECT W/THOR, ABD INCS; W/SB RECON	No pre-authorization is required for all providers.	N/A
43121	PART ESOPHAGECT W/THORCTMY, W/ESOPHGASTROST	No pre-authorization is required for all providers.	N/A
43122	PART ESOPHAGECT THORABD APPRO; W/ESOPHGASTROST	No pre-authorization is required for all providers.	N/A
43123	PART ESOPHAGECT THORABD APPRO; W/INTRPOS/SB RECN	No pre-authorization is required for all providers.	N/A
43124	TOT/PART ESOPHAGECT WO RECON W/CERV ESOPHAGOSTMY	No pre-authorization is required for all providers.	N/A
43130	DIVERTICULECTOMY HYPOPHARYNX/ESOPHAGUS; CERV	No pre-authorization is required for all providers.	N/A
43135	DIVERTICULECTOMY HYPOPHARYNX/ESOPHAGUS; THORACIC	No pre-authorization is required for all providers.	N/A
43180	ESOPHAGOSCOPY RIGID TRNSO	No pre-authorization is required for all providers.	N/A
43191	ESOPHAGOSCOPY RIGID TRNSO DX	No pre-authorization is required for all providers.	N/A
43192	ESOPHAGOSCP RIG TRNSO INJECT	No pre-authorization is required for all providers.	N/A
43193	ESOPHAGOSCP RIG TRNSO BIOPSY	No pre-authorization is required for all providers.	N/A
43194	ESOPHAGOSCP RIG TRNSO REM FB	No pre-authorization is required for all providers.	N/A
43195	ESOPHAGOSCOPY RIGID BALLOON	No pre-authorization is required for all providers.	N/A
43196	ESOPHAGOSCP GUIDE WIRE DILAT	No pre-authorization is required for all providers.	N/A
43197	ESOPHAGOSCOPY FLEX DX BRUSH	No pre-authorization is required for all providers.	N/A
43198	ESOPHAGOSC FLEX TRNSN BIOPSY	No pre-authorization is required for all providers.	N/A
43200	ESOPHAGOSCOPY FLEXIBLE BRUSH	No pre-authorization is required for all providers.	N/A
43201	ESOPH SCOPE W/SUBMUCOUS INJ	No pre-authorization is required for all providers.	N/A
43202	ESOPHAGOSCOPY FLEX BIOPSY	No pre-authorization is required for all providers.	N/A
43204	ESOPH SCOPE W/SCLEROSIS INJ	No pre-authorization is required for all providers.	N/A
43205	ESOPHAGUS ENDOSCOPY/LIGATION	No pre-authorization is required for all providers.	N/A
43206	ESOPH OPTICAL ENDOMICROSCOPY	No pre-authorization is required for all providers.	N/A
43210	EGD ESOPHAGOGASTRC FNDOPSTY	No pre-authorization is required for all providers.	N/A
43211	ESOPHAGOSCP MUCOSAL RESECT	No pre-authorization is required for all providers.	N/A
43212	ESOPHAGOSCP STENT PLACEMENT	No pre-authorization is required for all providers.	N/A
43213	ESOPHAGOSCOPY RETRO BALLOON	No pre-authorization is required for all providers.	N/A
43214	ESOPHAGOSC DILATE BALLOON 30	No pre-authorization is required for all providers.	N/A
43215	ESOPHAGOSCOPY FLEX REMOVE FB	No pre-authorization is required for all providers.	N/A
43216	ESOPHAGOSCOPY LESION REMOVAL	No pre-authorization is required for all providers.	N/A
43217	ESOPHAGOSCOPY SNARE LES REMV	No pre-authorization is required for all providers.	N/A
43219	ESOPHAGOSCOPY RIGID/FLEX; W/INSRT TUBE/STENT	This is no longer a valid code.	N/A
43220	ESOPHAGOSCOPY BALLOON <30MM	No pre-authorization is required for all providers.	N/A
43226	ESOPH ENDOSCOPY DILATION	No pre-authorization is required for all providers.	N/A
43227	ESOPHAGOSCOPY CONTROL BLEED	No pre-authorization is required for all providers.	N/A
43228	ESOPHAGOSCOPY RIGID/FLEX; W/ABLAT TUMR-NOT AMENA	This is no longer a valid code.	N/A
43229	ESOPHAGOSCOPY LESION ABLATE	No pre-authorization is required for all providers.	N/A
43231	ESOPHAGOSCP ULTRASOUND EXAM	No pre-authorization is required for all providers.	N/A
43232	ESOPHAGOSCOPY W/US NEEDLE BX	No pre-authorization is required for all providers.	N/A
43233	EGD BALLOON DIL ESOPH30 MM/>	No pre-authorization is required for all providers.	N/A
43235	EGD DIAGNOSTIC BRUSH WASH	No pre-authorization is required for all providers.	N/A
43236	UPPR GI SCOPE W/SUBMUC INJ	No pre-authorization is required for all providers.	N/A
43237	ENDOSCOPIC US EXAM ESOPH	No pre-authorization is required for all providers.	N/A
43238	EGD US FINE NEEDLE BX/ASPIR	No pre-authorization is required for all providers.	N/A
43239	EGD BIOPSY SINGLE/MULTIPLE	No pre-authorization is required for all providers.	N/A
43240	EGD W/TRANSMURAL DRAIN CYST	No pre-authorization is required for all providers.	N/A
43241	EGD TUBE/CATH INSERTION	No pre-authorization is required for all providers.	N/A
43242	EGD US FINE NEEDLE BX/ASPIR	No pre-authorization is required for all providers.	N/A
43243	EGD INJECTION VARICES	No pre-authorization is required for all providers.	N/A
43244	EGD VARICES LIGATION	No pre-authorization is required for all providers.	N/A
43245	EGD DILATE STRICTURE	No pre-authorization is required for all providers.	N/A
43246	EGD PLACE GASTROSTOMY TUBE	No pre-authorization is required for all providers.	N/A
43247	EGD REMOVE FOREIGN BODY	No pre-authorization is required for all providers.	N/A
43248	EGD GUIDE WIRE INSERTION	No pre-authorization is required for all providers.	N/A
43249	ESOPH EGD DILATION <30 MM	No pre-authorization is required for all providers.	N/A
43250	EGD CAUTERY TUMOR POLYP	No pre-authorization is required for all providers.	N/A
43251	EGD REMOVE LESION SNARE	No pre-authorization is required for all providers.	N/A
43252	EGD OPTICAL ENDOMICROSCOPY	No pre-authorization is required for all providers.	N/A
43253	EGD US TRANSMURAL INJXN/MARK	No pre-authorization is required for all providers.	N/A
43254	EGD ENDO MUCOSAL RESECTION	No pre-authorization is required for all providers.	N/A
43255	EGD CONTROL BLEEDING ANY	No pre-authorization is required for all providers.	N/A
43256	UGI ENDO; W/TRNSENDO STNT PLCLMT 6.17	This is no longer a valid code.	N/A
43257	EGD W/THRML TXMNT GERD	This service is not covered by Superior HealthPlan.	N/A
43258	UGI ENDO; W/ABLAT LES NOT AMENABLE TO CAUT/SNARE	This is no longer a valid code.	N/A
43259	EGD US EXAM DUODENUM/JEJUNUM	No pre-authorization is required for all providers.	N/A
43260	ERCP W/SPECIMEN COLLECTION	No pre-authorization is required for all providers.	N/A
43261	ENDO RETROGRAD CHOLANGIOPANCREATOG; W/BX 1/MX	No pre-authorization is required for all providers.	N/A
43262	ERCP; W/SPHINCTEROTOMY/PAPILLOTOMY	No pre-authorization is required for all providers.	N/A
43263	ERCP SPHINCTER PRESSURE MEAS	No pre-authorization is required for all providers.	N/A
43264	ERCP REMOVE DUCT CALCULI	No pre-authorization is required for all providers.	N/A
43265	ERCP LITHOTRIPSY CALCULI	No pre-authorization is required for all providers.	N/A
43266	EGD ENDOSCOPIC STENT PLACE	No pre-authorization is required for all providers.	N/A
43267	ERCP; W/ENDO RETRO INSRT NASOBILI DRAINAGE TUBE	This is no longer a valid code.	N/A
43268	ERCP; W/ENDO RETRO INSRT TUBE/STENT-BILE DUCT	This is no longer a valid code.	N/A
43269	ERCP; W/ENDO RETRO REMOV FB &/OR CHANGE TUBE	This is no longer a valid code.	N/A
43270	EGD LESION ABLATION	No pre-authorization is required for all providers.	N/A
43271	ERCP; W/ENDO RETRO BALOON DILAT-AMPULLA/BILI DUC	This is no longer a valid code.	N/A
43272	ERCP; W/ABLAT TUMOR/LES NOT AMENABLE TO SNARE	This is no longer a valid code.	N/A
43273	ENDOSCOPIC PANCREATOSCOPY	No pre-authorization is required for all providers.	N/A
43274	ERCP DUCT STENT PLACEMENT	No pre-authorization is required for all providers.	N/A
43275	ERCP REMOVE FORGN BODY DUCT	No pre-authorization is required for all providers.	N/A
43276	ERCP STENT EXCHANGE W/DILATE	No pre-authorization is required for all providers.	N/A
43277	ERCP EA DUCT/AMPULLA DILATE	No pre-authorization is required for all providers.	N/A
43278	ERCP LESION ABLATE W/DILATE	No pre-authorization is required for all providers.	N/A
43279	LAP MYOTOMY HELLER	No pre-authorization is required for all providers.	N/A
43280	LAPAROSCOPY, SURGICAL, ESOPHAGOGASTRIC FUNDOPLASTY	No pre-authorization is required for all providers.	N/A
43281	LAP PARAESOPHAG HERN REPAIR	No pre-authorization is required for all providers.	N/A
43282	LAP PARAESOPH HER RPR W/MESH	No pre-authorization is required for all providers.	N/A
43283	LAP ESOPH LENGTHENING	No pre-authorization is required for all providers.	N/A
43284	LAPS ESOPHGL SPHNCTR AGMNTJ PLMT DEV CRRPL	This service is not covered by Superior HealthPlan.	N/A
43285	REMOVAL ESOPHAGEAL SPHINCTER AGMNTJ DEVICE	This service is not covered by Superior HealthPlan.	N/A
43286	ESPHG TOT W/LAPS MOBLJ	No pre-authorization is required for all providers.	N/A
43287	ESPHG DSTL 2/3 W/LAPS MOBLJ	No pre-authorization is required for all providers.	N/A
43288	ESPHG THRC MOBLJ	No pre-authorization is required for all providers.	N/A
43289	UNLISTED LAPAROSCOPY PROCEDURE, ESOPHAGUS	No pre-authorization is required for all providers.	N/A
43300	ESOPHGPLSTY CERV APPRCH;NO REP FIST	No pre-authorization is required for all providers.	N/A
43305	ESOPHGPLSTY CERV APPRCH; W/REP FIST	No pre-authorization is required for all providers.	N/A
43310	ESOPHGPLSTY THOR APPRCH;NO REP FIST	No pre-authorization is required for all providers.	N/A
43312	ESOPHGPLSTY THOR APPRCH; W/REP FIST	No pre-authorization is required for all providers.	N/A
43313	ESOPHGPLSTY CONGN THOR; NO REP FIST	No pre-authorization is required for all providers.	N/A
43314	ESOPHGPLSTY CONGN THOR; W/REP FIST	No pre-authorization is required for all providers.	N/A
43320	ESOPHAGOGASTROST W/WO VAGOTOMY THOR/ABD APPROACH	No pre-authorization is required for all providers.	N/A
43325	ESOPHAGOGASTRIC FUNDOPLASTY; W/FUNDIC PATCH	No pre-authorization is required for all providers.	N/A
43327	ESOPH FUNDOPLASTY LAP	No pre-authorization is required for all providers.	N/A
43328	ESOPH FUNDOPLASTY THOR	No pre-authorization is required for all providers.	N/A
43330	ESOPHAGOMYOTOMY; ABD APPROACH	No pre-authorization is required for all providers.	N/A
43331	ESOPHAGOMYOTOMY; THORACIC APPROACH	No pre-authorization is required for all providers.	N/A

43332	TRANSAB ESOPH HIAT HERN RPR	No pre-authorization is required for all providers.	N/A
43333	TRANSAB ESOPH HIAT HERN RPR	No pre-authorization is required for all providers.	N/A
43334	TRANSTHOR DIAPHRAG HERN RPR	No pre-authorization is required for all providers.	N/A
43335	TRANSTHOR DIAPHRAG HERN RPR	No pre-authorization is required for all providers.	N/A
43336	THORABD DIAPHR HERN REPAIR	No pre-authorization is required for all providers.	N/A
43337	THORABD DIAPHR HERN REPAIR	No pre-authorization is required for all providers.	N/A
43338	ESOPH LENGTHENING	No pre-authorization is required for all providers.	N/A
43340	ESOPHAGOJEJUNOSTOMY; ABD APPROACH	No pre-authorization is required for all providers.	N/A
43341	ESOPHAGOJEJUNOSTOMY; THORACIC APPROACH	No pre-authorization is required for all providers.	N/A
43350	ESOPHAGOSTOMY FISTULIZATION-EXT; ABD APPROACH	This is no longer a valid code.	N/A
43351	ESOPHAGOSTOMY FISTULIZATION-EXT; THORACIC	No pre-authorization is required for all providers.	N/A
43352	ESOPHAGOSTOMY FISTULIZATION-EXT; CERV APPROACH	No pre-authorization is required for all providers.	N/A
43360	GI RECON-PREV ESOPHAGECTOMY; W/STOMACH	No pre-authorization is required for all providers.	N/A
43361	GI RECON-PREV ESOPHAGECTOMY; W/BOWEL RECON	No pre-authorization is required for all providers.	N/A
43400	LIG DIRECT ESOPH VARICES	No pre-authorization is required for all providers.	N/A
43401	TRANSECTION ESOPHAGUS W/REPR ESOPH VARICES	No pre-authorization is required for all providers.	N/A
43405	LIG/STAPLE GASTESOPH JNCTN-EXIST ESOPH PERFORATN	No pre-authorization is required for all providers.	N/A
43410	SUTURE ESOPH WOUND/INJURY; CERV APPROACH	No pre-authorization is required for all providers.	N/A
43415	SUTURE ESOPH WOUND/INJURY; THORAC/ABD APPROACH	No pre-authorization is required for all providers.	N/A
43420	CLO ESOPHAGOSTOMY/FISTULA; CERV APPROACH	No pre-authorization is required for all providers.	N/A
43425	CLO ESOPHAGOSTOMY/FISTULA; THORACIC/ABD APPROACH	No pre-authorization is required for all providers.	N/A
43450	DILAT ESOPH-UNGUIDED SOUND/BOUGIE-1/MX PASSES	No pre-authorization is required for all providers.	N/A
43453	DILAT ESOPH OVER GUIDE WIRE	No pre-authorization is required for all providers.	N/A
43456	DILAT ESOPH BALLOON/DILAT RETRO	This is no longer a valid code.	N/A
43458	DILAT ESOPHAGUS W/BALLOON-ACHALASIA	This is no longer a valid code.	N/A
43460	ESOPHAGOGASTRIC TAMPONADE W/BALLOON	No pre-authorization is required for all providers.	N/A
43496	FREE JEJUNUM TRANS W/MICROVASC ANASTOM	No pre-authorization is required for all providers.	N/A
43499	UNLISTED PROC ESOPHAGUS	No pre-authorization is required for all providers.	N/A
43500	GASTROTOMY; W/EXPLOR/FB REMOV	No pre-authorization is required for all providers.	N/A
43501	GASTROTOMY; W/SUTURE REPR BLEEDING ULCER	No pre-authorization is required for all providers.	N/A
43502	GASTROTOMY; W/SUTURE REPR EXIST ESOGAST LACERATN	No pre-authorization is required for all providers.	N/A
43510	GASTROTOMY; W/ESOPH DILAT & INSRT PERM TUBE	No pre-authorization is required for all providers.	N/A
43520	PYLOROMYOTOMY CUTTING PYLORIC MUSCL	No pre-authorization is required for all providers.	N/A
43605	BIOPSY OF STOMACH	No pre-authorization is required for all providers.	N/A
43610	EXC LOCAL; ULCER/BEN TUMOR-STOMACH	No pre-authorization is required for all providers.	N/A
43611	EXC LOCAL; MALIG TUMOR STOMACH	No pre-authorization is required for all providers.	N/A
43620	GASTRECTOMY TOT; W/ESOPHAGOENTEROSTOMY	No pre-authorization is required for all providers.	N/A
43621	GASTRECTOMY TOT; W/ROUX-EN-Y RECON	No pre-authorization is required for all providers.	N/A
43622	GASTRECTOMY TOT; W/FORMAT INTEST POUCH ANY TYPE	No pre-authorization is required for all providers.	N/A
43631	GASTRECTOMY PART DISTAL; W/GASTRODUODENOSTOMY	No pre-authorization is required for all providers.	N/A
43632	GASTRECTOMY PART DISTAL; W/GASTROJEJUNOSTOMY	No pre-authorization is required for all providers.	N/A
43633	GASTRECTOMY PART DISTAL; W/ROUX-EN-Y RECON	Pre-authorization is required for all providers.	Prior to 09/01/2019
43634	GASTRECTOMY PART DISTAL; W/FORM INTESTINAL POUCH	No pre-authorization is required for all providers.	N/A
43635	VAGOTOMY PERFORMED W/PART DIST GASTRECTOMY	No pre-authorization is required for all providers.	N/A
43640	VAGOTOMY INCL PYLOROPLASTY; TRUNCAL/SELECT	No pre-authorization is required for all providers.	N/A
43641	VAGOTOMY INCL PYLOROPLASTY; PARIETAL CELL	No pre-authorization is required for all providers.	N/A
43644	LAP GASTR RSTRICV PROC; GASTR BYPS & ROUX-EN-Y	Pre-authorization is required for all providers.	Prior to 09/01/2019
43645	LAP GASTR RSTRICV PROC;GASTR BYPS&SM INTST RECON	Pre-authorization is required for all providers.	Prior to 09/01/2019
43647	LAPAROSCOPY	Pre-authorization is required for all providers.	Prior to 09/01/2019
43648	REVISION OR REMOVAL OF GASTRIC NEUROSTIMULATOR ELECTRODES	No pre-authorization is required for all providers.	N/A
43651	LAPAROSCOPY SURGICAL TRANSECTION OF VAGUS NERVES, TRUNCAL	Pre-authorization is required for all providers.	Prior to 09/01/2019
43652	LAPAROSCOPY TRANSECTION OF VAGUS NERVES SELECTIVE OR HIGHLY SELECTIVE	Pre-authorization is required for all providers.	Prior to 09/01/2019
43653	LAPAROSCOPY GASTROSTOMY W/O CONSTRUCTION OF GASTRIC TUBE	Pre-authorization is required for all providers.	Prior to 09/01/2019
43659	UNLISTED LAPAROSCOPY PROCEDURE, STOMACH	Pre-authorization is required for all providers.	Prior to 09/01/2019
43752	NASO/ORO-GAS TUBE PLC MD SKLL&FLORO	No pre-authorization is required for all providers.	N/A
43753	TX GASTRO INTUB W/ASP	No pre-authorization is required for all providers.	N/A
43754	DX GASTR INTUB W/ASP SPEC	No pre-authorization is required for all providers.	N/A
43755	DX GASTR INTUB W/ASP SPECS	No pre-authorization is required for all providers.	N/A
43756	DX DUOD INTUB W/ASP SPEC	No pre-authorization is required for all providers.	N/A
43757	DX DUOD INTUB W/ASP SPECS	No pre-authorization is required for all providers.	N/A
43760	CHANGE GASTROSTOMY TUBE PERCUTANEOUS W/O GUIDE	This is no longer a valid code.	N/A
43761	REPOSITION GASTRIC FEEDING TUBE THRU DUODENUM	No pre-authorization is required for all providers.	N/A
43762	PERQ REPLACEMENT GTUBE NOT REQ REVJ GSTRST TRC	No pre-authorization is required for all providers.	N/A
43763	PERQ REPLACEMENT GTUBE REQ REVJ GSTRST TRC	No pre-authorization is required for all providers.	N/A
43770	LAPS GASTRIC RESTRICTIVE PROCEDURE PLACE DEVICE	Pre-authorization is required for all providers.	Prior to 09/01/2019
43771	LAPS GASTRIC RESTRICTIVE PX REVISION DEVICE	Pre-authorization is required for all providers.	Prior to 09/01/2019
43772	LAPS GASTRIC RESTRICTIVE PX REMOVE DEVICE	Pre-authorization is required for all providers.	Prior to 09/01/2019
43773	LAPS GASTRIC RESTRICTIVE PX REMOVE&RPLCMT DEVICE	Pre-authorization is required for all providers.	Prior to 09/01/2019
43774	LAPS GASTRIC RESTRICTIVE PX REMOVE DEVICE &PORT	Pre-authorization is required for all providers.	Prior to 09/01/2019
43775	LAP SLEEVE GASTRECTOMY	Pre-authorization is required for all providers.	Prior to 09/01/2019
43800	PYLOROPLASTY	No pre-authorization is required for all providers.	N/A
43810	GASTRODUODENOSTOMY	No pre-authorization is required for all providers.	N/A
43820	GASTROJEJUNOSTOMY; WO VAGOTOMY	No pre-authorization is required for all providers.	N/A
43825	GASTROJEJUNOSTOMY; W/VAGOTOMY ANY TYPE	No pre-authorization is required for all providers.	N/A
43830	GASTROSTOMY TEMPORARY (SEPART PROC)	No pre-authorization is required for all providers.	N/A
43831	GASTROSTOMY TEMP (SEPART PROC); NEONAT FEEDING	No pre-authorization is required for all providers.	N/A
43832	GASTROSTOMY PERM W/CONSTRUCTION GASTRIC TUBE	No pre-authorization is required for all providers.	N/A
43840	GASTRORRHAPHY SUTURE-PERFORATED ULCER/WOUND	No pre-authorization is required for all providers.	N/A
43842	GASTRIC RESTRICT WO BYP-MORBID OBES; VERTCL BAND	Pre-authorization is required for all providers.	Prior to 09/01/2019
43843	GAST RESTRICT WO BYP-MORBID OBES; NOT VERT BAND	Pre-authorization is required for all providers.	Prior to 09/01/2019
43845	GASTRIC RESTRICTIVE PROC PARTIAL GASTRECTOMY	Pre-authorization is required for all providers.	Prior to 09/01/2019
43846	GAST RESTRICT W/BYP-MORBID OBES; SHORT ROUX-EN-Y	Pre-authorization is required for all providers.	Prior to 09/01/2019
43847	GAST RESTRICT W/BYP-MORBID OBES; W/SM BOWEL RECON	Pre-authorization is required for all providers.	Prior to 09/01/2019
43848	REVISION OPEN GASTRIC RESTRICTIVE PX NOT DEVICE	Pre-authorization is required for all providers.	Prior to 09/01/2019
43850	REVIS GASTRODUODENAL ANASTOM W/RECON; WO VAGOTMY	No pre-authorization is required for all providers.	N/A
43855	REVIS GASTRODUODENAL ANASTOM W/RECON; W/VAGOTOMY	No pre-authorization is required for all providers.	N/A
43860	REVIS GASTROJEJUNAL ANASTOM; WO VAGOTOMY	No pre-authorization is required for all providers.	N/A
43865	REVIS GASTROJEJUNAL ANASTOM; W/VAGOTOMY	No pre-authorization is required for all providers.	N/A
43870	CLO GASTROSTOMY SURG	No pre-authorization is required for all providers.	N/A
43880	CLO GASTROCOLIC FISTULA	No pre-authorization is required for all providers.	N/A
43881	IMPLANTATION / REPLACEMENT OF GASTRIC NEUROSTIMULATOR ELECTRODES,	No pre-authorization is required for all providers.	N/A
43882	REVISION OR REMOVAL OF GASTRIC NEUROSTIMULATOR ELECTRODES,	No pre-authorization is required for all providers.	N/A
43886	GSTR RSTCV PX OPN REVJ SUBQ PORT COMPONENT ONLY	Pre-authorization is required for all providers.	Prior to 09/01/2019
43887	GSTR RSTCV PX OPN RMVL SUBQ PORT COMPONENT ONLY	Pre-authorization is required for all providers.	Prior to 09/01/2019
43888	GSTR RSTCV OPN RMVL&RPLCMT SUBQ PORT	Pre-authorization is required for all providers.	Prior to 09/01/2019
43999	UNLISTED PROC STOMACH	Pre-authorization is required for all providers.	Prior to 09/01/2019
44005	ENTEROLYSIS (SEPART PROC)	No pre-authorization is required for all providers.	N/A
44010	DUODENOTOMY-EXPLOR/BX/FB REMOV	No pre-authorization is required for all providers.	N/A
44015	TUBE/NEEDLE CATH JEJUNOST-ENTERAL ALIMEN-INTRAOP	No pre-authorization is required for all providers.	N/A
44020	ENTEROTOMY-SM BOWEL; EXPLOR/BX/FB REMOV	No pre-authorization is required for all providers.	N/A
44021	ENTEROTOMY-SM BOWEL-NOT DUODENUM; DECOMP	No pre-authorization is required for all providers.	N/A
44025	COLOTOMY EXPLOR BX/FB REMOV	No pre-authorization is required for all providers.	N/A
44050	REDUCT VOLVULUS/INTUSSUSCEPTION BY LAPAROTOMY	No pre-authorization is required for all providers.	N/A
44055	CORRECT MALROTATION BY LYSIS DUODENAL BANDS	No pre-authorization is required for all providers.	N/A
44100	BX INTESTINE BY CAPSULE/TUBE/PERORAL	No pre-authorization is required for all providers.	N/A
44110	EXC 1/MORE LES-BOWEL WO ANASTOM; 1 ENTEROTOMY	No pre-authorization is required for all providers.	N/A
44111	EXC 1/MORE LES-BOWEL WO ANASTOM; MX ENTEROTOMIES	No pre-authorization is required for all providers.	N/A
44120	ENTERECTOMY SM INTES; SNGL RESECT & ANASTOM	No pre-authorization is required for all providers.	N/A
44121	ENTERECTOMY SM INTES; EA ADD RESECT & ANASTOM	No pre-authorization is required for all providers.	N/A
44125	ENTERECTOMY SM INTES; W/ENTEROSTOMY	No pre-authorization is required for all providers.	N/A
44126	ENTERECTOMY OF SMALL INTESTINE FOR CONGENITAL ATRESIA	No pre-authorization is required for all providers.	N/A

44127	ENTERECTOMY OF SMALL INTESTINE FOR CONGENITAL ATRESIA	No pre-authorization is required for all providers.	N/A
44128	ENTERECTOMY OF SMALL INTESTINE FOR CONGENITAL ATRESIA	No pre-authorization is required for all providers.	N/A
44130	ENTEROENTEROSTOMY W/WO CUTAN ENTEROST (SEP PROC)	No pre-authorization is required for all providers.	N/A
44132	DONOR ENTERECT-OP-W/PREP; CADAVER 0	This service is not covered by Superior HealthPlan.	N/A
44133	DONOR ENTERECT; PART- LIVING DONOR 0	This service is not covered by Superior HealthPlan.	N/A
44135	INTESTIN ALLOTRNSPLNT; CADAVER 0	Pre-authorization is required for all providers.	Prior to 09/01/2019
44136	INTESTIN ALLOTRNSPLNT; LIVING DONOR 0	Pre-authorization is required for all providers.	Prior to 09/01/2019
44137	REMOVAL TRANSPLANTED INTESTINAL ALLOGFT COMPETE	Pre-authorization is required for all providers.	Prior to 09/01/2019
44139	MOBILIZA SPLENIC FLEXURE PERFMD W/PART COLECTOMY	No pre-authorization is required for all providers.	N/A
44140	COLECTOMY PART; W/ANASTOM	No pre-authorization is required for all providers.	N/A
44141	COLECTOMY PART; W/SKIN LEVEL CECOSTOMY/COLOSTOMY	No pre-authorization is required for all providers.	N/A
44143	COLECTOMY PART; W/END COLOSTOMY & CLO DIST SEGMENT	No pre-authorization is required for all providers.	N/A
44144	COLECTOMY PART; W/RESECT & CREATION MUCOFISTULA	No pre-authorization is required for all providers.	N/A
44145	COLECTOMY PART; W/COLOPROCTOSTOMY	No pre-authorization is required for all providers.	N/A
44146	COLECTOMY PART; W/COLOPROCTOSTOMY W/COLOSTOMY	No pre-authorization is required for all providers.	N/A
44147	COLECTOMY PART; ABD & TRANSANAL APPROACH	No pre-authorization is required for all providers.	N/A
44150	COLECTOMY-TOT ABD-WO PROCTECTOMY; W/ILEOSTOMY	No pre-authorization is required for all providers.	N/A
44151	COLECTOMY WO PROCTECTOMY; W/CONTINENT ILEOSTOMY	No pre-authorization is required for all providers.	N/A
44155	COLECTOMY-TOT ABD-W/PROCTECTOMY; W/ILEOSTOMY	No pre-authorization is required for all providers.	N/A
44156	COLECTOMY-TOT ABD-W/PROCTECT; W/CONTINENT ILEOST	No pre-authorization is required for all providers.	N/A
44157	WITH ILEOANAL ANASTOMOSIS,	No pre-authorization is required for all providers.	N/A
44158	WITH ILEOANAL ANASTOMOSIS,	No pre-authorization is required for all providers.	N/A
44160	COLECTOMY W/REMOV TERM ILEUM & ILEOCOLOSTOMY	No pre-authorization is required for all providers.	N/A
44180	LAPS ENTEROLSS FRING INTSTINAL ADHESION SPX	No pre-authorization is required for all providers.	N/A
44186	LAPS JEJUNOSTOMY	No pre-authorization is required for all providers.	N/A
44187	LAPS ILEOST/JEJUNOSTOMY NON-TUBE	No pre-authorization is required for all providers.	N/A
44188	LAPS CLST/SKN LVL CECOSTOMY	No pre-authorization is required for all providers.	N/A
44202	LAPAROSCOPY INTESTINAL RESECTION	No pre-authorization is required for all providers.	N/A
44203	LAPAROSCOPIC RESECTION OF SMALL INTESTINE	No pre-authorization is required for all providers.	N/A
44204	LAPAROSCOPIC PARTIAL COLECTOMY	No pre-authorization is required for all providers.	N/A
44205	LAPAROSCOPIC PARTIAL COLECTOMY	No pre-authorization is required for all providers.	N/A
44206	LAP; COLECT PART W/END COLOST	No pre-authorization is required for all providers.	N/A
44207	LAP; COLECT PART W/COLOPROCTOST	No pre-authorization is required for all providers.	N/A
44208	LAP; COLECT PART COLOPRCTOST&COLOST	No pre-authorization is required for all providers.	N/A
44210	LAP; COLECT TOT ABD W/O PROCTECT	No pre-authorization is required for all providers.	N/A
44211	COLECTOMY TOTAL ABD W PROCTECTOMY W ILEOANAL ANASTOMOSIS, CREATION	No pre-authorization is required for all providers.	N/A
44212	LAP; COLECT TOT ABD PROCTECT ILEOST	No pre-authorization is required for all providers.	N/A
44213	LAPS MOBLJ SPLENIC FLXR PFRMD W/PRTL COLCT	No pre-authorization is required for all providers.	N/A
44227	LAPS CLSR NTRSTM LG/SM INT W/RESCJ&ANAST	No pre-authorization is required for all providers.	N/A
44238	UNLISTED LAP PROC INTEST NO RECTUM	No pre-authorization is required for all providers.	N/A
44300	PLACEMENT ENTEROSTOMY/CECOSTOMY TUBE OPEN	No pre-authorization is required for all providers.	N/A
44310	ILEOSTOMY/JEJUNOSTOMY NON-TUBE (SEPART PROC)	No pre-authorization is required for all providers.	N/A
44312	REVIS ILEOSTOMY; SIMPL (SEPART PROC)	No pre-authorization is required for all providers.	N/A
44314	REVIS ILEOSTOMY; COMPLIC (SEPART PROC)	No pre-authorization is required for all providers.	N/A
44316	CONTINENT ILEOSTOMY (SEPART PROC)	No pre-authorization is required for all providers.	N/A
44320	COLOSTOMY/SKIN LEVEL CECOSTOMY; (SEPART PROC)	No pre-authorization is required for all providers.	N/A
44322	COLOSTOMY/CECOSTOMY; W/MX BX (SEPART PROC)	No pre-authorization is required for all providers.	N/A
44340	REVIS COLOSTOMY; SIMPL (SEPART PROC)	No pre-authorization is required for all providers.	N/A
44345	REVIS COLOSTOMY; COMPLIC (SEPART PROC)	No pre-authorization is required for all providers.	N/A
44346	REVIS COLOSTOMY; W/REPR HERNIA (SEPART PROC)	No pre-authorization is required for all providers.	N/A
44360	SMALL BOWEL ENDOSCOPY	No pre-authorization is required for all providers.	N/A
44361	SM INTESTINAL ENDO NOT ILEUM; W/BX 1/MX	No pre-authorization is required for all providers.	N/A
44363	SMALL BOWEL ENDOSCOPY	No pre-authorization is required for all providers.	N/A
44364	SM INTESTINAL ENDO NOT ILEUM; W/REMOV LES-SNARE	No pre-authorization is required for all providers.	N/A
44365	SM INTEST ENDO WO ILEUM; W/REMOV TUMOR/POLYP/LES	No pre-authorization is required for all providers.	N/A
44366	SM INTESTINAL ENDO NOT ILEUM; W/CONTRL BLEEDING	No pre-authorization is required for all providers.	N/A
44369	SM INTEST ENDO NOT ILEUM; W/ABLAT TUMOR NOT SNAR	No pre-authorization is required for all providers.	N/A
44370	SM INTES ENDO WO ILEUM; W/STENT PLC 6.15	No pre-authorization is required for all providers.	N/A
44372	SM INTEST ENDO NOT ILEUM; W/PLCMT JEJUNOST TUBE	No pre-authorization is required for all providers.	N/A
44373	SM INTESTINAL ENDO; W/GASTRO TUBE TO JEJUNO TUBE	No pre-authorization is required for all providers.	N/A
44376	SM INTEST ENDO W/ILEUM; DX W/WO SPECMN (SEP PROC)	No pre-authorization is required for all providers.	N/A
44377	SM INTESTINAL W/ILEUM; W/BX 1/MX	No pre-authorization is required for all providers.	N/A
44378	SM INTEST ENDO W/ILEUM; W/CONTRL BLEED ANY METHD	No pre-authorization is required for all providers.	N/A
44379	SM INTES ENDO W/ILEUM; W/STENT PLC 10.04	No pre-authorization is required for all providers.	N/A
44380	SMALL BOWEL ENDOSCOPY BR/WA	No pre-authorization is required for all providers.	N/A
44381	SMALL BOWEL ENDOSCOPY BR/WA	No pre-authorization is required for all providers.	N/A
44382	ILEOSCOPY-STOMA; W/BX 1/MX	No pre-authorization is required for all providers.	N/A
44383	ILEOSCOPY THRU STOMA; W/STENT PLCMT 3.43	This is no longer a valid code.	N/A
44384	SMALL BOWEL ENDOSCOPY	This service is not covered by Superior HealthPlan.	N/A
44385	ENDOSCOPY OF BOWEL POUCH	No pre-authorization is required for all providers.	N/A
44386	ENDOSCOPY BOWEL POUCH/BIOP	No pre-authorization is required for all providers.	N/A
44388	COLONOSCOPY THRU STOMA SPX	No pre-authorization is required for all providers.	N/A
44389	COLONOSCOPY-STOMA; W/BX 1/MX	No pre-authorization is required for all providers.	N/A
44390	COLONOSCOPY FOR FOREIGN BODY	No pre-authorization is required for all providers.	N/A
44391	COLONOSCOPY FOR BLEEDING	No pre-authorization is required for all providers.	N/A
44392	COLONOSCOPY & POLYPECTOMY	No pre-authorization is required for all providers.	N/A
44393	COLONOSCOPY-STOMA; W/ABLAT TUMOR NOT AMENAB-SNAR	This is no longer a valid code.	N/A
44394	COLONOSCOPY-STOMA; W/REMOV TUMOR/POLYP/LES	No pre-authorization is required for all providers.	N/A
44397	COLONOSCOPY THRU STOMA W/STENT PLCMT 6.43	This is no longer a valid code.	N/A
44401	COLONOSCOPY WITH ABLATION	This service is not covered by Superior HealthPlan.	N/A
44402	COLONOSCOPY W/STENT PLCMT	This service is not covered by Superior HealthPlan.	N/A
44403	COLONOSCOPY W/RESECTION	No pre-authorization is required for all providers.	N/A
44404	COLONOSCOPY W/INJECTION	No pre-authorization is required for all providers.	N/A
44405	COLONOSCOPY W/DILATION	No pre-authorization is required for all providers.	N/A
44406	COLONOSCOPY W/ULTRASOUND	No pre-authorization is required for all providers.	N/A
44407	COLONOSCOPY W/NDL ASPIR/BX	No pre-authorization is required for all providers.	N/A
44408	COLONOSCOPY W/DECOMPRESSION	No pre-authorization is required for all providers.	N/A
44500	INTRO LONG GI TUBE (SEPART PROC)	No pre-authorization is required for all providers.	N/A
44602	SUTURE SM INTESTINE; SNGL PERFORATION	No pre-authorization is required for all providers.	N/A
44603	SUTURE SM INTESTINE; MX PERFORATIONS	No pre-authorization is required for all providers.	N/A
44604	SUTURE LG INTESTINE; WO COLOSTOMY	No pre-authorization is required for all providers.	N/A
44605	SUTURE LG INTESTINE; W/COLOSTOMY	No pre-authorization is required for all providers.	N/A
44615	INTEST STRICTUROPLASTY W/WO DILAT-INTEST OBSTRUC	No pre-authorization is required for all providers.	N/A
44620	CLO ENTEROSTOMY LG/SM INTEST	No pre-authorization is required for all providers.	N/A
44625	CLO ENTEROSTOMY; W/RESECT & ANAST NOT COLORECTAL	No pre-authorization is required for all providers.	N/A
44626	CLO ENTEROSTOMY; W/RESECT COLORECTAL ANASTOM	No pre-authorization is required for all providers.	N/A
44640	CLO INTESTINAL CUT FISTULA	No pre-authorization is required for all providers.	N/A
44650	CLO ENTEROENTERIC/ENTEROCOLIC FISTULA	No pre-authorization is required for all providers.	N/A
44660	CLO ENTEROVESICAL FISTULA; WO INTESTINAL RESECT	No pre-authorization is required for all providers.	N/A
44661	CLO ENTEROVESICAL FISTULA; W/BOWEL RESECT	No pre-authorization is required for all providers.	N/A
44680	INTESTINAL PLICATION (SEPART PROC)	No pre-authorization is required for all providers.	N/A
44700	EXCLUS SM BOWEL FROM PELV-MESH/OTH PROSTHT/ISS	No pre-authorization is required for all providers.	N/A
44701	INTRAOPERATIVE COLONIC LAVAGE	No pre-authorization is required for all providers.	N/A
44705	PREPARE FECAL MICROBIOTA	This service is not covered by Superior HealthPlan.	N/A
44715	BACKBENCH STD PREP CD/LD INTESTINE ALLOGFT	Pre-authorization is required for all providers.	Prior to 09/01/2019
44720	BCKBNCH RECNSTR CD/LD INTST ALLOGFT;VEN ANAST EA	Pre-authorization is required for all providers.	Prior to 09/01/2019
44721	BCKBNCH RECNSTR CD/LD INTST ALLOGFT;ART ANAST EA	Pre-authorization is required for all providers.	Prior to 09/01/2019
44799	UNLISTED PX SMALL INTESTINE	No pre-authorization is required for all providers.	N/A
44800	EXC MECKEL'S DIVERTIC/OMPHALOMESENTERIC DUCT	No pre-authorization is required for all providers.	N/A
44820	EXC LES MESENTERY (SEPART PROC)	No pre-authorization is required for all providers.	N/A
44850	SUTURE MESENTERY (SEPART PROC)	No pre-authorization is required for all providers.	N/A

44899	UNLISTED PROC MECKEL'S DIVERTIC & MESENTERY	No pre-authorization is required for all providers.	N/A
44900	I&D APPENDICEAL ABSC; OPEN	No pre-authorization is required for all providers.	N/A
44901	I&D APPENDICEAL ABSC; PERCUT	This is no longer a valid code.	N/A
44950	APPENDECTOMY	No pre-authorization is required for all providers.	N/A
44955	APPY; WHEN DONE PURPOSE @ TIME OF OTH PROC	No pre-authorization is required for all providers.	N/A
44960	APPY; RUPT APPY W/ABSCESS/GEN PERITONITIS	No pre-authorization is required for all providers.	N/A
44970	LAPAROSCOPIC APPENDECTOMY	No pre-authorization is required for all providers.	N/A
44979	UNLISTED LAPAROSCOPY, APPENDECTOMY	No pre-authorization is required for all providers.	N/A
45000	TRANSRECTAL DRAINAGE PELVIC ABSCESS	No pre-authorization is required for all providers.	N/A
45005	I&D SUBMUCOSAL ABSCESS RECTUM	No pre-authorization is required for all providers.	N/A
45020	I&D DEEP SUPRALEVATOR/PELVIRECTAL ABSCESS	No pre-authorization is required for all providers.	N/A
45100	BX ANORECTAL WALL ANAL APPROACH	No pre-authorization is required for all providers.	N/A
45108	ANORECTAL MYOMECTOMY	No pre-authorization is required for all providers.	N/A
45110	PROCTECTOMY; COMPLT-ABDOMINOPERINEAL W/COLOSTOMY	No pre-authorization is required for all providers.	N/A
45111	PROCTECTOMY; PART RESECT RECTUM TRNSABD APPROACH	No pre-authorization is required for all providers.	N/A
45112	PROCTECTOMY COMB ABDOMINOPERINEAL PULL-THRU PROC	No pre-authorization is required for all providers.	N/A
45113	PROCTECTOMY PART W/RECTAL MUCOSECT-ILEOANAL ANAS	No pre-authorization is required for all providers.	N/A
45114	PROCTECTOMY PART W/ANASTOM; ABD & TRANSACRAL	No pre-authorization is required for all providers.	N/A
45116	PROCTECTOMY PART W/ANASTOM; TRANSACRAL ONLY	No pre-authorization is required for all providers.	N/A
45119	PROCTECTOMY-COLONIC RESERVOIR W/WO PROX OSTOMY	No pre-authorization is required for all providers.	N/A
45120	PROCTECTOMY COMPLT; W/PULL-THRU & ANASTOM	No pre-authorization is required for all providers.	N/A
45121	PROCTECTOMY COMPLT; W/SUBTL/TOT COLECTMY & MX BX	No pre-authorization is required for all providers.	N/A
45123	PROCTECTOMY PART WO ANASTOM-PERINEAL APPROACH	No pre-authorization is required for all providers.	N/A
45126	PELV EXENTERATION-COLOREC MALIG W/PROCTECTOMY	No pre-authorization is required for all providers.	N/A
45130	EXC RECTAL PROCIDENTIA W/ANASTOM; PERINEAL	No pre-authorization is required for all providers.	N/A
45135	EXC RECTAL PROCIDENTIA W/ANASTOM; ABD & PERINEAL	No pre-authorization is required for all providers.	N/A
45136	EXCISION OF ILEOANAL RESERVOIR	No pre-authorization is required for all providers.	N/A
45150	DIVISION STRICT RECTUM	No pre-authorization is required for all providers.	N/A
45160	EXC RECTAL TUMOR-PROCTOTOMY/TRANSACRAL APPROACH	No pre-authorization is required for all providers.	N/A
45171	EXC RECT TUM TRANSANAL PART	No pre-authorization is required for all providers.	N/A
45172	EXC RECT TUM TRANSANAL FULL	No pre-authorization is required for all providers.	N/A
45190	DESTRCT RECTAL TUMOR ANY METHD TRANSANAL APPRO	No pre-authorization is required for all providers.	N/A
45300	PROCSIGMOIDOSCOPY RIGID; DX W/WO SPECMN (SEP PROC)	No pre-authorization is required for all providers.	N/A
45303	PROCTOSIGMOIDOSCOPY RIGID; W/DILAT ANY METHD	No pre-authorization is required for all providers.	N/A
45305	PROCTOSIGMOIDOSCOPY RIGID; W/BX 1/MX	No pre-authorization is required for all providers.	N/A
45307	PROCTOSIGMOIDOSCOPY RIGID; W/REMOV FB	No pre-authorization is required for all providers.	N/A
45308	PROCTOSIGMOIDOSCOPY RIGID; REMOV LES-HOT FORCEPS	No pre-authorization is required for all providers.	N/A
45309	PROCTOSIGMOIDOSCOPY RIGID; REMOV LES-SNARE	No pre-authorization is required for all providers.	N/A
45315	PROCTOSIGMOIDOS RIGID; W/REMOV LES-FORCEPS/SNARE	No pre-authorization is required for all providers.	N/A
45317	PROCTOSIGMOIDOSCOPY RIGID; W/CONTRL BLEEDING	No pre-authorization is required for all providers.	N/A
45320	PROCTOSIGMOIDOSCOPY RIGID; W/ABLAT LES-NOT SNARE	No pre-authorization is required for all providers.	N/A
45321	PROCTOSIGMOIDOSCOPY RIGID W/DECOMP VOLVULUS	No pre-authorization is required for all providers.	N/A
45327	PROCTOSIGSCOPY RIGID; W/STENT PLCMT 2.41	No pre-authorization is required for all providers.	N/A
45330	DIAGNOSTIC SIGMOIDOSCOPY	No pre-authorization is required for all providers.	N/A
45331	SIGMOIDOSCOPY FLEX; W/BX 1/MX	No pre-authorization is required for all providers.	N/A
45332	SIGMOIDOSCOPY W/FB REMOVAL	No pre-authorization is required for all providers.	N/A
45333	SIGMOIDOSCOPY & POLYPECTOMY	No pre-authorization is required for all providers.	N/A
45334	SIGMOIDOSCOPY FOR BLEEDING	No pre-authorization is required for all providers.	N/A
45335	SIGMOIDSCPY FLX; DIR SUBMUCOS INJ	No pre-authorization is required for all providers.	N/A
45337	SIGMOIDOSCOPY & DECOMPRESS	No pre-authorization is required for all providers.	N/A
45338	SIGMOIDOSCOPY FLEX; REMOV LES-SNARE	No pre-authorization is required for all providers.	N/A
45339	SIGMOIDOSCOPY FLEX; ABLAT TUMOR/LES-NOT AMENABLE	This is no longer a valid code.	N/A
45340	SIG W/TNDSCL BALLOON DILATION	No pre-authorization is required for all providers.	N/A
45341	SIGMOIDOSCOPY FLEX; W/ENDO US EXAM 5.36	No pre-authorization is required for all providers.	N/A
45342	SIGMOIDSCPY FLEX; W/US GUID ASP/BX 6.18	No pre-authorization is required for all providers.	N/A
45345	SIGMOIDOSCOPY FLEX; W/STENT PLCMT 4.14	This is no longer a valid code.	N/A
45346	SIGMOIDOSCOPY W/ABLATION	No pre-authorization is required for all providers.	N/A
45347	SIGMOIDOSCOPY W/PLCMT STENT	No pre-authorization is required for all providers.	N/A
45349	SIGMOIDOSCOPY W/RESECTION	No pre-authorization is required for all providers.	N/A
45350	SGMDSC W/BAND LIGATION	No pre-authorization is required for all providers.	N/A
45355	COLONOSCOPY RIGID/FLEX TRNSABD VIA COLOTOMY 1/MX	This is no longer a valid code.	N/A
45378	DIAGNOSTIC COLONOSCOPY	No pre-authorization is required for all providers.	N/A
45379	COLONOSCOPY W/FB REMOVAL	No pre-authorization is required for all providers.	N/A
45380	COLONOSCOPY AND BIOPSY	No pre-authorization is required for all providers.	N/A
45381	COLONOSCOPY SUBMUCOUS NJX	No pre-authorization is required for all providers.	N/A
45382	COLONOSCOPY W/CONTROL BLEED	No pre-authorization is required for all providers.	N/A
45383	COLONOSCOPY FLEX; W/ABLAT LES NOT AMENABLE-SNARE	This is no longer a valid code.	N/A
45384	COLONOSCOPY W/LESION REMOVAL	No pre-authorization is required for all providers.	N/A
45385	COLONOSCOPY W/LESION REMOVAL	No pre-authorization is required for all providers.	N/A
45386	COLONOSCOPY W/BALLOON DILAT	No pre-authorization is required for all providers.	N/A
45387	COLONOSCPY PROX SPLEN FLEX; W/STENT 8.39	This is no longer a valid code.	N/A
45388	COLONOSCOPY W/ABLATION	No pre-authorization is required for all providers.	N/A
45389	COLONOSCOPY W/STENT PLCMT	No pre-authorization is required for all providers.	N/A
45390	COLONOSCOPY W/RESECTION	No pre-authorization is required for all providers.	N/A
45391	COLONOSCOPY W/ENDOSCOPE US	No pre-authorization is required for all providers.	N/A
45392	COLONOSCOPY W/ENDOSCOPIC FNB	No pre-authorization is required for all providers.	N/A
45393	COLONOSCOPY W/DECOMPRESSION	No pre-authorization is required for all providers.	N/A
45395	LAPS PRCTECT COMPL CMBN ABDOMINOPRNL W/CLST	No pre-authorization is required for all providers.	N/A
45397	LAPS PRCTECT CMBN PULL-THRU CRTJ RSVR	No pre-authorization is required for all providers.	N/A
45398	COLONOSCOPY W/BAND LIGATION	No pre-authorization is required for all providers.	N/A
45399	UNLISTED PROCEDURE COLON	This service is not covered by Superior HealthPlan.	N/A
45400	LAPS PROCTOPEXY FOR PROLAPSE	No pre-authorization is required for all providers.	N/A
45402	LAPS PROCTOPEXY FOR PROLAPSE SIGMOID RESCJ	No pre-authorization is required for all providers.	N/A
45499	UNLIS LAPS PX RECTUM	No pre-authorization is required for all providers.	N/A
45500	PROCTOPLASTY; STENOSIS	No pre-authorization is required for all providers.	N/A
45505	PROCTOPLASTY; PROLAPSE MUCOS MEMBRN	No pre-authorization is required for all providers.	N/A
45520	PERIRECTAL INJ SCLEROSING SOLUTION PROLAPSE	No pre-authorization is required for all providers.	N/A
45540	PROCTOPEXY PROLAPSE; ABD APPROACH	No pre-authorization is required for all providers.	N/A
45541	PROCTOPEXY PROLAPSE; PERINEAL APPROACH	No pre-authorization is required for all providers.	N/A
45550	PROCTOPEXY COMBO W/SIGMOID RESECT-ABD APPROACH	No pre-authorization is required for all providers.	N/A
45560	REPR RECTOCELE (SEPART PROC)	No pre-authorization is required for all providers.	N/A
45562	EXPLOR, REPR & DRAIN PRESACRUM-RECTAL INJURY;	No pre-authorization is required for all providers.	N/A
45563	EXPLOR, REPR & DRAIN-RECTAL INJURY; W/COLOSTOMY	No pre-authorization is required for all providers.	N/A
45800	CLO RECTOVESICAL FISTULA	No pre-authorization is required for all providers.	N/A
45805	CLO RECTOVESICAL FISTULA; W/COLOSTOMY	No pre-authorization is required for all providers.	N/A
45820	CLO RECTOURETHRAL FISTULA	No pre-authorization is required for all providers.	N/A
45825	CLO RECTOURETHRAL FISTULA; W/COLOSTOMY	No pre-authorization is required for all providers.	N/A
45900	REDUCTION PROCIDENTIA (SEPART PROC) UNDER ANES	No pre-authorization is required for all providers.	N/A
45905	DILAT ANAL SPHINCTER (SEP PRO) W/ANES-NOT LOCAL	No pre-authorization is required for all providers.	N/A
45910	DILAT RECTAL STRICT (SEP PRO) W/ANES-NOT LOCAL	No pre-authorization is required for all providers.	N/A
45915	REMOV FECAL IMPACTION/FB (SEP PRO) W/GEN ANES	No pre-authorization is required for all providers.	N/A
45990	ANRCT XM SURG REQ ANES GENERAL SPI/EDRL DX	No pre-authorization is required for all providers.	N/A
45999	UNLISTED PROC RECTUM	No pre-authorization is required for all providers.	N/A
46020	PLACEMENT OF ANAL SETON	No pre-authorization is required for all providers.	N/A
46030	REMOV ANAL SETON OTHER MARKER	No pre-authorization is required for all providers.	N/A
46040	I&D ISCHIORECTAL &/OR PERIRECT ABSCESS (SEP PRO)	No pre-authorization is required for all providers.	N/A
46045	I&D INTRAMURAL/IM ABSCESS TRANSANAL UNDER ANES	No pre-authorization is required for all providers.	N/A
46050	I&D PERIANAL ABSCESS SUPERF	No pre-authorization is required for all providers.	N/A
46060	I&D ISCHIORECTAL/INTRAMURAL ABSCESS W/FISTULECT	No pre-authorization is required for all providers.	N/A
46070	INCS ANAL SEPTUM (INFANT)	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
46080	SPHINCTEROTOMY ANAL DIVIS SPHINCTER (SEP PRO)	No pre-authorization is required for all providers.	N/A

46083	INCS THROMBOSED HEMORRHOID EXT	No pre-authorization is required for all providers.	N/A
46200	FISSURECTOMY W/WO SPHINCTEROTOMY	No pre-authorization is required for all providers.	N/A
46220	PAPILLECTOMY/EXC SNGL TAG ANUS (SEPART PROC)	No pre-authorization is required for all providers.	N/A
46221	HEMORRHOIDECTOMY BY SIMPL LIG	No pre-authorization is required for all providers.	N/A
46230	EXC EXT HEMORRHOID TAGS &/OR MX PAPPILLAE	No pre-authorization is required for all providers.	N/A
46250	HEMORRHOIDECTOMY EXT COMPLT	No pre-authorization is required for all providers.	N/A
46255	HEMORRHOIDECTOMY INT & EXT SIMPL	No pre-authorization is required for all providers.	N/A
46257	HEMORRHOIDECTOMY INT & EXT SIMPL; W/FISSURECTOMY	No pre-authorization is required for all providers.	N/A
46258	HEMORRHOIDECTOMY INT & EXT SIMPL; W/FISTULECTOMY	No pre-authorization is required for all providers.	N/A
46260	HEMORRHOIDECTOMY INT & EXT COMPLX/EXTEN	No pre-authorization is required for all providers.	N/A
46261	HEMORRHOIDECTOMY COMPLX/EXTEN; W/FISSURECTOMY	No pre-authorization is required for all providers.	N/A
46262	HEMORRHOIDECTOMY COMPLX/EXTEN; W/FISTULECTOMY	No pre-authorization is required for all providers.	N/A
46270	SURG TX ANAL FISTULA; SUBQ	No pre-authorization is required for all providers.	N/A
46275	SURG TX ANAL FISTULA; SUBMUSCULAR	No pre-authorization is required for all providers.	N/A
46280	SURG TX ANAL FISTULA; COMPLX/MX W/WO PLCLMT SETON	No pre-authorization is required for all providers.	N/A
46285	SURG TX ANAL FISTULA; 2ND STAGE	No pre-authorization is required for all providers.	N/A
46288	CLO ANAL FISTULA W/RECTAL ADVANCEMENT FLAP	No pre-authorization is required for all providers.	N/A
46320	ENUCLEATION/EXC EXT THROMBOTIC HEMORRHOID	No pre-authorization is required for all providers.	N/A
46500	INJ SCLEROSING SOLUTION HEMORRHOIDS	No pre-authorization is required for all providers.	N/A
46505	CHEMODNRVTJ INT ANAL SPHNCTR	No pre-authorization is required for all providers.	N/A
46600	DIAGNOSTIC ANOSCOPY SPX	No pre-authorization is required for all providers.	N/A
46601	DIAGNOSTIC ANOSCOPY	This service is not covered by Superior HealthPlan.	N/A
46604	ANOSCOPY; DILAT ANY METHD	No pre-authorization is required for all providers.	N/A
46606	ANOSCOPY; W/BX 1/MX	No pre-authorization is required for all providers.	N/A
46607	DIAGNOSTIC ANOSCOPY & BIOPSY	This service is not covered by Superior HealthPlan.	N/A
46608	ANOSCOPY; W/REMOV FB	No pre-authorization is required for all providers.	N/A
46610	ANOSCOPY; W/REMOV 1 TUMOR/POLYP/LES-FORCEPS/CAUT	No pre-authorization is required for all providers.	N/A
46611	ANOSCOPY; W/REMOV 1 TUMOR/POLYP/LES-SNARE TECH	No pre-authorization is required for all providers.	N/A
46612	ANOSCOPY; W/REMOV MX TUMOR/LES-FORCEP/CAUT/SNARE	No pre-authorization is required for all providers.	N/A
46614	ANOSCOPY; W/CONTRL BLEEDING ANY METHD	No pre-authorization is required for all providers.	N/A
46615	ANOSCOPY; W/ABLAT TUMOR/LES NOT AMENABLE-FORCEPS	No pre-authorization is required for all providers.	N/A
46700	ANOPLASTY PLASTIC OR STRICT; ADULT	No pre-authorization is required for all providers.	N/A
46705	ANOPLASTY PLASTIC OR STRICT; INFANT	No pre-authorization is required for all providers.	N/A
46706	REPAIR ANAL FISTULA W/FIBRIN GLUE	No pre-authorization is required for all providers.	N/A
46707	REPAIR ANORECTAL FIST W/PLUG	No pre-authorization is required for all providers.	N/A
46710	RPR ILEOANAL POUCH FSTL/POUCH ADVMNT TPRNL APPR	No pre-authorization is required for all providers.	N/A
46712	RPR ILEOANAL POUCH FSTL/POUCH ADVMNT CMBN APPR	No pre-authorization is required for all providers.	N/A
46715	REPR LOW IMPERFORATE ANUS; W/ANOPERINEAL FISTULA	No pre-authorization is required for all providers.	N/A
46716	REPR LOW IMPERFORATE ANUS; W/TRANSPPOSIT FISTULA	No pre-authorization is required for all providers.	N/A
46730	REPR HIGH IMPERFORATE ANUS; PERINEAL/SACROPERINL	No pre-authorization is required for all providers.	N/A
46735	REPR HIGH IMPERFORATE ANUS; COMBO APPROACHES	No pre-authorization is required for all providers.	N/A
46740	REPR HI IMPERFORATE ANUS W/FIST; PERINEL/SACROPR	No pre-authorization is required for all providers.	N/A
46742	REPR HI IMPERFORATE ANUS W/FIST; COMBO APPROACHES	No pre-authorization is required for all providers.	N/A
46744	REPR CLOACAL ANOMALY-SACROPERINEAL APPROACH	No pre-authorization is required for all providers.	N/A
46746	REPR CLOACAL ANOMALY-COMBO ABD-SACROPER APPROACH	No pre-authorization is required for all providers.	N/A
46748	REPR CLOACAL ANOMALY; W/VAG LENGTH-GFT/FLAP	No pre-authorization is required for all providers.	N/A
46750	SPHINCTEROPLASTY-ANAL-INCONT/PROLAPSE; ADULT	No pre-authorization is required for all providers.	N/A
46751	SPHINCTEROPLASTY-ANAL-INCONT/PROLAPSE; CHILD	No pre-authorization is required for all providers.	N/A
46753	GFT RECTAL INCONT &/OR PROLAPSE	No pre-authorization is required for all providers.	N/A
46754	REMOV THIERSCH WIRE/SUTURE ANAL CANAL	No pre-authorization is required for all providers.	N/A
46760	SPHINCTEROPLASTY ANAL-ADULT; MUSCL TRANSPL	No pre-authorization is required for all providers.	N/A
46761	SPHINCTEROPLASTY-ANAL; LEVATOR MUSCL IMBRICATION	No pre-authorization is required for all providers.	N/A
46762	SPHINCTEROPLASTY-ANAL; IMPLNT ARTIFICIAL SPHNCT	This is no longer a valid code.	N/A
46900	DESTRCT LES ANUS SIMPL; CHEM	No pre-authorization is required for all providers.	N/A
46910	DESTRCT LES ANUS SIMPL; ELECTRODESICCATION	No pre-authorization is required for all providers.	N/A
46916	DESTRCT LES ANUS SIMPL; CRYOSURGERY	No pre-authorization is required for all providers.	N/A
46917	DESTRCT LES ANUS SIMPL; LASER SURG	No pre-authorization is required for all providers.	N/A
46922	DESTRCT LES ANUS SIMPL; SURG EXC	No pre-authorization is required for all providers.	N/A
46924	DESTRCT LES ANUS EXTEN ANY METHD	No pre-authorization is required for all providers.	N/A
46930	DESTROY INTERNAL HEMORRHOIDS	No pre-authorization is required for all providers.	N/A
46940	CURET/CAUT ANAL FISSURE (SEPART PROC); INIT	No pre-authorization is required for all providers.	N/A
46942	CURET/CAUT ANAL FISSURE (SEPART PROC); SUBSQT	No pre-authorization is required for all providers.	N/A
46945	INT HRHC BY LIGATION SINGLE HROID W/O IMG GDN	No pre-authorization is required for all providers.	N/A
46946	INT HRHC BY LIGATION 2+ HROID W/O IMG GDN	No pre-authorization is required for all providers.	N/A
46947	HEMORRHOIDOPEXY BY STAPLING	This service is not covered by Superior HealthPlan.	N/A
46948	INT HRHC TRANSANAL HROID DARTLZJ 2+ W/US GDN	No pre-authorization is required for all providers.	N/A
46999	UNLISTED PROC ANUS	No pre-authorization is required for all providers.	N/A
47000	NEEDLE BIOPSY OF LIVER	No pre-authorization is required for all providers.	N/A
47001	BX LIVER NEEDLE; DONE @ TIME OTH MAJ PROC	No pre-authorization is required for all providers.	N/A
47010	HEPATOTOMY; OPEN DRAIN ABSC/CYST 1 OR 2 STAGES	No pre-authorization is required for all providers.	N/A
47011	HEPATOTOMY; PERCUT DRAIN ABSC/CYST 1 OR 2 STAGES	This is no longer a valid code.	N/A
47015	LAPAROT W/ASPIR/INJ HEPATIC PARASITIC CYST/ABSC	No pre-authorization is required for all providers.	N/A
47100	BX LIVER WEDGE	No pre-authorization is required for all providers.	N/A
47120	HEPATECTOMY RESECT LIVER; PART LOBEC	No pre-authorization is required for all providers.	N/A
47122	HEPATECTOMY RESECT LIVER; TRISEGMENTECTOMY	No pre-authorization is required for all providers.	N/A
47125	HEPATECTOMY RESECT LIVER; TOT LT LOBEC	No pre-authorization is required for all providers.	N/A
47130	HEPATECTOMY RESECT LIVER; TOT RT LOBEC	No pre-authorization is required for all providers.	N/A
47133	DONOR HEPATECTOMY W/PREP/MAINT ALLOGFT; CADAVER	This service is not covered by Superior HealthPlan.	N/A
47135	LIVER ALLOTRANSPL; ORTHOTOPIC-PART/WHOLE-ANY AGE	Pre-authorization is required for all providers.	Prior to 09/01/2019
47136	LIVER ALLOTRANSPL; HETEROTOPIC-PART/WHOLE	This is no longer a valid code.	N/A
47140	DONR HEPATECT LIVE DONR LT LAT SEG	This service is not covered by Superior HealthPlan.	N/A
47141	DONR HEPATECT LIVE DONR LT LOBECT	This service is not covered by Superior HealthPlan.	N/A
47142	DONR HEPATECT LIVE DONR RT LOBECT	This service is not covered by Superior HealthPlan.	N/A
47143	BCKBNCH STD PREP CD WHOLE LG;NO TRISEG/LOBE SPLT	This service is not covered by Superior HealthPlan.	N/A
47144	BCKBNCH STD PREP CD WHOLE LIVR GFT; TRISEG SPLT	This service is not covered by Superior HealthPlan.	N/A
47145	BCKBNCH STD PREP CD WHOLE LIVR GFT; W/LOBE SPLT	This service is not covered by Superior HealthPlan.	N/A
47146	BACKBENCH RECONSTR CD/LD LG; VENUS ANASTOM EA	This service is not covered by Superior HealthPlan.	N/A
47147	BACKBENCH RECONSTR CD/LD LIVR GFT;ART ANASTOM EA	This service is not covered by Superior HealthPlan.	N/A
47300	MARSUPIALIZATION CYST/ABSCESS LIVER	No pre-authorization is required for all providers.	N/A
47350	MGMT LIVER HEMORR; SIMPL SUT LIVER WOUND/INJURY	No pre-authorization is required for all providers.	N/A
47360	MGMT LIVER HEMORR; COMPLX SUT W/WO HEPAT ART LIG	No pre-authorization is required for all providers.	N/A
47361	MGMT LIVER HEMORR; EXPLOR/EXTEN DEBRID/COAG/SUT	No pre-authorization is required for all providers.	N/A
47362	MGMT LIVER HEMORR; RE-EXPLOR WOUND-REMOV PACKING	No pre-authorization is required for all providers.	N/A
47370	LAPAROSCOPIC RADIOFREQUENCY ABLATION OF LIVER TUMOR	No pre-authorization is required for all providers.	N/A
47371	LAPAROSCOPIC CRYOSURGICAL ABLATION OF LIVER TUMOR	No pre-authorization is required for all providers.	N/A
47379	UNL LAP PROC LIVER 0	No pre-authorization is required for all providers.	N/A
47380	OPEN RADIOFREQUENCY ABLATION OF LIVER TUMOR	No pre-authorization is required for all providers.	N/A
47381	OPEN CRYOSURGICAL ABLATION OF LIVER TUMOR	No pre-authorization is required for all providers.	N/A
47382	PERCUTANEOUS RADIOFREQUENCY ABLATION OF LIVER TUMOR	No pre-authorization is required for all providers.	N/A
47383	PERQ ABLTJ LVR CRYOABLATION	No pre-authorization is required for all providers.	N/A
47399	UNLISTED PROC LIVER	No pre-authorization is required for all providers.	N/A
47400	HEPATICOTOMY W/EXPLOR/DRAINAGE/REMOV CALCU	No pre-authorization is required for all providers.	N/A
47420	CHOLEDOCH W/EXPLOR/REMOV CALC; WO SPHINCTEROTOMY	No pre-authorization is required for all providers.	N/A
47425	CHOLEDOCHOTOMY; W/TRANSUDODENAL SPHINCTEROTONY	No pre-authorization is required for all providers.	N/A
47460	TRANSUDODENAL SPHINCTEROTOMY (SEPART PROC)	No pre-authorization is required for all providers.	N/A
47480	INCISION OF GALLBLADDER	No pre-authorization is required for all providers.	N/A
47490	INCISION OF GALLBLADDER	No pre-authorization is required for all providers.	N/A
47500	INJ PROC PERCUT TRANSHEPATIC CHOLANGIOGRAPHY	This is no longer a valid code.	N/A
47505	INJ PROC CHOLANGIOGRAPHY THRU AN EXISTING CATH	This is no longer a valid code.	N/A
47510	INTRO PERCUT TRANSHEPATIC CATH BILI DRAINAGE	This is no longer a valid code.	N/A
47511	INTRO TRANSHEPATIC STENT INT & EXT BILI DRAINAGE	This is no longer a valid code.	N/A

47525	CHANGE PERCUT BILI DRAINAGE CATH	This is no longer a valid code.	N/A
47530	REVIS &/OR REINSERTION TRANSHEPATIC TUBE	This is no longer a valid code.	N/A
47531	INJECTION FOR CHOLANGIOGRAM	No pre-authorization is required for all providers.	N/A
47532	INJECTION FOR CHOLANGIOGRAM	No pre-authorization is required for all providers.	N/A
47533	PLMT BILIARY DRAINAGE CATH	No pre-authorization is required for all providers.	N/A
47534	PLMT BILIARY DRAINAGE CATH	No pre-authorization is required for all providers.	N/A
47535	CONVERSION EXT BIL DRG CATH	No pre-authorization is required for all providers.	N/A
47536	EXCHANGE BILIARY DRG CATH	No pre-authorization is required for all providers.	N/A
47537	REMOVAL BILIARY DRG CATH	No pre-authorization is required for all providers.	N/A
47538	PERQ PLMT BILE DUCT STENT	No pre-authorization is required for all providers.	N/A
47539	PERQ PLMT BILE DUCT STENT	No pre-authorization is required for all providers.	N/A
47540	PERQ PLMT BILE DUCT STENT	No pre-authorization is required for all providers.	N/A
47541	PLMT ACCESS BIL TREE SM BWL	No pre-authorization is required for all providers.	N/A
47542	DILATE BILIARY DUCT/AMPULLA	No pre-authorization is required for all providers.	N/A
47543	ENDOLUMINAL BX BILIARY TREE	No pre-authorization is required for all providers.	N/A
47544	REMOVAL DUCT GLBLDR CALCULI	No pre-authorization is required for all providers.	N/A
47550	BILI ENDO INTRAOPERATIVE	No pre-authorization is required for all providers.	N/A
47552	BILIARY ENDO PERQ DX W/SPECI	No pre-authorization is required for all providers.	N/A
47553	BILI ENDO PERCUT VIA T-TUBE/OTHER; W/BX 1/MX	No pre-authorization is required for all providers.	N/A
47554	BILI ENDO PERCUT VIA T-TUBE; W/REMOV STONE(S)	No pre-authorization is required for all providers.	N/A
47555	BILI ENDO VIA T-TUBE; W/DILAT BILI DUCT WO STENT	No pre-authorization is required for all providers.	N/A
47556	BILI ENDO VIA T-TUBE; W/DILAT BILI DUCT W/STENT	No pre-authorization is required for all providers.	N/A
47560	LAPAROSCOPY, SURGICAL - WITH CHOLANGIOGRAPHY, W/O BIOPSY	This is no longer a valid code.	N/A
47561	LAPAROSCOPY, SURGICAL - WITH CHOLANGIOGRAPHY, WITH BIOPSY	This is no longer a valid code.	N/A
47562	LAPAROSCOPY, SURGICAL - CHOLECYSTECTOMY	No pre-authorization is required for all providers.	N/A
47563	LAPAROSCOPY, SURGICAL - CHOLECYSTECTOMY WITH CHOLANGIOGRAPHY	No pre-authorization is required for all providers.	N/A
47564	LAPAROSCOPY, SURGICAL - CHOLECYSTECTOMY W/ EXPLORATION OF COMMON DUCT	No pre-authorization is required for all providers.	N/A
47570	LAPAROSCOPY, SURGICAL - CHOLECYSTOENTEROSTOMY	No pre-authorization is required for all providers.	N/A
47579	UNLISTED LAPAROSCOPY PROCEDURE, BILIARY TRACT	No pre-authorization is required for all providers.	N/A
47600	CHOLEY	No pre-authorization is required for all providers.	N/A
47605	CHOLEY; W/CHOLANGIOGRAPHY	No pre-authorization is required for all providers.	N/A
47610	CHOLEY W/EXPLOR COMMON DUCT	No pre-authorization is required for all providers.	N/A
47612	CHOLEY W/EXPLOR COMMON DUCT; W/CHOLEDOCHOENTEROS	No pre-authorization is required for all providers.	N/A
47620	CHOLEY; W/TRANSDUODENAL SPHINCTEROTOMY	No pre-authorization is required for all providers.	N/A
47630	BILI DUCT STONE EXTRACTION VIA T-TUBE/BASKET	This is no longer a valid code.	N/A
47700	EXPLOR CONGEN ATRESIA BILE DUCTS WO REPR WO BX	No pre-authorization is required for all providers.	N/A
47701	PORTOENTEROSTOMY	No pre-authorization is required for all providers.	N/A
47711	EXC BILE DUCT TUMOR W/WO PRIM REPR; EXTRAHEPATIC	No pre-authorization is required for all providers.	N/A
47712	EXC BILE DUCT TUMOR W/WO PRIM REPR; INTRAHEPATIC	No pre-authorization is required for all providers.	N/A
47715	EXC CHOLEDOCHAL CYST	No pre-authorization is required for all providers.	N/A
47720	CHOLECYSTOENTEROSTOMY; DIRECT	No pre-authorization is required for all providers.	N/A
47721	CHOLECYSTOENTEROSTOMY; W/GASTROENTEROSTOMY	No pre-authorization is required for all providers.	N/A
47740	CHOLECYSTOENTEROSTOMY; ROUX-EN-Y	No pre-authorization is required for all providers.	N/A
47741	CHOLECYSTOENTEROSTOMY; ROUX-EN-Y W/GASTROENTEROS	No pre-authorization is required for all providers.	N/A
47760	ANASTOM EXTRAHEPATIC BILIARY DUCTS & GI TRACT	No pre-authorization is required for all providers.	N/A
47765	ANASTOM INTRAHEPATIC DUCTS & GI TRACT	No pre-authorization is required for all providers.	N/A
47780	ANASTOM ROUX-EN-Y EXTRAHEPATIC BILI DUCTS & GI	No pre-authorization is required for all providers.	N/A
47785	ANASTOM ROUX-EN-Y INTRAHEPATIC DUCTS & GI TRACT	No pre-authorization is required for all providers.	N/A
47800	RECON PLASTIC EXTRAHEPATIC BILI DUCT W/END-END	No pre-authorization is required for all providers.	N/A
47801	PLCMT CHOLEDOCHAL STENT	No pre-authorization is required for all providers.	N/A
47802	U-TUBE HEPATICOENTEROSTOMY	No pre-authorization is required for all providers.	N/A
47900	SUTURE EXTRAHEP DUCT PRE-EXIST INJURY (SEP PROC)	No pre-authorization is required for all providers.	N/A
47999	UNLISTED PROC BILI TRACT	No pre-authorization is required for all providers.	N/A
48000	PLCMT DRAINS PERIPANCREATIC-ACUTE PANCREATITIS	No pre-authorization is required for all providers.	N/A
48001	PLCMT DRAINS; W/CHOLECYSTOS GASTROS & JEJUNOSTMY	No pre-authorization is required for all providers.	N/A
48020	REMOV PANCREATIC CALCULI	No pre-authorization is required for all providers.	N/A
48100	BX PANCREAS OPEN ANY METHD	No pre-authorization is required for all providers.	N/A
48102	BX PANCREAS PERCUT NEEDLE	No pre-authorization is required for all providers.	N/A
48105	RESECTION OR DEBRIDEMENT OF PANCREAS	No pre-authorization is required for all providers.	N/A
48120	EXC LES PANCREAS	No pre-authorization is required for all providers.	N/A
48140	PANCREATECTOMY DIST SUBTOT; WO PANCREATICOJEJUNO	No pre-authorization is required for all providers.	N/A
48145	PANCREATECTOMY DISTAL SUBTL; W/PANCREATICOJEJUNO	No pre-authorization is required for all providers.	N/A
48146	PANCREATECTOMY DISTAL NEAR-TOT W/PRESERV DUODENM	No pre-authorization is required for all providers.	N/A
48148	EXC AMPULLA VATER	No pre-authorization is required for all providers.	N/A
48150	PANCREATECTOMY PROX SUBTL W/PANCREATICOJUDUODENECT	No pre-authorization is required for all providers.	N/A
48152	PANCREATECTOMY W/TOT DUODEN; WO PANCREATICOJEJUNOST	No pre-authorization is required for all providers.	N/A
48153	PANCREATEC W/NEAR-TOT DUODEN; W/PANCREATICOJEJUNOS	No pre-authorization is required for all providers.	N/A
48154	PANCREATEC W/NEAR-TOT DUODEN; WO PANCREATICOJEJUNO	No pre-authorization is required for all providers.	N/A
48155	PANCREATECTOMY TOT	No pre-authorization is required for all providers.	N/A
48160	PANCREATECTOMY TOT/SUBTOT W/AUTOLOGOUS TRANSPL	Pre-authorization is required for all providers.	Prior to 09/01/2019
48400	INJ PROC INTRAOPERATIVE PANCREATOGRAPHY	No pre-authorization is required for all providers.	N/A
48500	MARSUPIALIZATION CYST PANCREAS	No pre-authorization is required for all providers.	N/A
48510	EXT DRAIN PSEUDOCYST PANCREAS; OPEN	No pre-authorization is required for all providers.	N/A
48511	EXT DRAIN PSEUDOCYST PANCREAS; PERCUT	This is no longer a valid code.	N/A
48520	INT ANASTOM PANCREATIC CYST-GI TRACT; DIRECT	No pre-authorization is required for all providers.	N/A
48540	INT ANASTOM PANCREATIC CYST-GI TRACT; ROUX-EN-Y	No pre-authorization is required for all providers.	N/A
48545	PANCREATORRHAPHY TRAUMA	No pre-authorization is required for all providers.	N/A
48547	DUODENAL EXCLUS W/GASTROJEJUNOS-PANCREAT TRAUMA	No pre-authorization is required for all providers.	N/A
48548	PANCREATICOJEJUNOSTOMY	No pre-authorization is required for all providers.	N/A
48550	DONOR PANCREATECT W/PREP & MAINTEN ALLOGFT-CADVR	This service is not covered by Superior HealthPlan.	N/A
48551	BACKBENCH STD PREP CADVR DONR PANC ALLOGFT	This service is not covered by Superior HealthPlan.	N/A
48552	BACKBNCH RECONSTR CD PANC ALLOGFT VEN ANASTOM EA	This service is not covered by Superior HealthPlan.	N/A
48554	TRANSPC PANCREATIC ALLOGFT	Pre-authorization is required for all providers.	Prior to 09/01/2019
48556	REMOV TRANSPL PANCREATIC ALLOGFT	This service is not covered by Superior HealthPlan.	N/A
48999	UNLISTED PROC PANCREAS	No pre-authorization is required for all providers.	N/A
49000	EXPLOR LAPAROTOMY-CELIOTOMY W/WO BX (SEP PRO)	No pre-authorization is required for all providers.	N/A
49002	REOPENING RECENT LAPAROTOMY	No pre-authorization is required for all providers.	N/A
49010	EXPLOR RETROPERITONEAL AREA W/WO BX (SEP PRO)	No pre-authorization is required for all providers.	N/A
49013	PREPERITONEAL PEL PACK F/HEMRRG ASSOC PEL TRMA	No pre-authorization is required for all providers.	N/A
49014	REEXPL PEL WND W/RMVL PREPERITONEAL PEL PACKING	No pre-authorization is required for all providers.	N/A
49020	DRAIN PERITONEAL ABSC-NOT APPENDICEAL; OPEN	No pre-authorization is required for all providers.	N/A
49021	DRAIN PERITONEAL ABSC/LOCAL PERITONITIS; PERCUT	This is no longer a valid code.	N/A
49040	DRAIN SUBDIAPHRAGMATIC/SUBPHRENIC ABSC; OPEN	No pre-authorization is required for all providers.	N/A
49041	DRAIN SUBDIAPHRAGMATIC/SUBPHRENIC ABSC; PERCUT	This is no longer a valid code.	N/A
49060	DRAIN RETROPERITONEAL ABSC; OPEN	No pre-authorization is required for all providers.	N/A
49061	DRAIN RETROPERITONEAL ABSC; PERCUT	This is no longer a valid code.	N/A
49062	DRAIN EXTRAPERITONEAL LYMPHOCELE, OPEN	No pre-authorization is required for all providers.	N/A
49082	ABD PARACENTESIS	No pre-authorization is required for all providers.	N/A
49083	ABD PARACENTESIS W/IMAGING	No pre-authorization is required for all providers.	N/A
49084	PERITONEAL LAVAGE	No pre-authorization is required for all providers.	N/A
49180	BX ABD/RETROPERITONEAL MASS PERCUT NEEDLE	No pre-authorization is required for all providers.	N/A
49185	SCLEROTX FLUID COLLECTION	No pre-authorization is required for all providers.	N/A
49203	EXC ABD TUM 5 CM OR LESS	No pre-authorization is required for all providers.	N/A
49204	EXC ABD TUM OVER 5 CM	No pre-authorization is required for all providers.	N/A
49205	EXC ABD TUM OVER 10 CM	No pre-authorization is required for all providers.	N/A
49215	EXC PRESACRAL/SACROCOCCYGEAL TUMOR	No pre-authorization is required for all providers.	N/A
49220	STAGING CELIOTOMY-HODGKIN'S DISEASE/LYMPHOMA	No pre-authorization is required for all providers.	N/A
49250	UMBILECTOMY/OMPHALECTOMY-EXC UMBILICUS (SEP PRO)	No pre-authorization is required for all providers.	N/A
49255	OMENTECTOMY/EPIPLECTOMY-RESEC OMENTUM (SEP PRO)	No pre-authorization is required for all providers.	N/A
49320	LAPAROSCOPY, SURGICAL	No pre-authorization is required for all providers.	N/A
49321	LAPAROSCOPY W. BIOPSY	No pre-authorization is required for all providers.	N/A

49322	LAPAROSCOPY W/ASPIRATION OF CAVITY OR CYST	No pre-authorization is required for all providers.	N/A
49323	LAPAROSCOPY W/DRAINAGE OF LYMPHOCELE TO PERITONEAL CAVITY	No pre-authorization is required for all providers.	N/A
49324	LAP INSERT TUNNEL IP CATH	No pre-authorization is required for all providers.	N/A
49325	WITH REVISION OF PREVIOUSLY PLACED INTRAPERITONEAL CANNULA OR CATHETER	No pre-authorization is required for all providers.	N/A
49326	WITH OMENTOPEXY (OMENTAL TACKING PROCEDURE)	No pre-authorization is required for all providers.	N/A
49327	LAP INS DEVICE FOR RT	No pre-authorization is required for all providers.	N/A
49329	UNLISTED LAPAROSCOPY PROCEDURE, ABDOMEN, PERITONEUM AND OMENTUM	No pre-authorization is required for all providers.	N/A
49400	INJ AIR/CONTRAST-PERITONEAL CAVITY (SEP PRO)	No pre-authorization is required for all providers.	N/A
49402	REMOVAL OF PERITONEAL FOREIGN BODY FROM PERITONEAL CAVITY	No pre-authorization is required for all providers.	N/A
49405	IMAGE CATH FLUID COLXN VISC	No pre-authorization is required for all providers.	N/A
49406	IMAGE CATH FLUID PERI/RETRO	No pre-authorization is required for all providers.	N/A
49407	IMAGE CATH FLUID TRNS/VGNL	No pre-authorization is required for all providers.	N/A
49411	INS MARK ABD/PEL FOR RT PERQ	No pre-authorization is required for all providers.	N/A
49412	INS DEVICE FOR RT GUIDE OPE	No pre-authorization is required for all providers.	N/A
49418	INSERT TUN IP CATH PERC	No pre-authorization is required for all providers.	N/A
49419	INSERT TUN IP CATH W/PORT	No pre-authorization is required for all providers.	N/A
49421	INS TUN IP CATH FOR DIAL OP	No pre-authorization is required for all providers.	N/A
49422	REMOVE TUNNELED IP CATH	No pre-authorization is required for all providers.	N/A
49423	EXCHG ABSC/CYST DRAIN CATH-RAD GUIDE (SEP PROC)	No pre-authorization is required for all providers.	N/A
49424	CONTRAST INJ-ASSESS ABSC VIA PREV PLC CATH (SP)	No pre-authorization is required for all providers.	N/A
49425	INSRT PERITONEAL-VENOUS SHUNT	No pre-authorization is required for all providers.	N/A
49426	REVIS PERITONEAL-VENOUS SHUNT	No pre-authorization is required for all providers.	N/A
49427	INJ PROC-EVAL PREV PLACED PERITON-VENOUS SHUNT	No pre-authorization is required for all providers.	N/A
49428	LIG PERITONEAL-VENOUS SHUNT	No pre-authorization is required for all providers.	N/A
49429	REMOV PERITONEAL-VENOUS SHUNT	No pre-authorization is required for all providers.	N/A
49435	INSERTION OF SUBCUTANEOUS EXTENSION TO INTRAPERITONEAL CANNULA	No pre-authorization is required for all providers.	N/A
49436	DELAYED CREATION OF EXIT SITE FROM EMBEDDED SUBCUTANEOUS SEGMENT	No pre-authorization is required for all providers.	N/A
49440	PLACE GASTROSTOMY TUBE PERC	No pre-authorization is required for all providers.	N/A
49441	PLACE DUOD/JEJ TUBE PERC	No pre-authorization is required for all providers.	N/A
49442	PLACE CECOSTOMY TUBE PERC	No pre-authorization is required for all providers.	N/A
49446	CHANGE G-TUBE TO G-J PERC	No pre-authorization is required for all providers.	N/A
49450	REPLACE G/C TUBE PERC	No pre-authorization is required for all providers.	N/A
49451	REPLACE DUOD/JEJ TUBE PERC	No pre-authorization is required for all providers.	N/A
49452	REPLACE G-J TUBE PERC	No pre-authorization is required for all providers.	N/A
49460	FIX G/COLON TUBE W/DEVICE	No pre-authorization is required for all providers.	N/A
49465	FLUORO EXAM OF G/COLON TUBE	This service is not covered by Superior HealthPlan.	N/A
49491	REP ING HERN PRTERM INFNT; RDUC	No pre-authorization is required for all providers.	N/A
49492	REP ING HERN PRTERM INFNT; INCAR	No pre-authorization is required for all providers.	N/A
49495	REP ING HERN FULL TERM <6 MO; RDUC	No pre-authorization is required for all providers.	N/A
49496	REP ING HERN FULL TERM <6 MO; INCAR	No pre-authorization is required for all providers.	N/A
49500	REPR INIT ING HERNIA 6 MO-< 5 YR; REDUCIBLE	No pre-authorization is required for all providers.	N/A
49501	REPR INIT ING HERNIA 6MO-<5YR; INCARCERAT/STRANG	No pre-authorization is required for all providers.	N/A
49505	REPR INIT ING HERNIA 5 YR/MORE; REDUCIBLE	No pre-authorization is required for all providers.	N/A
49507	REPR INIT ING HERNIA 5 YR/MORE; INCARC/STRANGUL	No pre-authorization is required for all providers.	N/A
49520	REPR RECURRENT ING HERNIA ANY AGE; REDUCIBLE	No pre-authorization is required for all providers.	N/A
49521	REPR RECUR ING HERNIA; INCARCERAT/STRANGULATED	No pre-authorization is required for all providers.	N/A
49525	REPR ING HERNIA SLIDING ANY AGE	No pre-authorization is required for all providers.	N/A
49540	REPR LUMBAR HERNIA	No pre-authorization is required for all providers.	N/A
49550	REPR INIT FEM HERNIA ANY AGE; REDUCIBLE	No pre-authorization is required for all providers.	N/A
49553	REPR INIT FEM HERNIA REDUCIBLE; INCARCER/STRANG	No pre-authorization is required for all providers.	N/A
49555	REPR RECUR FEM HERNIA; REDUCIBLE	No pre-authorization is required for all providers.	N/A
49557	REPR RECUR FEM HERNIA; INCARCERAT/STRANGULATED	No pre-authorization is required for all providers.	N/A
49560	REPR INIT INCS/VENTRAL HERNIA; REDUCIBLE	No pre-authorization is required for all providers.	N/A
49561	REPR INIT INCS/VENTRAL HERNIA; INCARCER/STRANGUL	No pre-authorization is required for all providers.	N/A
49565	REPR RECUR INCS/VENTRAL HERNIA; REDUCIBLE	No pre-authorization is required for all providers.	N/A
49566	REPR RECUR INCS/VENTRAL HERNIA; INCARCER/STRANGU	No pre-authorization is required for all providers.	N/A
49568	HERNIA REPAIR W/MESH	No pre-authorization is required for all providers.	N/A
49570	REPR EPIGASTRIC HERNIA; REDUCIBLE (SEPART PROC)	No pre-authorization is required for all providers.	N/A
49572	REPR EPIGASTRIC HERNIA; INCARCERAT/STRANGULATD	No pre-authorization is required for all providers.	N/A
49580	REPR UMBILICAL HERNIA < 5 YR; REDUCIBLE	No pre-authorization is required for all providers.	N/A
49582	REPR UMBILIC HERNIA <5 YR; INCARCERAT/STRANGULAT	No pre-authorization is required for all providers.	N/A
49585	REPR UMBILICAL HERNIA 5 YR/OVER; REDUCIBLE	No pre-authorization is required for all providers.	N/A
49587	REPR UMBILIC HERNIA 5 YR/OVER; INCARCER/STRANGUL	No pre-authorization is required for all providers.	N/A
49590	REPR SPIGELIAN HERNIA	No pre-authorization is required for all providers.	N/A
49600	REPR SM OMPHALOCELE W/PRIM CLO	No pre-authorization is required for all providers.	N/A
49605	REPR LG OMPHALOCELE/GASTROSCHISIS; W/WO PROSTH	No pre-authorization is required for all providers.	N/A
49606	REPR LG OMPHALOCELE; W/REMOV PROSTH REDUC & CLO	No pre-authorization is required for all providers.	N/A
49610	REPR OMPHALOCELE; FIRST STAGE	No pre-authorization is required for all providers.	N/A
49611	REPR OMPHALOCELE; SECOND STAGE	No pre-authorization is required for all providers.	N/A
49650	LAPAROSCOPY, SURGICAL	No pre-authorization is required for all providers.	N/A
49651	LAPAROSCOPY REPAIR RECURRENT INGUINAL HERNIA	No pre-authorization is required for all providers.	N/A
49652	LAP VENT/ABD HERNIA REPAIR	No pre-authorization is required for all providers.	N/A
49653	LAP VENT/ABD HERN PROC COMP	No pre-authorization is required for all providers.	N/A
49654	LAP INC HERNIA REPAIR	No pre-authorization is required for all providers.	N/A
49655	LAP INC HERN REPAIR COMP	No pre-authorization is required for all providers.	N/A
49656	LAP INC HERNIA REPAIR RECUR	No pre-authorization is required for all providers.	N/A
49657	LAP INC HERN RECUR COMP	No pre-authorization is required for all providers.	N/A
49659	UNLESTED LAPAROSCOPY PROCEDURE, HERNIOPLASTY, HERNIORRHAPHY, HERNIOTOMY	No pre-authorization is required for all providers.	N/A
49900	SUTURE SECNDRY ABD WALL EVISCERATION/DEHISCENCE	No pre-authorization is required for all providers.	N/A
49904	OMENTL FLAP EXTRA-ABDOMINAL	No pre-authorization is required for all providers.	N/A
49905	OMENTAL FLAP INTRA-ABDOMINAL	No pre-authorization is required for all providers.	N/A
49906	FREE OMENTAL FLAP W/MICROVASC ANASTOM	No pre-authorization is required for all providers.	N/A
49999	UNLISTED PROC ABD PERITONEUM & OMENTUM	No pre-authorization is required for all providers.	N/A
50010	RENAL EXPLOR WO NECES OTHER SPECIFIC PROC	No pre-authorization is required for all providers.	N/A
50020	DRAIN PERIRENAL/RENAL ABSC; OPEN	No pre-authorization is required for all providers.	N/A
50021	DRAIN PERIRENAL/RENAL ABSC; PERCUT	This is no longer a valid code.	N/A
50040	NEPHROSTOMY NEPHROTOMY W/DRAINAGE	No pre-authorization is required for all providers.	N/A
50045	NEPHROTOMY W/EXPLOR	No pre-authorization is required for all providers.	N/A
50060	NEPHROLITHOTOMY; REMOV CALCU	No pre-authorization is required for all providers.	N/A
50065	NEPHROLITHOTOMY; SECNDRY SURG FOR CALCU	No pre-authorization is required for all providers.	N/A
50070	NEPHROLITHOTOMY; COMPLIC BY CONGEN KIDNEY ABN	No pre-authorization is required for all providers.	N/A
50075	NEPHROLITHOTOMY; REMOV LG STAGHORN CALCU	No pre-authorization is required for all providers.	N/A
50080	PERCUT NEPHROSTOLITHOTOMY W/WO DILAT; UP TO 2 CM	No pre-authorization is required for all providers.	N/A
50081	PERCUT NEPHROSTOLITHOTOMY W/WO DILAT; OVER 2 CM	No pre-authorization is required for all providers.	N/A
50100	TRANSECT/REPOSIT ABERRANT RENAL VESS (SEP PRO)	No pre-authorization is required for all providers.	N/A
50120	PYELOTOMY; W/EXPLOR	No pre-authorization is required for all providers.	N/A
50125	PYELOTOMY; W/DRAINAGE PYELOSTOMY	No pre-authorization is required for all providers.	N/A
50130	PYELOTOMY; W/REMOV CALCU	No pre-authorization is required for all providers.	N/A
50135	PYELOTOMY; COMPLIC	No pre-authorization is required for all providers.	N/A
50200	RENAL BX; PERCUT BY TROCAR/NEEDLE	No pre-authorization is required for all providers.	N/A
50205	RENAL BX; BY SURG EXPOSURE KIDNEY	No pre-authorization is required for all providers.	N/A
50220	NEPHRECTOMY INCL PART URETERECTOMY W/RIB RESECT	No pre-authorization is required for all providers.	N/A
50225	NEPHRECT W/PART URETERECT; PREV SURG SAME KIDNEY	No pre-authorization is required for all providers.	N/A
50230	NEPHRECTOMY; RADICAL W/REGIONAL LYMPHADENECTOMY	No pre-authorization is required for all providers.	N/A
50234	NEPHRECTOMY W/TOT URETERECTOMY; THRU SAME INCS	No pre-authorization is required for all providers.	N/A
50236	NEPHRECTOMY W/TOT URETERECTOMY; THRU SEPART INCS	No pre-authorization is required for all providers.	N/A
50240	NEPHRECTOMY PART	No pre-authorization is required for all providers.	N/A
50250	CRYOABLATE RENAL MASS OPEN	No pre-authorization is required for all providers.	N/A
50280	EXC/UNROOFING CYST KIDNEY	No pre-authorization is required for all providers.	N/A
50290	EXC PERINEPHRIC CYST	No pre-authorization is required for all providers.	N/A
50300	DONOR NEPHRECTOMY W/PREP/MAINT ALLOGFT; CADAVER	This service is not covered by Superior HealthPlan.	N/A

50320	DONOR NEPHRECTOMY W/PREP/MAINT; LIVE DONOR	This service is not covered by Superior HealthPlan.	N/A
50323	BACKBENCH STD PREP CADVER DONOR RENL ALLOGFT	Pre-authorization is required for all providers.	Prior to 09/01/2019
50325	BACKBENCH STD PREP L/D RENAL ALLOGFT OPEN/LAP	Pre-authorization is required for all providers.	Prior to 09/01/2019
50327	BCKBNCH RECONSTR CD/LD RENL ALLOGFT;VEN ANAST EA	Pre-authorization is required for all providers.	Prior to 09/01/2019
50328	BCKBNCH RECONSTR CD/LD RENL ALLOGFT;ART ANAST EA	Pre-authorization is required for all providers.	Prior to 09/01/2019
50329	BCKBNCH RECNSTR CD/LD RENL ALLOGFT;URET ANAST EA	Pre-authorization is required for all providers.	Prior to 09/01/2019
50340	RECIPIENT NEPHRECTOMY (SEPART PROC)	Pre-authorization is required for all providers.	Prior to 09/01/2019
50360	RENAL ALLOTRANSPL; EXCLD DONOR & RECIP NEPHRECT	Pre-authorization is required for all providers.	Prior to 09/01/2019
50365	RENAL ALLOTRANSPL; W/RECIPIENT NEPHRECTOMY	Pre-authorization is required for all providers.	Prior to 09/01/2019
50370	REMOV TRANSPL RENAL ALLOGFT	Pre-authorization is required for all providers.	Prior to 09/01/2019
50380	RENAL AUTOTRANSPLANTATION REIMPLANTATION KIDNEY	Pre-authorization is required for all providers.	Prior to 09/01/2019
50382	RMVL&RPLCMT INTLY DWELLING URTRL STENT	No pre-authorization is required for all providers.	N/A
50384	RMVL INTLY DWELLING URTRL STENT	No pre-authorization is required for all providers.	N/A
50385	CHANGE STENT VIA TRANSURETH	No pre-authorization is required for all providers.	N/A
50386	REMOVE STENT VIA TRANSURETH	No pre-authorization is required for all providers.	N/A
50387	CHANGE NEPHROURETERAL CATH	No pre-authorization is required for all providers.	N/A
50389	RMVL NFROS TUBE REQ FLUOR GID	No pre-authorization is required for all providers.	N/A
50390	ASPIRAT &/OR INJ RENAL CYST/PELVIS-NEEDLE PERCUT	No pre-authorization is required for all providers.	N/A
50391	INSTL TX AGT RENL PELV&URETR THRU EST NEPHROST	No pre-authorization is required for all providers.	N/A
50392	INTRO INTRACATH/CATH-RENAL PELVIS-DRAIN PERCUT	This is no longer a valid code.	N/A
50393	INTRO URETERAL CATH THRU RENAL PELVIS PERCUT	This is no longer a valid code.	N/A
50394	INJ PROC PYELOGRAPHY THRU NEPHROSTOMY TUBE	This is no longer a valid code.	N/A
50395	INTRO-GUIDE-RENAL PELVIS W/DILAT ESTAB NEPHROST	This is no longer a valid code.	N/A
50396	MANOMETRIC STUDIES THRU NEPHROSTOMY TUBE	No pre-authorization is required for all providers.	N/A
50398	CHANGE NEPHROSTOMY/PYELOSTOMY TUBE	This is no longer a valid code.	N/A
50400	PYELOPLASTY W/WO PLASTIC ON URETER; SIMPL	No pre-authorization is required for all providers.	N/A
50405	PYELOPLASTY W/WO PLASTIC ON URETER; COMPLIC	No pre-authorization is required for all providers.	N/A
50430	NJX PX NFROSGRM &/URTRGRM	No pre-authorization is required for all providers.	N/A
50431	NJX PX NFROSGRM &/URTRGRM	No pre-authorization is required for all providers.	N/A
50432	PLMT NEPHROSTOMY CATHETER	No pre-authorization is required for all providers.	N/A
50433	PLMT NEPHROURETERAL CATHETER	No pre-authorization is required for all providers.	N/A
50434	CONVERT NEPHROSTOMY CATHETER	No pre-authorization is required for all providers.	N/A
50435	EXCHANGE NEPHROSTOMY CATH	No pre-authorization is required for all providers.	N/A
50436	PERQ DILATION XST TRC ENDOUROLOGIC PX W/IMG	No pre-authorization is required for all providers.	N/A
50437	PERQ DILATION XST TRC NEW ACCESS RENAL COLTJ SYS	No pre-authorization is required for all providers.	N/A
50500	NEPHRORRHAPHY SUTURE KIDNEY WOUND/INJURY	No pre-authorization is required for all providers.	N/A
50520	CLO NEPHROCUTANEOUS/PYELOCUTANEOUS FISTULA	No pre-authorization is required for all providers.	N/A
50525	CLO NEPHROVISCERAL FISTULA W/VISCERAL REPR; ABD	No pre-authorization is required for all providers.	N/A
50526	CLOSE NEPHROVISCERAL FISTULA	No pre-authorization is required for all providers.	N/A
50540	SYMPHYSIOTOMY W/WO PYELOPLASTY UNILAT/BILAT	No pre-authorization is required for all providers.	N/A
50541	LAPAROSCOPY, SURGICAL ABLATION OF RENAL CYSTS	No pre-authorization is required for all providers.	N/A
50542	LAPARO ABLATE RENAL MASS	No pre-authorization is required for all providers.	N/A
50543	LAPAROSCOPY SURGICAL; PART NEPHRECT	No pre-authorization is required for all providers.	N/A
50544	LAPAROSCOPY PYELOPLASTY	No pre-authorization is required for all providers.	N/A
50545	LAP SURG; RAD NEPHRECTOMY 35.22	No pre-authorization is required for all providers.	N/A
50546	LAPAROSCOPY NEPHRECTOMY	No pre-authorization is required for all providers.	N/A
50547	LAPAROSCOPY DONOR NEPHRECTOMY FROM LIVING DONOR	This service is not covered by Superior HealthPlan.	N/A
50548	LAPAROSCOPICALLY ASSISTED NEPHROURETERECTOMY	No pre-authorization is required for all providers.	N/A
50549	UNLESTED LAPAROSCOPY PROCEDURE, RENAL	No pre-authorization is required for all providers.	N/A
50551	RENAL ENDO-ESTAB NEPHROSTOMY EXCLUS OF RAD	No pre-authorization is required for all providers.	N/A
50553	RENAL ENDO-ESTAB NEPHROSTOMY; W/URETERAL CATH	No pre-authorization is required for all providers.	N/A
50555	RENAL ENDO-ESTAB NEPHROSTOMY; W/BX	No pre-authorization is required for all providers.	N/A
50557	RENAL ENDO-ESTAB NEPHROSTOMY; W/FULG &/OR INCS	No pre-authorization is required for all providers.	N/A
50561	RENAL ENDO-ESTAB NEPHROSTOMY; W/REMOV FB/CALCU	No pre-authorization is required for all providers.	N/A
50562	RENAL ENDO THRU EST OSTOMY; RES TUMR	No pre-authorization is required for all providers.	N/A
50570	RENAL ENDO-NEPHROTOMY; W/WO IRRIGA EXCLUS OF RAD	No pre-authorization is required for all providers.	N/A
50572	RENAL ENDO-NEPHROTOMY; W/URETERAL CATH	No pre-authorization is required for all providers.	N/A
50574	RENAL ENDO-NEPHROTOMY EXCLUS OF RAD; W/BX	No pre-authorization is required for all providers.	N/A
50575	RENAL ENDO-NEPHROTOMY; W/ENDOPYELOTOMY	No pre-authorization is required for all providers.	N/A
50576	RENAL ENDO-NEPHROTOMY; W/FULG &/OR INCS W/WO BX	No pre-authorization is required for all providers.	N/A
50580	RENAL ENDO-NEPHROTOMY EXCLUS OF RAD; REMOV FB	No pre-authorization is required for all providers.	N/A
50590	LITH EXTRACORPOREAL SHOCK WAVE	No pre-authorization is required for all providers.	N/A
50592	ABL TJ 1+ RNL TUM PRQ UNI RF	No pre-authorization is required for all providers.	N/A
50593	PERC CRYO ABLATE RENAL TUM	No pre-authorization is required for all providers.	N/A
50600	URETEROTOMY W/EXPLOR OR DRAINAGE (SEPART PROC)	No pre-authorization is required for all providers.	N/A
50605	URETEROTOMY INSRN INDWELLING STENT ALL TYPES	No pre-authorization is required for all providers.	N/A
50606	ENDOLUMINAL BX URTR RNL PLVS	No pre-authorization is required for all providers.	N/A
50610	URETEROLITHOTOMY; UPPER 1/3 URETER	No pre-authorization is required for all providers.	N/A
50620	URETEROLITHOTOMY; MID 1/3 URETER	No pre-authorization is required for all providers.	N/A
50630	URETEROLITHOTOMY; LOWER 1/3 URETER	No pre-authorization is required for all providers.	N/A
50650	URETERECTOMY W/BLADDER CUFF (SEPART PROC)	No pre-authorization is required for all providers.	N/A
50660	URETERECTOMY TOT-COMBO ABD/VAG &/OR PERINEAL	No pre-authorization is required for all providers.	N/A
50684	INJ PROC-URETEROGRAPHY THRU URETEROSTOMY/CATH	No pre-authorization is required for all providers.	N/A
50686	MANOMETRIC STUDIES THRU URETEROSTOMY/CATH	No pre-authorization is required for all providers.	N/A
50688	CHANGE URETEROSTOMY TUBE	No pre-authorization is required for all providers.	N/A
50690	INJ PROC-VISUALIZ ILEAL CONDUIT OF RAD	No pre-authorization is required for all providers.	N/A
50693	PLMT URETERAL STENT PRQ	No pre-authorization is required for all providers.	N/A
50694	PLMT URETERAL STENT PRQ	No pre-authorization is required for all providers.	N/A
50695	PLMT URETERAL STENT PRQ	No pre-authorization is required for all providers.	N/A
50700	URETEROPLASTY PLASTIC OR URETER	No pre-authorization is required for all providers.	N/A
50705	URETERAL EMBOLIZATION/OCCL	No pre-authorization is required for all providers.	N/A
50706	BALLOON DILATE URTRL STRIX	No pre-authorization is required for all providers.	N/A
50715	URETEROLYSIS W/WO REPOSIT URETER	No pre-authorization is required for all providers.	N/A
50722	URETEROLYSIS OVARIAN VEIN SYNDROME	No pre-authorization is required for all providers.	N/A
50725	URETEROLYSIS W/REANASTOM UPPER URIN TRACT	No pre-authorization is required for all providers.	N/A
50727	REVIS URIN-CUT ANASTOM	No pre-authorization is required for all providers.	N/A
50728	REVIS URIN-CUT ANASTOM; W/REPR FASCIAL DEFECT	No pre-authorization is required for all providers.	N/A
50740	URETEROPYELOSTOMY ANASTOM URETER & RENAL PELVIS	No pre-authorization is required for all providers.	N/A
50750	URETEROCALYCOSTOMY ANASTOM URETER TO RENAL CALYX	No pre-authorization is required for all providers.	N/A
50760	URETEROURETEROSTOMY	No pre-authorization is required for all providers.	N/A
50770	TRANSURETEROURETEROSTOMY ANASTOM URETER-CONTRALA	No pre-authorization is required for all providers.	N/A
50780	URETERONEOCYSTOSTOMY; ANASTOM SNGL URETER	No pre-authorization is required for all providers.	N/A
50782	URETERONEOCYSTOSTOMY; ANASTOM DUPLIC URETER	No pre-authorization is required for all providers.	N/A
50783	URETERONEOCYSTOSTOMY; W/EXTEN URETERAL TAILORING	No pre-authorization is required for all providers.	N/A
50785	URETERONEOCYSTOSTOMY; W/VESICO-PSOAS HITCH	No pre-authorization is required for all providers.	N/A
50800	URETEROENTEROSTOMY DIREC ANASTOM URETER-INTESTIN	No pre-authorization is required for all providers.	N/A
50810	URETEROSIGMOIDOSTOMY W/CREAT SIGMOID BLADDER	No pre-authorization is required for all providers.	N/A
50815	URETEROCOLON CONDUIT INCL BOWEL ANASTOM	No pre-authorization is required for all providers.	N/A
50820	URETEROILEAL CONDUIT INCL BOWEL ANASTOM	No pre-authorization is required for all providers.	N/A
50825	CONTINENT DIVERSION INCL BOWEL ANASTOM	No pre-authorization is required for all providers.	N/A
50830	URIN UNDIVERSION	No pre-authorization is required for all providers.	N/A
50840	REPL ALL/PART URETER BY BOWEL SEGMENT W/ANASTOM	No pre-authorization is required for all providers.	N/A
50845	CUT APPENDICO-VESICOSTOMY	No pre-authorization is required for all providers.	N/A
50860	URETEROSTOMY TRANSPL URETER TO SKIN	No pre-authorization is required for all providers.	N/A
50900	URETERORRHAPHY SUTURE URETER (SEPART PROC)	No pre-authorization is required for all providers.	N/A
50920	CLO URETEROCUTANEOUS FISTULA	No pre-authorization is required for all providers.	N/A
50930	CLO URETEROISCERAL FISTULA	No pre-authorization is required for all providers.	N/A
50940	DELIGATION URETER	No pre-authorization is required for all providers.	N/A
50945	LAPAROSCOPY SURGICAL, URETEROLITHOTOMY	No pre-authorization is required for all providers.	N/A
50947	LAP SURG; URETERNEOCYSTOST W/STENT 37.96	No pre-authorization is required for all providers.	N/A
50948	LAP SURG; URETERNEOCYST WO STENT 34.71	No pre-authorization is required for all providers.	N/A

50949	UNL LAP PROC-URETER 0	No pre-authorization is required for all providers.	N/A
50951	URETERAL ENDO-URETEROSTOMY EXCLUS OF RAD SERV	No pre-authorization is required for all providers.	N/A
50953	URETERAL ENDO-URETEROSTOMY; W/URETERAL CATH	No pre-authorization is required for all providers.	N/A
50955	URETERAL ENDO-URETEROSTOMY W/WO IRRIGA; W/BX	No pre-authorization is required for all providers.	N/A
50957	URETERAL ENDO-URETEROSTOMY; W/FULG &/OR INCS	No pre-authorization is required for all providers.	N/A
50961	URETERAL ENDO-URETEROSTOMY; W/REMOV FB/CALCU	No pre-authorization is required for all providers.	N/A
50970	URETERAL ENDO-URETEROTOMY EXCLUS OF RAD SERV	No pre-authorization is required for all providers.	N/A
50972	URETERAL ENDO-URETEROTOMY; W/URETERAL CATH	No pre-authorization is required for all providers.	N/A
50974	URETERAL ENDO-URETEROTOMY W/WO IRRIGA; W/BX	No pre-authorization is required for all providers.	N/A
50976	URETERAL ENDO-URETEROTOMY; W/FULG &/OR INCS	No pre-authorization is required for all providers.	N/A
50980	URETERAL ENDO-URETEROTOMY; W/REMOV FB/CALCU	No pre-authorization is required for all providers.	N/A
51020	CYSTOTOMY/CYSTOSTOMY; W/FULG &/OR INSRD RADIOACT	No pre-authorization is required for all providers.	N/A
51030	CYSTOTOMY/CYSTOSTOMY; W/CRYOSURG DESTRUCT LES	No pre-authorization is required for all providers.	N/A
51040	CYSTOTOMY CYSTOTOMY W/DRAINAGE	No pre-authorization is required for all providers.	N/A
51045	CYSTOTOMY W/INSRT URETERAL CATH/STENT (SEP PRO)	No pre-authorization is required for all providers.	N/A
51050	CYSTOLITHOTOMY WO VESICAL NECK RESECT	No pre-authorization is required for all providers.	N/A
51060	TRANSVESICAL URETEROLITHOTOMY	No pre-authorization is required for all providers.	N/A
51065	CYSTOTOMY W/STONE BASKET EXTRACT URETERAL CALCU	No pre-authorization is required for all providers.	N/A
51080	DRAINAGE PERIVESICAL/PREVESICAL SPACE ABSCESS	No pre-authorization is required for all providers.	N/A
51100	DRAIN BLADDER BY NEEDLE	No pre-authorization is required for all providers.	N/A
51101	DRAIN BLADDER BY TROC/CATH	No pre-authorization is required for all providers.	N/A
51102	DRAIN BL W/CATH INSERTION	No pre-authorization is required for all providers.	N/A
51500	EXC URACHAL CYST W/WO UMBILICAL HERNIA REPR	No pre-authorization is required for all providers.	N/A
51520	CYSTOTOMY; SIMPL EXC VESICAL NECK (SEPART PROC)	No pre-authorization is required for all providers.	N/A
51525	CYSTOTOMY; EXC BLADDER DIVERTIC 1/MX (SEP PRO)	No pre-authorization is required for all providers.	N/A
51530	CYSTOTOMY; EXC BLADDER TUMOR	No pre-authorization is required for all providers.	N/A
51535	CYSTOTOMY EXC INCS/REPR URETEROCELE	No pre-authorization is required for all providers.	N/A
51550	CYSTEOTOMY PART; SIMPL	No pre-authorization is required for all providers.	N/A
51555	CYSTEOTOMY PART; COMPLIC	No pre-authorization is required for all providers.	N/A
51565	CYSTEOTOMY PART W/REIMPLNT URETER INTO BLADDER	No pre-authorization is required for all providers.	N/A
51570	CYSTEOTOMY COMPLT; (SEPART PROC)	No pre-authorization is required for all providers.	N/A
51575	CYSTEOTOMY COMPLT; W/BILAT PELVIC LYMPHADENECTMY	No pre-authorization is required for all providers.	N/A
51580	CYSTEOTOMY COMPLT W/URETEROSIGMOIDOSTOMY	No pre-authorization is required for all providers.	N/A
51585	CYSTEOTOMY W/URETEROSIGMOIDOSTOMY; W/LYMPHADENECT	No pre-authorization is required for all providers.	N/A
51590	CYSTEOTOMY COMPLT W/URETEROILEAL CONDUIT	No pre-authorization is required for all providers.	N/A
51595	CYSTEOTOMY COMPLT W/SIDMOID BLADDER; W/LYMPHADEN	No pre-authorization is required for all providers.	N/A
51596	CYSTEOTOMY COMPLT W/CONTINENT DIVERSION	No pre-authorization is required for all providers.	N/A
51597	PELVIC EXENTERATION FOR PROSTATIC/URETHRAL MALIG	No pre-authorization is required for all providers.	N/A
51600	INJ PROC-CYSTOGRAPHY/VOIDING URETHROCISTOGRAPHY	No pre-authorization is required for all providers.	N/A
51605	INJ PROC/PLCMT CHAIN-CONTRAST URETHROCISTOGRAPHY	No pre-authorization is required for all providers.	N/A
51610	INJ PROC RETROGRADE URETHROCISTOGRAPHY	No pre-authorization is required for all providers.	N/A
51700	BLADDER IRRIGA SIMPL LAVAGE &/OR INSTILL	No pre-authorization is required for all providers.	N/A
51701	INSERTION NON-INDWLL BLADDER CATH	No pre-authorization is required for all providers.	N/A
51702	INSERT TEMP INDWLL BLADD CATH; SMPL	No pre-authorization is required for all providers.	N/A
51703	INSRT TEMP INDWELL BLADD CATH; COMP	No pre-authorization is required for all providers.	N/A
51705	CHANGE CYSTOSTOMY TUBE; SIMPL	No pre-authorization is required for all providers.	N/A
51710	CHANGE CYSTOSTOMY TUBE; COMPLIC	No pre-authorization is required for all providers.	N/A
51715	ENDO INJ IMPLNT MAT-URETHRE &/OR BLADDER NECK	No pre-authorization is required for all providers.	N/A
51720	BLADDER INSTILLATION ANTICARCINOGENIC AGENT INCLUDING RETETION TIME	No pre-authorization is required for all providers.	N/A
51725	SIMPL CYSTOMETROGRAM	No pre-authorization is required for all providers.	N/A
51726	COMPLX CYSTOMETROGRAM	No pre-authorization is required for all providers.	N/A
51727	CYSTOMETROGRAM W/IUP	No pre-authorization is required for all providers.	N/A
51728	CYSTOMETROGRAM W/VP	No pre-authorization is required for all providers.	N/A
51729	CYSTOMETROGRAM W/VP&UP	No pre-authorization is required for all providers.	N/A
51736	SIMPL UROFLOWMETRY	No pre-authorization is required for all providers.	N/A
51741	COMPLX UROFLOWMETRY	No pre-authorization is required for all providers.	N/A
51745	EDNOSCOPIC INJECTION OF URETHA	No pre-authorization is required for all providers.	N/A
51784	EMG ANAL/URETHRAL SPHINCTER-NOT NEEDLE-ANY TECH	No pre-authorization is required for all providers.	N/A
51785	NEEDLE EMG STDY ANAL/URETHRAL SPHINCTER ANY TECH	No pre-authorization is required for all providers.	N/A
51792	STIMULUS EVOKED RESPONSE	No pre-authorization is required for all providers.	N/A
51797	VOIDING PRESS STDS INTRA-ABDOMINAL VOID	No pre-authorization is required for all providers.	N/A
51798	MSR PVR U&/BLADD CAPACITY US NON-IMG	No pre-authorization is required for all providers.	N/A
51800	CYSTOPLASTY/CYSTOURETHROPLASTY WO RESECT VESICAL	No pre-authorization is required for all providers.	N/A
51820	CYSTOURETHROPLASTY W/UNILAT/BILAT URETERONEOCYST	No pre-authorization is required for all providers.	N/A
51840	ANT VESICourethropeXY/UREthropeXY; SIMPL	No pre-authorization is required for all providers.	N/A
51841	ANT VESICourethropeXY/UREthropeXY; COMPLIC	No pre-authorization is required for all providers.	N/A
51845	ABD-VAG VESICAL NECK SUSPEN W/WO ENDO CONTRL	No pre-authorization is required for all providers.	N/A
51860	CYSTORRHAPHY WOUND/INJURY/RUPT; SIMPL	No pre-authorization is required for all providers.	N/A
51865	CYSTORRHAPHY WOUND/INJURY/RUPT; COMPLIC	No pre-authorization is required for all providers.	N/A
51880	CLO CYSTOSTOMY (SEPART PROC)	No pre-authorization is required for all providers.	N/A
51900	CLO VESICOVAGINAL FISTULA ABD APPROACH	No pre-authorization is required for all providers.	N/A
51920	CLO VESICOUTERINE FISTULA	No pre-authorization is required for all providers.	N/A
51925	CLO VESICOUTERINE FISTULA; W/HYST	Pre-authorization is required for all providers.	Prior to 09/01/2019
51940	CLO BLADDER EXSTROPHY	No pre-authorization is required for all providers.	N/A
51960	ENTEROCYSTOPLASTY INCL BOWEL ANASTOM	No pre-authorization is required for all providers.	N/A
51980	CUT VESICOSTOMY	No pre-authorization is required for all providers.	N/A
51990	LAPAROSCOPY SURGICAL URETHRAL SUSPENSION FOR STRESS INCONTINENCE	No pre-authorization is required for all providers.	N/A
51992	LAPAROSCOPY SLING OPERATION FOR STRESS INCONTINENCE	No pre-authorization is required for all providers.	N/A
51999	UNLIS LAPS PX BLDR	No pre-authorization is required for all providers.	N/A
52000	CYSTOURETHROSCOPY (SEPART PROC)	No pre-authorization is required for all providers.	N/A
52001	CYSTURTHRSCP IRRG&EVC MX OBST CLOT	No pre-authorization is required for all providers.	N/A
52005	CYSTOURETHROSCOPY W/URETERAL CATH EXCLUS-RAD	No pre-authorization is required for all providers.	N/A
52007	CYSTOURETHROSCOPY EXCLUS-RAD SERV; W/BRUSH BX	No pre-authorization is required for all providers.	N/A
52010	CYSTOURETHROSCOPY W/EJACULATORY DUCT CATH	No pre-authorization is required for all providers.	N/A
52204	CYSTOURETHROSCOPY, WITH BIOPSY(S)	No pre-authorization is required for all providers.	N/A
52214	CYSTOURETHROSCOPY W/FULG TRIGONE/BLADDER NECK	No pre-authorization is required for all providers.	N/A
52224	CYSTOURETHROSCOPY W/FULG/TX MINOR (< 0.5CM) LES	No pre-authorization is required for all providers.	N/A
52234	CYSTOURETHROSCOPY W/FULG &/OR RESECT; SM TUMOR	No pre-authorization is required for all providers.	N/A
52235	CYSTOURETHROSCOPY W/FULG &/OR RESECT; MED TUMOR	No pre-authorization is required for all providers.	N/A
52240	CYSTOURETHROSCOPY W/FULG &/OR RESECT; LG TUMOR	No pre-authorization is required for all providers.	N/A
52250	CYSTOURETHROSCOPY W/INSRT RADIOACT SUBSTANCE	No pre-authorization is required for all providers.	N/A
52260	CYSTOURETHROSCOPY W/DILAT BLADDER; GEN ANES	No pre-authorization is required for all providers.	N/A
52265	CYSTOURETHROSCOPY W/DILAT BLADDER; LOCAL ANES	No pre-authorization is required for all providers.	N/A
52270	CYSTOURETHROSCOPY W/INT URETHROTOMY; FE	No pre-authorization is required for all providers.	N/A
52275	CYSTOURETHROSCOPY W/INT URETHROTOMY; MALE	No pre-authorization is required for all providers.	N/A
52276	CYSTOURETHROSCOPY W/DIREC VISION INT URETHROTOMY	No pre-authorization is required for all providers.	N/A
52277	CYSTOURETHROSCOPY W/RESECT EXT SPHINCTER	No pre-authorization is required for all providers.	N/A
52281	CYSTOURETHROSCOPY W/CALIBRAT &/OR DILAT URETHRAL	No pre-authorization is required for all providers.	N/A
52282	CYSTOURETHROSCOPY W/INSRT URETHRAL STENT	No pre-authorization is required for all providers.	N/A
52283	CYSTOURETHROSCOPY W/STEROID INJ INTO STRICT	No pre-authorization is required for all providers.	N/A
52285	CYSTOURETHROSCOPY TX FE URETHRAL SYNDROME	No pre-authorization is required for all providers.	N/A
52287	CYSTOSCOPY CHEMODENERVATION	No pre-authorization is required for all providers.	N/A
52290	CYSTOURETHROSCOPY; W/URETERAL MEATOTOMY	No pre-authorization is required for all providers.	N/A
52300	CYSTOURETHROSCOPY; W/RESECT ORTHOTOP URETEROCELE	No pre-authorization is required for all providers.	N/A
52301	CYSTOURETHROSCOPY; W/RESECT ECTOPIC URETEROCELE	No pre-authorization is required for all providers.	N/A
52305	CYSTOURETHROSCOPY; W/INCS BLADDER DIVERTIC	No pre-authorization is required for all providers.	N/A
52310	CYSTOURETHROSCOPY W/REMOV FB (SEP PRO); SIMPL	No pre-authorization is required for all providers.	N/A
52315	CYSTOURETHROSCOPY W/REMOV FB (SEP PRO); COMPLIC	No pre-authorization is required for all providers.	N/A
52317	LITH: CRUSH CALCU-BLADDER; SIMPL/SM (< 2.5 CM)	No pre-authorization is required for all providers.	N/A
52318	LITH: CRUSH CALCU-BLADDER; COMPLIC/LG (>2.5 CM)	No pre-authorization is required for all providers.	N/A
52320	CYSTOURETHROSCOPY; W/REMOV URETERAL CALCU	No pre-authorization is required for all providers.	N/A

52325	CYSTOURETHROSCOPY; W/FRAGMNT URETERAL CALCU	No pre-authorization is required for all providers.	N/A
52327	CYSTOURETHROSCOPY; W/SUBURETER INJ IMPLNT MAT	No pre-authorization is required for all providers.	N/A
52330	CYSTOURETHROSCOPY; W/MANIP WO REMOV CALCU	No pre-authorization is required for all providers.	N/A
52332	CYSTOURETHROSCOPY W/INSRT INDWELLING STENT	No pre-authorization is required for all providers.	N/A
52334	CYSTOURETHROSCOPY W/INSRT GUIDE WIRE THRU KIDNEY	No pre-authorization is required for all providers.	N/A
52341	CYSTOURETHROSCOPY; W/TX URETER STRIC 8.74	No pre-authorization is required for all providers.	N/A
52342	CYSTOURETHROSCOPY; W/TX UPJ STRICT 9.46	No pre-authorization is required for all providers.	N/A
52343	CYSTOURETHSCPY; TX INTRARENAL STRIC 10.48	No pre-authorization is required for all providers.	N/A
52344	CYSTURETHSCPY W/URETERSOPY; TX STRI 11.2	No pre-authorization is required for all providers.	N/A
52345	CYSTOURETH/URETERSOPY; TX UPJ STRIC 11.94	No pre-authorization is required for all providers.	N/A
52346	CYSTOURETH/URETERSOPY; TX RENL STRI 13.43	No pre-authorization is required for all providers.	N/A
52351	CYSTOURETH/URETER & PYELOSOPY; DX 8.92	Pre-authorization required for all providers.	Prior to 09/01/2019
52352	CYSURETH/URETR/PYELSCPY; REMOV CALC 11.04	No pre-authorization is required for all providers.	N/A
52353	CYSURETH/URETR/PYELSCPY; LITHOTRPS 12.79	No pre-authorization is required for all providers.	N/A
52354	CYSTURETH-URETR&PYELSCPY; BX&FULG	No pre-authorization is required for all providers.	N/A
52355	CYSTURETH-URETR&PYELSCPY; RES TUMR	No pre-authorization is required for all providers.	N/A
52356	CYSTO/URETERO W/LITHOTRIPSY	No pre-authorization is required for all providers.	N/A
52400	CYSTURETHSCPY W/RESECT CONGEN VALV 15.63	No pre-authorization is required for all providers.	N/A
52402	CYSTURETHSCPY TRNSURETH RES/INCI EJACULAT DUCTS	This service is not covered by Superior HealthPlan.	N/A
52441	CYSTOURETHRO W/IMPLANT	This service is not covered by Superior HealthPlan.	N/A
52442	CYSTOURETHRO W/ADDL IMPLANT	This service is not covered by Superior HealthPlan.	N/A
52450	TRANSURETHRAL INCS PROSTATE	No pre-authorization is required for all providers.	N/A
52500	REVISION OF BLADDER NECK	No pre-authorization is required for all providers.	N/A
52601	T U R P INCL CONTRL POSTOP BLEEDING COMPLT	No pre-authorization is required for all providers.	N/A
52630	REMOVE PROSTATE REGROWTH	No pre-authorization is required for all providers.	N/A
52640	TRANSURETH RESEC; POSTOP BLADDER NECK CONTRACTUR	No pre-authorization is required for all providers.	N/A
52647	NON-CONTACT LASER COAGULATION PROSTATE COMPLT	No pre-authorization is required for all providers.	N/A
52648	CONTACT LASER VAPORIZA PROSTATE W/WO TURP COMPLT	No pre-authorization is required for all providers.	N/A
52649	PROSTATE LASER ENUCLEATION	No pre-authorization is required for all providers.	N/A
52700	TRANSURETHRAL DRAINAGE PROSTATIC ABSCESS	No pre-authorization is required for all providers.	N/A
53000	URETHROTOMY EXT (SEPART PROC); PENDULOUS URETHRA	No pre-authorization is required for all providers.	N/A
53010	URETHROTOMY EXT (SEPART PROC); PERINEAL URETHRA	No pre-authorization is required for all providers.	N/A
53020	MEATOTOMY CUT MEATUS (SEPART PROC); EX INFANT	No pre-authorization is required for all providers.	N/A
53025	MEATOTOMY CUTTING MEATUS (SEPART PROC); INFANT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
53040	DRAINAGE DEEP PERIURETHRAL ABSCESS	No pre-authorization is required for all providers.	N/A
53060	DRAINAGE SKENE'S GLAND ABSCESS/CYST	No pre-authorization is required for all providers.	N/A
53080	DRAIN PERINEAL URIN EXTRAVASAT; UNCOMP (SEP PRO)	No pre-authorization is required for all providers.	N/A
53085	DRAINAGE PERINEAL URIN EXTRAVASATION; COMPLIC	No pre-authorization is required for all providers.	N/A
53200	BX URETHRA	No pre-authorization is required for all providers.	N/A
53210	URETHRECTOMY TOT INCL CYSTOSTOMY; FE	No pre-authorization is required for all providers.	N/A
53215	URETHRECTOMY TOT INCL CYSTOSTOMY; MALE	No pre-authorization is required for all providers.	N/A
53220	EXC/FULG CARCINOMA URETHRA	No pre-authorization is required for all providers.	N/A
53230	EXC URETHRAL DIVERTIC (SEPART PROC); FE	No pre-authorization is required for all providers.	N/A
53235	EXC URETHRAL DIVERTIC (SEPART PROC); MALE	No pre-authorization is required for all providers.	N/A
53240	MARSUPIALIZATION URETHRAL DIVERTIC MALE/FE	No pre-authorization is required for all providers.	N/A
53250	EXC BULBOURETHRAL GLAND	No pre-authorization is required for all providers.	N/A
53260	EXC/FULG; URETHRAL POLYP DISTAL URETHRA	No pre-authorization is required for all providers.	N/A
53265	EXC/FULG; URETHRAL CARUNCLE	No pre-authorization is required for all providers.	N/A
53270	EXC/FULG; SKENE'S GLANDS	No pre-authorization is required for all providers.	N/A
53275	EXC/FULG; URETHRAL PROLAPSE	No pre-authorization is required for all providers.	N/A
53400	URETHROPLASTY; 1ST STAGE-FISTULA/DIVERTIC/STRICT	No pre-authorization is required for all providers.	N/A
53405	URETHROPLASTY; 2ND STAGE INCL URIN DIVERSION	No pre-authorization is required for all providers.	N/A
53410	URETHROPLASTY 1-STAGE RECON MALE ANT URETHRA	No pre-authorization is required for all providers.	N/A
53415	URETHROPLASTY 1 STAGE RECON PROSTATIC URETHRA	No pre-authorization is required for all providers.	N/A
53420	URETHROPLASTY 2-STAGE RECON URETHRA; 1ST STAGE	No pre-authorization is required for all providers.	N/A
53425	URETHROPLASTY; 2-STAGE RECON URETHRA; 2ND STAGE	No pre-authorization is required for all providers.	N/A
53430	URETHROPLASTY RECON FE URETHRA	No pre-authorization is required for all providers.	N/A
53431	URETHROPLASTY	No pre-authorization is required for all providers.	N/A
53440	SLING OP CORR MALE URIN INCONT	No pre-authorization is required for all providers.	N/A
53442	REMO/REV SLING MALE URIN INCONT	No pre-authorization is required for all providers.	N/A
53444	INSERTION OF TANDEM CUFF	No pre-authorization is required for all providers.	N/A
53445	OR-CORRECT URIN INCONT W/PLCMT SPHINCTER	No pre-authorization is required for all providers.	N/A
53446	REMOVAL OF URETHRAL/BLADDER NECK SPHINCTER	No pre-authorization is required for all providers.	N/A
53447	REMOV/REPR/REPLAC INFLATABLE SPHINCTER	No pre-authorization is required for all providers.	N/A
53448	REMOVAL/REPLACEMENT OF URETHRAL/BLADDER NECK SPHINCTER	No pre-authorization is required for all providers.	N/A
53449	SURG CORRECT HYDRAULIC ABNL INFLATABLE SPHINCTER	No pre-authorization is required for all providers.	N/A
53450	URETHROMEATOPLASTY W/MUCOS ADVANCEMENT	No pre-authorization is required for all providers.	N/A
53460	URETHROMEATOPLASTY W/PART EXC DISTAL URETHRL SEG	No pre-authorization is required for all providers.	N/A
53500	URETHROLYS TRNSVAG 2 OPN CYSTOURETH	No pre-authorization is required for all providers.	N/A
53502	URETHRORRHAPHY SUTURE URETHRAL WOUND/INJURY; FE	No pre-authorization is required for all providers.	N/A
53505	URETHRORRHAPHY SUTURE URETHRAL WOUND; PENILE	No pre-authorization is required for all providers.	N/A
53510	URETHRORRHAPHY SUTURE URETHRAL WOUND PERINEAL	No pre-authorization is required for all providers.	N/A
53515	URETHRORRHAPHY SUTURE WOUND; PROSTATOMEMBRANOUS	No pre-authorization is required for all providers.	N/A
53520	CLO URETHROSTOMY FISTULA MALE (SEPART PROC)	No pre-authorization is required for all providers.	N/A
53600	DILAT URETHRAL STRICT-SOUND DILAT-MALE; INIT	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
53601	DILAT URETHRAL STRICT-SOUND/DILAT-MALE; SUBSQT	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
53605	DILAT URETHRAL STRICT-MALE-GEN/CONDUCTION ANES	No pre-authorization is required for all providers.	N/A
53620	DILAT URETHRAL STRICT-FILLIFORM-MALE; INIT	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
53621	DILAT URETHRAL STRICT-FILLIFORM-MALE; SUBSQT	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
53660	DILAT FE URETHRA INCL SUPPOSITORY; INIT	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
53661	DILAT FE URETHRA INCL SUPPOSITORY; SUBSQT	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
53665	DILAT FE URETHRA GEN/CONDUCTION ANES	No pre-authorization is required for all providers.	N/A
53850	TRNSURETHRAL DESTRUC PROSTATE; MICROWAV THERMOTX	No pre-authorization is required for all providers.	N/A
53852	TRNSURETHRAL DESTRUC PROSTATE; RADIOFRQ THERMOTX	This service is not covered by Superior HealthPlan.	N/A
53854	TRURL DSTRJ PRST8 TISS RF WV THERMOTHERAPY	No pre-authorization is required for all providers.	N/A
53855	INSERT PROST URETHRAL STENT	No pre-authorization is required for all providers.	N/A
53860	TRANSURETHRAL RF TREATMENT	This service is not covered by Superior HealthPlan.	N/A
53899	UNLISTED PROC URIN SYST	No pre-authorization is required for all providers.	N/A
54000	SLITTING PREPUCE DORSAL/LAT (SEPART PROC); NB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
54001	SLITTING PREPUCE DORSAL/LAT (SEPART PROC); EX NB	No pre-authorization is required for all providers.	N/A
54015	I&D PENIS DEEP	No pre-authorization is required for all providers.	N/A
54050	DESTRCT LES PENIS SIMPL; CHEM	No pre-authorization is required for all providers.	N/A
54055	DESTRCT LES PENIS SIMPL; ELECTRODESICCATION	No pre-authorization is required for all providers.	N/A
54056	DESTRCT LES PENIS SIMPL; CRYOSURGERY	No pre-authorization is required for all providers.	N/A
54057	DESTRCT LES PENIS SIMPL; LASER SURG	No pre-authorization is required for all providers.	N/A
54060	DESTRCT LES PENIS SIMPL; SURG EXC	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
54065	DESTRCT LES PENIS EXTEN ANY METHD	No pre-authorization is required for all providers.	N/A
54100	BX PENIS; CUT (SEPART PROC)	No pre-authorization is required for all providers.	N/A
54105	BX PENIS; DEEP STRUCT	No pre-authorization is required for all providers.	N/A
54110	EXC PENILE PLAQUE	No pre-authorization is required for all providers.	N/A
54111	EXC PENILE PLAQUE; W/GFT TO 5 CM LENGTH	No pre-authorization is required for all providers.	N/A
54112	EXC PENILE PLAQUE; W/GFT > 5 CM LENGTH	No pre-authorization is required for all providers.	N/A
54115	REMOV FB FROM DEEP PENILE TISS	No pre-authorization is required for all providers.	N/A
54120	AMPUTA PENIS; PART	No pre-authorization is required for all providers.	N/A
54125	AMPUTA PENIS; COMPLT	No pre-authorization is required for all providers.	N/A
54130	AMPUTA PENIS RAD; W/BILAT INGUINFEM LYMPHADENEC	No pre-authorization is required for all providers.	N/A

54135	AMPUTA PENIS RAD; W/BILAT PELVIC LYMPHADENECTOMY	No pre-authorization is required for all providers.	N/A
54150	CIRCUMCISION USING CLAMP/OTH DEVICE W/REG DORSAL PENILE OR RING BLOCK	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
54160	CIRCUMCISION SURG EXC OTH THN CLAMP,DEVICE,DORS SL,NEONATE (<28 DAYS)	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
54161	CIRCUMCISION SURG EXC OTH THAN CLAMP,DEVICE, DORSAL SLIT, (28+ DAYS)	Pre-authorization is required for members 1 year of age and of ageer.	Prior to 09/01/2019
54162	LYSIS OF PENILE CIRCUMCISION	Pre-authorization is required for members 1 year of age and of ageer.	Prior to 09/01/2019
54163	REPAIR OF INCOMPLETE CIRCUMCISION	Pre-authorization is required for members 1 year of age and of ageer.	Prior to 09/01/2019
54164	FRENULOTOMY OF THE PENIS	Pre-authorization is required for members 1 year of age and of ageer.	Prior to 09/01/2019
54200	INJ PROC PEYRONIE DISEASE	No pre-authorization is required for all providers.	N/A
54205	INJ PROC PEYRONIE DISEASE; W/SURG EXPOSURE PLAQ	No pre-authorization is required for all providers.	N/A
54220	IRRIGA CORPORA CAVERNOSA PRIAPISM	No pre-authorization is required for all providers.	N/A
54230	INJ PROC CORPORA CAVERNOSOGRAPHY	No pre-authorization is required for all providers.	N/A
54231	DYNAMIC CAVERNOSOMETRY INCL INJ VASOACTIVE DRUGS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
54235	INJ CORPORA CAVERNOSA W/PHARMACOLOGIC AGENT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
54240	PENILE PLETHYSMOGRAPHY	This service is not covered by Superior HealthPlan.	N/A
54250	NOCTURNAL PENILE TUMESCENCE &/OR RIGIDITY TEST	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
54300	PLASTIC OPERAT PENIS-STRAIGHT CHORDEE	No pre-authorization is required for all providers.	N/A
54304	PLASTIC OPERAT PENIS W/WO TRANSPL PREPUCE	No pre-authorization is required for all providers.	N/A
54308	URETHROPLASTY 2ND STAGE HYPOSPADIAS REPR; < 3 CM	No pre-authorization is required for all providers.	N/A
54312	URETHROPLASTY 2ND STAGE HYPOSPADIAS REPR; > 3 CM	No pre-authorization is required for all providers.	N/A
54316	URETHROPLASTY 2ND STAGE HYPOSPADIAS REPR; W/GFT	No pre-authorization is required for all providers.	N/A
54318	URETHROPLASTY 3RD STAGE RELEAS PENIS FRM SCROTUM	No pre-authorization is required for all providers.	N/A
54322	1 STAGE DISTAL HYPOSPADIAS REPR; W/SIMPL ADVANCE	No pre-authorization is required for all providers.	N/A
54324	1 STAGE DISTAL HYPOSPADIAS REPR; W/URETHROPLASTY	No pre-authorization is required for all providers.	N/A
54326	1 STAGE DISTAL HYPOSPADIAS REPR; MOBILIZ URETHRA	No pre-authorization is required for all providers.	N/A
54328	1 STAGE DISTAL HYPOSPADIAS REPR; W/EXTEN DISSECT	No pre-authorization is required for all providers.	N/A
54332	1 STAGE PROX PENILE REPR REQUIR EXTEN DISSECTION	No pre-authorization is required for all providers.	N/A
54336	1 STAGE PERINEAL HYPOSPADIAS REPR W/DISSECTION	No pre-authorization is required for all providers.	N/A
54340	REPR HYPOSPADIAS COMPLIC; BY CLO INCS/EXC SIMPL	No pre-authorization is required for all providers.	N/A
54344	REPR HYPOSPADIAS COMPLIC; REQ MOBILIZ-SKIN FLAPS	No pre-authorization is required for all providers.	N/A
54348	REPR HYPOSPADIAS COMPLIC; REQ EXTEN DISSECTION	No pre-authorization is required for all providers.	N/A
54352	REPR HYPOSPADIAS CRIPPLE REQ EXTEN DISSECTION	No pre-authorization is required for all providers.	N/A
54360	PLASTIC OR PENIS TO CORRECT ANGLUATION	No pre-authorization is required for all providers.	N/A
54380	PLASTIC OR PENIS EPISPADIAS DISTAL-EXT SPHINCTER	No pre-authorization is required for all providers.	N/A
54385	PLASTIC OR PENIS EPISPADIAS; W/INCONT	No pre-authorization is required for all providers.	N/A
54390	PLASTIC OR PENIS EPISPADIAS; W/EXSTROPHY BLADDER	No pre-authorization is required for all providers.	N/A
54400	INSRT PENILE PROSTH; NON-INFLATABLE	This service is not covered by Superior HealthPlan.	N/A
54401	INSRT PENILE PROSTH; INFLATABLE	This service is not covered by Superior HealthPlan.	N/A
54405	INSRT INFLATBL PENILE PROSTH W/PLCMT PUMP/CYLIND	This service is not covered by Superior HealthPlan.	N/A
54406	REMOVAL OF PENILE PROSTHESIS	No pre-authorization is required for all providers.	N/A
54408	REPAIR OF PENILE PROSTHESIS	This service is not covered by Superior HealthPlan.	N/A
54410	REMOVAL/REPLACEMENT OF PENILE PROSTHESIS	This service is not covered by Superior HealthPlan.	N/A
54411	REMOVAL/REPLACEMENT OF PENILE PROSTHESIS	This service is not covered by Superior HealthPlan.	N/A
54415	REMOVAL OF PENILE PROTHESIS	No pre-authorization is required for all providers.	N/A
54416	REMOVAL/REPLACEMENT OF PENILE PROSTHESIS	This service is not covered by Superior HealthPlan.	N/A
54417	REMOVAL/REPLACEMENT OF PENILE PROSTHESIS	This service is not covered by Superior HealthPlan.	N/A
54420	CORPORA CAVERNOSA-SAPHENOUS VEIN SHUNT UNI/BILAT	No pre-authorization is required for all providers.	N/A
54430	CORPORA CAVERNOSA-CORPUS SPONGIOSUM SHUNT	No pre-authorization is required for all providers.	N/A
54435	CORPORA CAVERNOSA-GLANS PENIS FISTULIZ-PRIDISM	No pre-authorization is required for all providers.	N/A
54437	REPAIR CORPOREAL TEAR	No pre-authorization is required for all providers.	N/A
54438	REPLANTATION OF PENIS	No pre-authorization is required for all providers.	N/A
54440	PLASTIC OR PENIS INJURY	No pre-authorization is required for all providers.	N/A
54450	FORESKIN MANIP INCL LYSIS PREPUTIAL ADHESIONS	No pre-authorization is required for all providers.	N/A
54500	BX TESTIS NEEDLE (SEPART PROC)	No pre-authorization is required for all providers.	N/A
54505	BX TESTIS INCS (SEPART PROC)	No pre-authorization is required for all providers.	N/A
54512	EXC EXTRAPARENCHYMAL LES TESTIS 13.95	No pre-authorization is required for all providers.	N/A
54520	ORCHIECTOMY SIMPL W/WO TESTICULAR PROSTH	No pre-authorization is required for all providers.	N/A
54522	ORCHIECTOMY-PART 15.86	No pre-authorization is required for all providers.	N/A
54530	ORCHIECTOMY RADICAL TUMOR; ING APPROACH	No pre-authorization is required for all providers.	N/A
54535	ORCHIECTOMY RADICAL TUMOR; W/ABD EXPLOR	No pre-authorization is required for all providers.	N/A
54550	EXPLOR UNDESCENDED TESTIS	No pre-authorization is required for all providers.	N/A
54560	EXPLOR UNDESCENDED TESTIS W/ABD EXPLOR	No pre-authorization is required for all providers.	N/A
54600	REDUCTION TORSION TESTIS-SURG W/WO FIX CONTRALAT	No pre-authorization is required for all providers.	N/A
54620	FIXA CONTRALATERAL TESTIS (SEPART PROC)	No pre-authorization is required for all providers.	N/A
54640	ORCHIOPEXY INGUINAL OR SCROTAL APPROACH	No pre-authorization is required for all providers.	N/A
54650	ORCHIOPEXY ABD APPROACH INTRA-ABD TESTIS	No pre-authorization is required for all providers.	N/A
54660	INSRT TESTICULAR PROSTH (SEPART PROC)	No pre-authorization is required for all providers.	N/A
54670	SUTURE/REPR TESTICULAR INJURY	No pre-authorization is required for all providers.	N/A
54680	TRANSPL TESTIS TO THIGH	No pre-authorization is required for all providers.	N/A
54690	LAPAROSCOPY, SURGICAL, ORCHIECTOMY	No pre-authorization is required for all providers.	N/A
54692	LAPAROSCOPY ORCHIOPEXY FOR INTRA-ABDOMINAL TESTIS	No pre-authorization is required for all providers.	N/A
54699	UNLISTED LAPAROSCOPY PROCEDURE, TESTIS	No pre-authorization is required for all providers.	N/A
54700	I&D EPIDIDYMIS TESTIS &/OR SCROTAL SPACE	No pre-authorization is required for all providers.	N/A
54800	BX EPIDIDYMIS NEEDLE	No pre-authorization is required for all providers.	N/A
54830	EXC LOCAL LES EPIDIDYMIS	No pre-authorization is required for all providers.	N/A
54840	EXC SPERMATOCELE W/WO EPIDIDYMECTOMY	No pre-authorization is required for all providers.	N/A
54860	EPIDIDYMECTOMY; UNILAT	No pre-authorization is required for all providers.	N/A
54861	EPIDIDYMECTOMY; BILAT	No pre-authorization is required for all providers.	N/A
54865	EXPLORATION OF EPIDIDYMIS, WITH OR WITHOUT BIOPSY	No pre-authorization is required for all providers.	N/A
54900	EPIDIDYMOVASOSTOMY ANASTOM EPIDIDY-VAS; UNILAT	This service is not covered by Superior HealthPlan.	N/A
54901	EPIDIDYMOVASOSTOMY ANASTOM EPIDIDY-VAS; BILAT	This service is not covered by Superior HealthPlan.	N/A
55000	PUNCT ASPIRAT HYDROCELE TUNICA VAG W/WO INJ MEDS	No pre-authorization is required for all providers.	N/A
55040	EXC HYDROCELE; UNILAT	No pre-authorization is required for all providers.	N/A
55041	EXC HYDROCELE; BILAT	No pre-authorization is required for all providers.	N/A
55060	REPR TUNICA VAG HYDROCELE	No pre-authorization is required for all providers.	N/A
55100	DRAINAGE SCROTAL WALL ABSCESS	No pre-authorization is required for all providers.	N/A
55110	SCROTAL EXPLOR	No pre-authorization is required for all providers.	N/A
55120	REMOV FB SCROTUM	No pre-authorization is required for all providers.	N/A
55150	RESECT SCROTUM	No pre-authorization is required for all providers.	N/A
55175	SCROTOPLASTY; SIMPL	No pre-authorization is required for all providers.	N/A
55180	SCROTOPLASTY; COMPLIC	No pre-authorization is required for all providers.	N/A
55200	VASOTOMY CANNULIZ W/WO INCS VAS (SEPART PROC)	This service is not covered by Superior HealthPlan.	N/A
55250	VASECTOMY UNILAT/BILAT (SEP PRO) W/POSTOP SEMEN	No pre-authorization is required for all providers.	N/A
55300	VASOTOMY-VASOGMS/SEMINAL VESICULOGMS UNI/BILAT	This service is not covered by Superior HealthPlan.	N/A
55400	VASOVASOSTOMY VASOVASORRHAPHY	This service is not covered by Superior HealthPlan.	N/A
55450	LIG VAS DEFERENS UNI/BILAT (SEPART PROC)	This is no longer a valid code.	N/A
55500	EXC HYDROCELE SPERMATIC CORD UNILAT (SEP PRO)	No pre-authorization is required for all providers.	N/A
55520	EXC LES SPERMATIC CORD (SEPART PROC)	No pre-authorization is required for all providers.	N/A
55530	EXC VARICOCELE/LIG SPERMATC VEINS; (SEPART PROC)	No pre-authorization is required for all providers.	N/A
55535	EXC VARICOCELE/LIG SPERMATIC VEINS; ABD APPROACH	No pre-authorization is required for all providers.	N/A
55540	EXC VARICOCELE/LIG SPERMATC VEINS; W/HERNIA REPR	No pre-authorization is required for all providers.	N/A
55550	LAPAROSCOPY SURGICAL W/LIGATION OF SPERMATIC VEINS	No pre-authorization is required for all providers.	N/A
55559	UNLISTED LAPAROSCOPY PROCEDURE, SPERMATIC CORD	No pre-authorization is required for all providers.	N/A
55600	VESICULOTOMY	No pre-authorization is required for all providers.	N/A
55605	VESICULOTOMY; COMPLIC	No pre-authorization is required for all providers.	N/A
55650	VESICULECTOMY ANY APPROACH	No pre-authorization is required for all providers.	N/A
55680	EXC MULLERIAN DUCT CYST	No pre-authorization is required for all providers.	N/A
55700	BX PROSTATE; NEEDLE/PUNCH SNGL/MX ANY APPROACH	No pre-authorization is required for all providers.	N/A
55705	BX PROSTATE; INCS ANY APPROACH	No pre-authorization is required for all providers.	N/A
55706	PROSTATE SATURATION SAMPLING	No pre-authorization is required for all providers.	N/A
55720	PROSTATOMY EXT DRAIN PROSTATIC ABSCESS; SIMPL	No pre-authorization is required for all providers.	N/A
55725	PROSTATOMY EXT DRAIN PROSTATIC ABSCESS; COMPLIC	No pre-authorization is required for all providers.	N/A

55801	PROSTATECTOMY PERINEAL SUBTL	No pre-authorization is required for all providers.	N/A
55810	PROSTATECTOMY PERINEAL RADICAL	No pre-authorization is required for all providers.	N/A
55812	PROSTATECTOMY PERINEAL RAD; W/LYMPH NODE BX	No pre-authorization is required for all providers.	N/A
55815	PROSTATECTOMY PERINEAL; W/BILAT PELVIC LYMPHADEN	No pre-authorization is required for all providers.	N/A
55821	PROSTATECTOMY; SUPRAPUBIC SUBTL 1/2 STAGES	No pre-authorization is required for all providers.	N/A
55831	PROSTATECTOMY; RETROPUBIC SUBTL	No pre-authorization is required for all providers.	N/A
55840	PROSTATECTOMY RETROPUBIC RAD W/WO NERV SPARING	No pre-authorization is required for all providers.	N/A
55842	PROSTATECTOMY RETROPUBIC RAD; W/LYMPH NODE BX	No pre-authorization is required for all providers.	N/A
55845	PROSTATECTOMY RETROPUBIC RAD; W/BILAT LYMPHADEN	No pre-authorization is required for all providers.	N/A
55860	EXPOSURE PROSTATE-INSRT RADIOACTIVE SUBSTANCE	No pre-authorization is required for all providers.	N/A
55862	EXPOS PROSTATE-INSRT RADIOACT; W/LYMPH NODE BX	No pre-authorization is required for all providers.	N/A
55865	EXPOSURE PROSTATE-INSRT RADIOACT; W/BILAT LYMPH	No pre-authorization is required for all providers.	N/A
55866	LAPARO RADICAL PROSTATECTOM	No pre-authorization is required for all providers.	N/A
55870	ELECTROEJACULATION	This service is not covered by Superior HealthPlan.	N/A
55873	CRYOSURG ABLATION-PROSTATE 28.97	This service is not covered by Superior HealthPlan.	N/A
55874	TPRNL PLMT BIODEGRDABL MATRL	No pre-authorization is required for all providers.	N/A
55875	TRANSPERINEAL PLACEMENT OF NEEDLES OR CATHETERS INTO PROSTATE	No pre-authorization is required for all providers.	N/A
55876	PLACE RT DEVICE/MARKER PROS	No pre-authorization is required for all providers.	N/A
55899	UNLISTED PROC MALE GENIT SYST	No pre-authorization is required for all providers.	N/A
55920	PLACE NEEDLES PELVIC FOR RT	This service is not covered by Superior HealthPlan.	N/A
55970	INTERSEX SURG; MALE TO FE	This service is not covered by Superior HealthPlan.	N/A
55980	INTERSEX SURG; FE TO MALE	This service is not covered by Superior HealthPlan.	N/A
56405	I&D VULVA/PERINEAL ABSCESS	No pre-authorization is required for all providers.	N/A
56420	I&D BARTHOLIN'S GLAND ABSCESS	No pre-authorization is required for all providers.	N/A
56440	MARSUPIALIZATION BARTHOLIN'S GLAND CYST	No pre-authorization is required for all providers.	N/A
56441	LYSIS LABIAL ADHESIONS	No pre-authorization is required for all providers.	N/A
56442	HYMENOTOMY, SIMPLE INCISION	No pre-authorization is required for all providers.	N/A
56501	DESTRCT LES VULVA; SIMPL ANY METHD	No pre-authorization is required for all providers.	N/A
56515	DESTRCT LES VULVA; EXTEN ANY METHD	No pre-authorization is required for all providers.	N/A
56605	BX VULVA/PERINEUM (SEPART PROC); 1 LES	No pre-authorization is required for all providers.	N/A
56606	BX VULVA/PERINEUM (SEP PRO); EA SEP ADD LES	No pre-authorization is required for all providers.	N/A
56620	VULVECTOMY SIMPL; PART	No pre-authorization is required for all providers.	N/A
56625	VULVECTOMY SIMPL; COMPLT	No pre-authorization is required for all providers.	N/A
56630	VULVECTOMY RADICAL PART	No pre-authorization is required for all providers.	N/A
56631	VULVECTOMY RAD PART; W/UNILAT INGUINOFEM LYMPHAD	No pre-authorization is required for all providers.	N/A
56632	VULVECT RAD PART; W/BILAT INGUINOFEM LYMPHADNECT	No pre-authorization is required for all providers.	N/A
56633	VULVECTOMY RADICAL COMPLT	No pre-authorization is required for all providers.	N/A
56634	VULVECTOMY RAD COMPLT; W/UNILAT INGUINOFEM LYMPH	No pre-authorization is required for all providers.	N/A
56637	VULVECTOMY RAD COMPLT; W/BILAT INGUINOFEM LYMPH	No pre-authorization is required for all providers.	N/A
56640	VULVECTOMY RAD COMPLT W/INGUINOFEM/ILIAIC LYMPH	No pre-authorization is required for all providers.	N/A
56700	PART HYMENECTOMY/REVIS HYMENAL RING	No pre-authorization is required for all providers.	N/A
56740	EXC BARTHOLIN'S GLAND/CYST	No pre-authorization is required for all providers.	N/A
56800	PLASTIC REPR INTROITUS	No pre-authorization is required for all providers.	N/A
56805	CLITOROPLASTY INTERSEX STATE	No pre-authorization is required for all providers.	N/A
56810	PERINEOPLASTY REPR PERINEUM NON-OB (SEPART PROC)	No pre-authorization is required for all providers.	N/A
56820	COLPOSCOPY OF THE VULVA;	No pre-authorization is required for all providers.	N/A
56821	COLPOSCOPY OF THE VULVA; W/BIOPSY	No pre-authorization is required for all providers.	N/A
57000	COLPOTOMY; W/EXPLOR	No pre-authorization is required for all providers.	N/A
57010	COLPOTOMY; W/DRAINAGE PELVIC ABSCESS	No pre-authorization is required for all providers.	N/A
57020	COLPOCENTESIS (SEPART PROC)	No pre-authorization is required for all providers.	N/A
57022	INCIS & DRAIN VAG HEMAT; POST-OB 4.3	No pre-authorization is required for all providers.	N/A
57023	INCIS & DRAIN VAG HEMAT; NON-OB 4.3	No pre-authorization is required for all providers.	N/A
57061	DESTRCT VAG LES; SIMPL ANY METHD	No pre-authorization is required for all providers.	N/A
57065	DESTRCT VAG LES; EXTEN ANY METHD	No pre-authorization is required for all providers.	N/A
57100	BX VAG MUCOS; SIMPL (SEPART PROC)	No pre-authorization is required for all providers.	N/A
57105	BX VAG MUCOS; EXTEN REQUIRING SUTURE	No pre-authorization is required for all providers.	N/A
57106	VAGINECTOMY PART REMOV VAG WALL;	No pre-authorization is required for all providers.	N/A
57107	VAGINECT PART REMOV VAG WALL; REMOV PARAVAG TISS	No pre-authorization is required for all providers.	N/A
57109	VAGINECT PART REMOV VAG WALL; W/TOT LYMPHADENECT	No pre-authorization is required for all providers.	N/A
57110	VAGINECT COMPLT REMOV VAG WALL;	No pre-authorization is required for all providers.	N/A
57111	VAGINECT COMPLT REMOV VAG WALL; REMOV PARAVAG	No pre-authorization is required for all providers.	N/A
57112	VAGINECT COMPLT REMOV WALL; W/TOT LYMPHADENECTMY	No pre-authorization is required for all providers.	N/A
57120	COLPOCLEISIS	No pre-authorization is required for all providers.	N/A
57130	EXC VAG SEPTUM	No pre-authorization is required for all providers.	N/A
57135	EXC VAG CYST/TUMOR	No pre-authorization is required for all providers.	N/A
57150	IRRIGA VAG &/OR APPLIC MEDICAMENT-TX BACTERIAL	No pre-authorization is required for all providers.	N/A
57155	INSERT UTERI TANDEMS/OVOIDS	No pre-authorization is required for all providers.	N/A
57156	INS VAG BRACHYTX DEVICE	No pre-authorization is required for all providers.	N/A
57160	FIT/INSRT PESSARY-OTH INTRAVAGIN SUPPORT DEVICE	No pre-authorization is required for all providers.	N/A
57170	DIAPHRAGM/CERV CAP FITTING W/INSTRUC	No pre-authorization is required for all providers.	N/A
57180	INTRO HEMOSTATIC AGENT VAG HEMORR (SEPART PROC)	No pre-authorization is required for all providers.	N/A
57200	COLPORRHAPHY SUTURE INJURY VAG	No pre-authorization is required for all providers.	N/A
57210	COLPOPERINEORRHAPHY SUTURE INJURY VAG	No pre-authorization is required for all providers.	N/A
57220	PLASTIC OR URETHRAL SPHINCTER VAG APPROACH	No pre-authorization is required for all providers.	N/A
57230	PLASTIC REPR URETHROCELE	No pre-authorization is required for all providers.	N/A
57240	ANTERIOR COLPORRHAPHY	No pre-authorization is required for all providers.	N/A
57250	POST COLPORRHAPHY REPR RECTOCELE W/WO PERINEORRH	No pre-authorization is required for all providers.	N/A
57260	CMBN ANT PST COLPRHY	No pre-authorization is required for all providers.	N/A
57265	CMBN AP COLPRHY W/NTRCL RPR	No pre-authorization is required for all providers.	N/A
57267	INSRT MESH/OTH REPR PELV FLR EA SITE VAG APPRCH	No pre-authorization is required for all providers.	N/A
57268	REPR ENTEROCELE VAG APPROACH (SEPART PROC)	No pre-authorization is required for all providers.	N/A
57270	REPR ENTEROCELE ABD APPROACH (SEPART PROC)	No pre-authorization is required for all providers.	N/A
57280	COLPOPEXY ABD APPROACH	No pre-authorization is required for all providers.	N/A
57282	SACROSPINOUS LIGAMNT FIXA PROLAPSE VAG	No pre-authorization is required for all providers.	N/A
57283	COLPOPEXY VAGNIAL; INTRA-PERITONEAL APPROACH	No pre-authorization is required for all providers.	N/A
57284	PARAVAGINAL DEFECT REPAIR OPEN ABDOMINAL APPR	No pre-authorization is required for all providers.	N/A
57285	REPAIR PARAVAG DEFECT VAG	No pre-authorization is required for all providers.	N/A
57287	REMOV/REVIS STRESS INCONT SLING 18.37	No pre-authorization is required for all providers.	N/A
57288	SLING OPERATION FOR STRESS INCONT	No pre-authorization is required for all providers.	N/A
57289	PEREYRA PROC INCL ANT COLPORRHAPHY	No pre-authorization is required for all providers.	N/A
57291	CONSTRUCTION ARTIFICIAL VAG; WO GFT	Pre-authorization is required for all providers.	Prior to 09/01/2019
57292	CONSTRUCTION ARTIFICIAL VAG; W/GFT	Pre-authorization is required for all providers.	Prior to 09/01/2019
57295	REVJ RMVL PROSTC VAG GRF VAG APPR	No pre-authorization is required for all providers.	N/A
57296	OPEN ABDOMINAL APPROACH	No pre-authorization is required for all providers.	N/A
57300	CLO RECTOVAG FISTULA; VAG/TRANSANAL APPROACH	No pre-authorization is required for all providers.	N/A
57305	CLO RECTOVAGINAL FISTULA; ABD APPROACH	No pre-authorization is required for all providers.	N/A
57307	CLO RECTOVAG FIST; ABD W/CONCOMITANT COLOSTOMY	No pre-authorization is required for all providers.	N/A
57308	CLO RECTOVAG FIST; TRNSPERIT APPROACH W/RECONSTR	No pre-authorization is required for all providers.	N/A
57310	CLO URETHROVAGINAL FISTULA	No pre-authorization is required for all providers.	N/A
57311	CLO URETHROVAG FIST; W/BULBOCAVERNOSUS TRANSPL	No pre-authorization is required for all providers.	N/A
57320	CLO VESICOVAGINAL FISTULA; VAG APPROACH	No pre-authorization is required for all providers.	N/A
57330	CLO VESICOVAG FIST; TRANSVESICAL & VAG APPROACH	No pre-authorization is required for all providers.	N/A
57335	VAGINOPLASTY INTERSEX STATE	No pre-authorization is required for all providers.	N/A
57400	DILATION OF VAGINA	No pre-authorization is required for all providers.	N/A
57410	PELVIC EXAMINATION	No pre-authorization is required for all providers.	N/A
57415	REMOVE VAGINAL FOREIGN BODY	No pre-authorization is required for all providers.	N/A
57420	COLPSCPY ENTIRE VAG W/CERV IF PRS;	No pre-authorization is required for all providers.	N/A
57421	COLPSCPY VAG W/CERV IF PRS; W/BX	No pre-authorization is required for all providers.	N/A
57423	REPAIR PARAVAG DEFECT LAP	No pre-authorization is required for all providers.	N/A
57425	LAPAROSCOPY SURGICAL COLPOPEXY	No pre-authorization is required for all providers.	N/A
57426	REVISE PROSTH VAG GRAFT LAP	No pre-authorization is required for all providers.	N/A

57452	COLPOSCOPY CERV INCL UP/ADJ VAGINA;	No pre-authorization is required for all providers.	N/A
57454	COLPSCPY CERV UP/ADJ VAG; BX&CURET	No pre-authorization is required for all providers.	N/A
57455	COLPOSCOPY CERV W/UP VAG; W/BX CERV	No pre-authorization is required for all providers.	N/A
57456	COLPSCPY CERV UP VAG;ENDOCERV CURET	No pre-authorization is required for all providers.	N/A
57460	COLPSCPY CERV W/UP/ADJ VAG ;LOOP BX	No pre-authorization is required for all providers.	N/A
57461	COLPSCPY CERV VAG;LOOP ELEC CONIZAT	No pre-authorization is required for all providers.	N/A
57500	BIOPSY CERVIX 1/MLT OR EXCISION OF LESION	No pre-authorization is required for all providers.	N/A
57505	ENDOCERVICAL CURET	No pre-authorization is required for all providers.	N/A
57510	CAUT CERV; ELEC/THERMAL	No pre-authorization is required for all providers.	N/A
57511	CAUT CERV; CRYOCAUTERY INIT/REPEAT	No pre-authorization is required for all providers.	N/A
57513	CAUT CERV; LASER ABLATION	No pre-authorization is required for all providers.	N/A
57520	CONIZATION CERV W/WO D&C W/WO REPR; KNIFE/LASER	No pre-authorization is required for all providers.	N/A
57522	CONIZATN CERV W/WO D&C W/WO REPR; LOOP ELEC EXC	No pre-authorization is required for all providers.	N/A
57530	TRACHELECTOMY AMPUTA CERV (SEPART PROC)	No pre-authorization is required for all providers.	N/A
57531	RAD TRACHELECTOMY W/BIL TOT PELV LYMPHADENECTOMY	No pre-authorization is required for all providers.	N/A
57540	EXC CERV STUMP ABD APPROACH	No pre-authorization is required for all providers.	N/A
57545	EXC CERV STUMP ABD APPROACH; W/PELVIC FLOOR REPR	No pre-authorization is required for all providers.	N/A
57550	EXC CERV STUMP VAG APPROACH	No pre-authorization is required for all providers.	N/A
57555	EXC CERV STUMP VAG; W/ANT &/OR POST REPR	No pre-authorization is required for all providers.	N/A
57556	EXC CERV STUMP VAG APPROACH; W/REPR ENTEROCELE	No pre-authorization is required for all providers.	N/A
57558	DILATION AND CURETTAGE OF CERVICAL STUMP	No pre-authorization is required for all providers.	N/A
57700	CERCLAGE UTERINE CERV NON-OB	No pre-authorization is required for all providers.	N/A
57720	TRACHELORRHAPHY PLASTIC REPR CERV-VAG APPROACH	No pre-authorization is required for all providers.	N/A
57800	DILAT CERV CANAL INSTRUM (SEPART PROC)	No pre-authorization is required for all providers.	N/A
58100	ENDOMETRIAL BX W/WO ENDOCERV BX (SEPART PROC)	No pre-authorization is required for all providers.	N/A
58110	ENDOMETRIAL BX CONJUNCT W/COLPOSCOPY	No pre-authorization is required for all providers.	N/A
58120	DILAT & CURET DX &/OR THERAP (NON OB)	No pre-authorization is required for all providers.	N/A
58140	MYOMECT 1-4MYOM 250 GM/<&/SURFC;ABD	No pre-authorization is required for all providers.	N/A
58145	MYOMECT 1-4MYOM 250 GM/<&/SURFC;VAG	No pre-authorization is required for all providers.	N/A
58146	MYOMECT 5/>MYOMA&/TOT WT>250 GM ABD	No pre-authorization is required for all providers.	N/A
58150	TOT ABD HYST W/WO REMOV TUBE(S) - OVARY(S)	Pre-authorization is required for all providers.	Prior to 09/01/2019
58152	TOT ABD HYST; W/COLPO-URETHROCYSOTPEXY	Pre-authorization is required for all providers.	Prior to 09/01/2019
58180	SUPRACERV ABD HYST W/WO REMOV TUBE(S) - OVARY(S)	Pre-authorization is required for all providers.	Prior to 09/01/2019
58200	TAH INCL PART VAGINECT W/LYMPH NODE SAMPL	Pre-authorization is required for all providers.	Prior to 09/01/2019
58210	RAD ABD HYST W/BILAT TOT PELVIC LYMPHADENECTOMY	Pre-authorization is required for all providers.	Prior to 09/01/2019
58240	PELVIC EXENTERATION FOR GYN MALIG W/TOT ABD HYST	Pre-authorization is required for all providers.	Prior to 09/01/2019
58260	VAG HYST UTERUS 250 GRAMS OR LESS;	No pre-authorization is required for all providers.	N/A
58262	VAG HYST UTRUS 250 GMS/<; REMV T&/O	No pre-authorization is required for all providers.	N/A
58263	VAG HYST UTRUS 250 GM/<;REP ENTERCL	No pre-authorization is required for all providers.	N/A
58267	VAG HYST 250 GM/<;CLPO-URTHRCYSTPYX	No pre-authorization is required for all providers.	N/A
58270	VAG HYST UTRUS 250 GM/<;REP ENTROCL	No pre-authorization is required for all providers.	N/A
58275	VAG HYST W/TOT/PART COLPECTOMY	No pre-authorization is required for all providers.	N/A
58280	VAG HYST W/TOT/PART COLPECTOMY; W/REPR ENTEROCEL	No pre-authorization is required for all providers.	N/A
58285	VAG HYST RADICAL	No pre-authorization is required for all providers.	N/A
58290	VAG HYST UTERUS > 250 GRAMS;	No pre-authorization is required for all providers.	N/A
58291	VAG HYST UTRUS>250 GMS; REMV T&/O	No pre-authorization is required for all providers.	N/A
58292	VAG HYST UTRUS>250 GM; T&/O ENTROCL	No pre-authorization is required for all providers.	N/A
58293	VAG HYST UT>250 GM;CLPO-URTHRCYSTPX	No pre-authorization is required for all providers.	N/A
58294	VAG HYST UTRUS >250 GM;REP ENTEROCL	No pre-authorization is required for all providers.	N/A
58300	INSRT INTRAUTERINE DEVICE	No pre-authorization is required for all providers.	N/A
58301	REMOV INTRAUTERINE DEVICE	No pre-authorization is required for all providers.	N/A
58321	ARTIFICIAL INSEMINATION; INTRA-CERV	This service is not covered by Superior HealthPlan.	N/A
58322	ARTIFICIAL INSEMINATION; INTRA-UTERINE	This service is not covered by Superior HealthPlan.	N/A
58323	SPERM WASHING-ARTIFICIAL INSEMINATION	This service is not covered by Superior HealthPlan.	N/A
58340	CATHETER FOR HYSTEROGRAPHY	No pre-authorization is required for all providers.	N/A
58345	TRANSERV INTRO FALLOPIAN TUBE CATH-DX	This service is not covered by Superior HealthPlan.	N/A
58346	INSERTION OF HEYMAN CAPSULES FOR CLINICAL BRACHYTHERAPY	No pre-authorization is required for all providers.	N/A
58350	CHROMOTUBATION OVIDUCT INCL MAT	This service is not covered by Superior HealthPlan.	N/A
58353	ENDOMET ABLAT THERM WO SCOP GUID 5.91	No pre-authorization is required for all providers.	N/A
58356	ENDOMET CRYOABLAT W/US GUID INCL ENDOMETRL CURET	No pre-authorization is required for all providers.	N/A
58400	UTERINE SUSPEN W/WO SHORTEN LIGAMNT; (SEP PRO)	No pre-authorization is required for all providers.	N/A
58410	UTERINE SUSPEN; W/PRESACRAL SYMPATHECTOMY	No pre-authorization is required for all providers.	N/A
58520	HYSTERORRHAPHY REPR RUPT UTERUS (NON-OB)	No pre-authorization is required for all providers.	N/A
58540	HYSTEROPLASTY REPR UTERINE ANOMALY	No pre-authorization is required for all providers.	N/A
58541	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY	No pre-authorization is required for all providers.	N/A
58542	WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)	No pre-authorization is required for all providers.	N/A
58543	LAPAROSCOPY, SURGICAL, SUPERACERVICAL HYSTERECTOMY	No pre-authorization is required for all providers.	N/A
58544	WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)	No pre-authorization is required for all providers.	N/A
58545	LAP MYOMCT;1-4 MYOM 250 GM/<&/SURFC	No pre-authorization is required for all providers.	N/A
58546	LAP MYOMCT;5/>MYOM&/MYOM TOT>250 GM	No pre-authorization is required for all providers.	N/A
58548	LAPAROSCOPY, SURGICAL, WITH RADICAL HYSTERECTOMY	No pre-authorization is required for all providers.	N/A
58550	LAP SURG VAG HYST UTRUS 250 GMS/<;	No pre-authorization is required for all providers.	N/A
58552	LAP VAG HYST UTRUS 250 GMS/<; T&/O	No pre-authorization is required for all providers.	N/A
58553	LAP W/VAG HYST UTRUS > 250 GMS;	No pre-authorization is required for all providers.	N/A
58554	LAP VAG HYST UTRUS>250 GM;REMV T&/O	No pre-authorization is required for all providers.	N/A
58555	HYSTEROSCOPY, DIAGNOSTIC	No pre-authorization is required for all providers.	N/A
58558	HYSTEROSCOPY SURGICAL W/SAMPLING	No pre-authorization is required for all providers.	N/A
58559	HYSTEROSCOPY W/LYSIS OF INTRAUTERINE ADHESIONS	No pre-authorization is required for all providers.	N/A
58560	HYSTEROSCOPY W.DIVISION OR RESECTION OF INTRAUTERINE SEPTUM	No pre-authorization is required for all providers.	N/A
58561	HYSTEROSCOPY W/REMOVAL OF LEIOMYOMATA	No pre-authorization is required for all providers.	N/A
58562	HYSTEROSCOPY W/REMOVAL IF IMPACTED FOREIGN BODY	No pre-authorization is required for all providers.	N/A
58563	HYSTEROSCOPY W.ENDOMETRIAL ABLATION	No pre-authorization is required for all providers.	N/A
58565	HYSTEROSC;BIL FALLP TUBE CANNULAT PLCMT PRM IMPL	No pre-authorization is required for all providers.	N/A
58570	TLH UTERUS 250 G OR LESS	No pre-authorization is required for all providers.	N/A
58571	TLH W/T/O 250 G OR LESS	No pre-authorization is required for all providers.	N/A
58572	TLH UTERUS OVER 250 G	No pre-authorization is required for all providers.	N/A
58573	TLH W/T/O UTERUS OVER 250 G	No pre-authorization is required for all providers.	N/A
58575	LAPS TOT HYST RESJ MAL	No pre-authorization is required for all providers.	N/A
58578	UNLISTED LAPAROSCOPY PROCEDURE, UTERUS	No pre-authorization is required for all providers.	N/A
58579	UNLISTED HYSTEROSCOPY PROCEDURE, UTERUS	No pre-authorization is required for all providers.	N/A
58600	LIG/TRANSECTION FALLOPIAN TUBE ABD/VAG UNI/BILAT	No pre-authorization is required for all providers.	N/A
58605	LIG/TRANSECT FALLOPIAN TUBE-SAME HOSP (SEP PRO)	No pre-authorization is required for all providers.	N/A
58611	LIG/TRANSECT FALLOPIAN TUBE-W/C SECT/INTRA-ABD	No pre-authorization is required for all providers.	N/A
58615	OCCLUD FALLOPIAN TUBE-DEVICE VAG/SUPRAPUBIC	No pre-authorization is required for all providers.	N/A
58660	LAPAROSCOPY W/LYSIS OF ADHESIONS	No pre-authorization is required for all providers.	N/A
58661	LAPAROSCOPY W/REMOVAL OF ADNEXAL STRUCTURES	No pre-authorization is required for all providers.	N/A
58662	LAPAROSCOPY W/FULGURATION OR EXCISION OF LESIONS OF OVARY	No pre-authorization is required for all providers.	N/A
58670	LAPAROSCOPY W/FULGURATION OF OVIDUCTS	No pre-authorization is required for all providers.	N/A
58671	LAPAROSCOPY W/OCCCLUSION OF OVIDUCTS BY DEVICE	No pre-authorization is required for all providers.	N/A
58672	LAPAROSCOPY W/FIMBRIOPLASTY	No pre-authorization is required for all providers.	N/A
58673	LAPAROSCOPY W/SALPINGOSTOMY	No pre-authorization is required for all providers.	N/A
58674	LAPS ABLTJ UTERINE FIBROIDS W/INTRAOP US GDN	No pre-authorization is required for all providers.	N/A
58679	UNLESTED LAPAROSCOPY PROCEDURE OVIDUCT OVARY	No pre-authorization is required for all providers.	N/A
58700	SALPINGECTOMY COMPLT/PART UNI/BILAT (SEP PRO)	No pre-authorization is required for all providers.	N/A
58720	SALPINGO-OOPHORECTOMY COMPLT/PART (SEPART PROC)	No pre-authorization is required for all providers.	N/A
58740	LYSIS ADHESIONS	No pre-authorization is required for all providers.	N/A
58750	TUBOTUBAL ANASTOM	This service is not covered by Superior HealthPlan.	N/A
58752	TUBOUTERINE IMPLNT	This service is not covered by Superior HealthPlan.	N/A
58760	FIMBRIOPLASTY	This service is not covered by Superior HealthPlan.	N/A
58770	SALPINGOSTOMY	No pre-authorization is required for all providers.	N/A
58800	DRAIN OVARIAN CYST UNI/BILAT (SEPART PROC); VAG	No pre-authorization is required for all providers.	N/A

58805	DRAIN OVARIAN CYST UNI/BILAT (SEPART PROC) ABD	No pre-authorization is required for all providers.	N/A
58820	DRAIN OVARIAN ABS; VAG APPROACH OPEN	No pre-authorization is required for all providers.	N/A
58822	DRAINAGE OVARIAN ABSCESS; ABD APPROACH	No pre-authorization is required for all providers.	N/A
58823	DRAIN PELV ABS; TRNSVAG/TRNSRECTAL-PERCU	This is no longer a valid code.	N/A
58825	TRANSPOSITION OVARY	No pre-authorization is required for all providers.	N/A
58900	BX OVARY UNILAT/BILAT (SEPART PROC)	No pre-authorization is required for all providers.	N/A
58920	WEDGE RESECT/BISECTION OVARY UNILAT/BILAT	No pre-authorization is required for all providers.	N/A
58925	OVARIAN CYSTECTOMY UNILAT/BILAT	No pre-authorization is required for all providers.	N/A
58940	OOPHORECTOMY PART/TOT UNILAT/BILAT	No pre-authorization is required for all providers.	N/A
58943	OOPHORECTOMY; OVARIAN MALIG W/LYMPH NODE BX	No pre-authorization is required for all providers.	N/A
58950	RESECT OVARIAN, TUBAL OR PRIMARY PERITONEAL MALIGN W BILAT SALPINGO-OOPH	No pre-authorization is required for all providers.	N/A
58951	RESECT OVARIAN MALIG; W/TAH LTD LYMPHADENECTOMY	Pre-authorization is required for all providers.	Prior to 09/01/2019
58952	RESECT OVARIAN MALIG; W/RADICAL DISSECTION	No pre-authorization is required for all providers.	N/A
58953	HYSTERECTOMY/REMOVAL OF TUBES/OVARIES W/RADICAL DISSECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
58954	HYSTERECTOMY/REMOVAL OF TUBES/OVARIES W/RADICAL DISSECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
58956	BIL SALPINGOOPHORECT W/TOT OMENTECT TAH MALIG	Pre-authorization is required for all providers.	Prior to 09/01/2019
58957	RESECTION (TUMOR DEBULKING)	No pre-authorization is required for all providers.	N/A
58958	PELVIC LYMPHADENECTOMY / LIMITED PARA-AORTIC LYMPHADENECTOMY	No pre-authorization is required for all providers.	N/A
58960	LAPAROTOMY STAGING/RESTAGING OVARIAN MALIG	No pre-authorization is required for all providers.	N/A
58970	FOLLICLE PUNCT OOCYTE RETRIEVAL ANY METHD	This service is not covered by Superior HealthPlan.	N/A
58974	EMBRYO TRANSF, INTRAUTERINE	This service is not covered by Superior HealthPlan.	N/A
58976	GAMETE/ZYGOTE/EMBRYO INTRAFALLOP TRANSF ANY METH	This service is not covered by Superior HealthPlan.	N/A
58999	UNLISTED PROC FE GENIT SYST	No pre-authorization is required for all providers.	N/A
59000	AMNIOCENTESIS ANY METHD	For Perinate members pre-authorization is required for non-participating providers. For participating providers, no authorization is required.	Prior to 09/01/2019
59001	THERAPEUTIC AMNIOTIC FLUID REDUCTION	No pre-authorization is required for all providers.	N/A
59012	CORDOCENTESIS ANY METHD	For Perinate members pre-authorization is required for non-participating providers. For participating providers, no authorization is required.	Prior to 09/01/2019
59015	CHORIONIC VILLUS SAMPL ANY METHD	For Perinate members pre-authorization is required for non-participating providers. For participating providers, no authorization is required.	Prior to 09/01/2019
59020	FETAL CONTRACTION STRESS TEST	No pre-authorization is required for all providers.	N/A
59025	FETAL NON-STRESS TEST	Pre-authorization is required Alere providers.	Prior to 09/01/2019
59030	FETAL SCLP BLD SAMPL	No pre-authorization is required for all providers.	N/A
59050	FETAL MONITOR-LABOR-CONS MD; SUPRVIS & INTRP	No pre-authorization is required for all providers.	N/A
59051	FETAL MONITOR-LABOR-CONS MD; INTERP ONLY	No pre-authorization is required for all providers.	N/A
59070	TRANSABD AMNIOINFUS INCL US GUID	No pre-authorization is required for all providers.	N/A
59072	FETAL UMB CORD OCCL INCL US GUID	No pre-authorization is required for all providers.	N/A
59074	FETAL FL DRAIN INCL ULTRASOUND GUID	No pre-authorization is required for all providers.	N/A
59076	FETAL SHNT PLCMT INCL US GUID	No pre-authorization is required for all providers.	N/A
59100	HYSTEROTOMY ABD	Pre-authorization is required for all providers.	Prior to 09/01/2019
59120	SURG TX ECTOPIC PG; REQ SALPINGECT &/OR OOPHORECT	No pre-authorization is required for all providers.	N/A
59121	SURG TX ECTOPIC PG; WO SALPINGECT &/OR OOPHORECT	No pre-authorization is required for all providers.	N/A
59130	SURG TX ECTOPIC PG; ABD PG	No pre-authorization is required for all providers.	N/A
59135	SURG TX ECTOPIC PG; UTERINE PG REQ TOT HYST	No pre-authorization is required for all providers.	N/A
59136	SURG TX ECTOPIC PG; UTERINE PG PART RESEC UTERUS	No pre-authorization is required for all providers.	N/A
59140	SURG TX ECTOPIC PG; CERV W/EVACUATION	No pre-authorization is required for all providers.	N/A
59150	LAP TX ECTOPIC PG; WO SALPINGECT &/OR OOPHORECT	No pre-authorization is required for all providers.	N/A
59151	LAP TX ECTOPIC PG; W/SALPINGECT &/OR OOPHORECT	No pre-authorization is required for all providers.	N/A
59160	CURET PP	No pre-authorization is required for all providers.	N/A
59200	INSRT CERV DILAT (SEPART PROC)	No pre-authorization is required for all providers.	N/A
59300	EPISIOTOMY OR VAGINAL REPAIR	No pre-authorization is required for all providers.	N/A
59320	CERCLAGE CERV DURING PG; VAG	No pre-authorization is required for all providers.	N/A
59325	CERCLAGE CERV DURING PG; ABD	No pre-authorization is required for all providers.	N/A
59350	HYSTERORRHAPHY RUPT UTERUS	No pre-authorization is required for all providers.	N/A
59400	ROUTINE OB CARE INCL ANTEPARTUM CARE-VAG DEL-PP	This service is not covered by Superior HealthPlan.	N/A
59409	VAG DELIV ONLY	No pre-authorization is required for all providers.	N/A
59410	VAG DELIV ONLY; INCL PP CARE	No pre-authorization is required for all providers.	N/A
59412	EXT CEPHALIC VERSION W/WO TOCOLYSIS (ADD TO DEL)	No pre-authorization is required for all providers.	N/A
59414	DELIV PLACENTA (SEPART PROC)	No pre-authorization is required for all providers.	N/A
59425	ANTEPARTUM CARE ONLY; 4-6 VISITS	This service is not covered by Superior HealthPlan.	N/A
59426	ANTEPARTUM CARE ONLY; 7/MORE VISITS	This service is not covered by Superior HealthPlan.	N/A
59430	PP CARE ONLY (SEPART PROC)	No pre-authorization is required for all providers.	N/A
59510	ROUTINE OB CARE INCL ANTEPARTUM CARE-C SECT-PP	This service is not covered by Superior HealthPlan.	N/A
59514	C DELIV ONLY;	No pre-authorization is required for all providers.	N/A
59515	C DELIV ONLY; INCL PP CARE	No pre-authorization is required for all providers.	N/A
59525	SUBTL/TOT HYST AFTER CESAREAN DELIV	No pre-authorization is required for all providers.	N/A
59610	ROUT OB CARE ANTEPAR-VAG DELIV-PP PREV C DELIV	This service is not covered by Superior HealthPlan.	N/A
59612	VAG DELIV ONLY AFTER PREV C DELIV;	No pre-authorization is required for all providers.	N/A
59614	VAG DELIV ONLY AFTER PREV C DELIV; INCL PP CARE	No pre-authorization is required for all providers.	N/A
59618	ROUT OB CARE-C DELIV AFT VAG TRY-PREV C DELIV	This service is not covered by Superior HealthPlan.	N/A
59620	C DELIV ONLY AFT VAG TRY-PREV C DELIV;	No pre-authorization is required for all providers.	N/A
59622	C DELIV ONLY AFT VAG TRY-PREV C DELIV; INCL PP	No pre-authorization is required for all providers.	N/A
59812	TX INCOMPL AB ANY TRIMESTER COMPLT SURGICALLY	No pre-authorization is required for all providers.	N/A
59820	TX MISSED AB COMPLT SURGICALLY; FIRST TRIMESTER	No pre-authorization is required for all providers.	N/A
59821	TX MISSED AB COMPLT SURG; 2ND TRIMESTER	No pre-authorization is required for all providers.	N/A
59830	TX SEPTIC AB COMPLT SURGICALLY	Pre-authorization is required for all providers.	Prior to 09/01/2019
59840	INDUCED AB BY DILAT & CURET	Pre-authorization is required for all providers.	Prior to 09/01/2019
59841	INDUCED AB BY DILAT & EVACUATION	Pre-authorization is required for all providers.	Prior to 09/01/2019
59850	INDUCED AB BY INTRA-AMNIOTIC INJ INCL HOSP ADMIN	Pre-authorization is required for all providers.	Prior to 09/01/2019
59851	INDUCED AB BY INTRA-AMNIOTIC INJ; W/D&C	Pre-authorization is required for all providers.	Prior to 09/01/2019
59852	INDUCED AB BY INTRA-AMNIOTIC INJ; W/HYSTEROTOMY	Pre-authorization is required for all providers.	Prior to 09/01/2019
59855	INDUCED AB BY VAG SUPPOS W/WO CERV DIL;	Pre-authorization is required for all providers.	Prior to 09/01/2019
59856	INDUCED AB-VAG SUPPOS W/WO CERV DIL; W/D&C/EVAC	Pre-authorization is required for all providers.	Prior to 09/01/2019
59857	INDUCED AB-VAG SUPPOS W/WO CERV DIL; W/HYSTEROT	Pre-authorization is required for all providers.	Prior to 09/01/2019
59866	MULTIFETAL PG REDUCTION(S) (MPR)	This service is not covered by Superior HealthPlan.	N/A
59870	UTERINE EVACUATION & CURET HYDATIDIFORM MOLE	Pre-authorization is required for all providers.	Prior to 09/01/2019
59871	REMOV CERCLAGE SUT UNDER ANES (NOT LOCAL)	No pre-authorization is required for all providers.	N/A
59897	UNLIST FETL INVASV PROC W/US GUID	No pre-authorization is required for all providers.	N/A
59898	UNLISTED LAPAROSCOPY PROCEDURE, MATERNITY CARE AND DELIVERY	No pre-authorization is required for all providers.	N/A
59899	UNLISTED PROC MATERN CARE & DELIV	No pre-authorization is required for all providers.	N/A
60000	I&D THYROID GLAND CYST INFEC	No pre-authorization is required for all providers.	N/A
60100	BX THYROID PERCU CORE NEEDLE	No pre-authorization is required for all providers.	N/A
60200	EXC CYST/ADENOMA THYROID/TRANSECTION ISTHMUS	No pre-authorization is required for all providers.	N/A
60210	PART THYROID LOBEC UNILAT; W/WO ISTHMUSECTOMY	No pre-authorization is required for all providers.	N/A
60212	PART THYROID LOBEC UNILAT; W/CONTRALAT SUBTL LOB	No pre-authorization is required for all providers.	N/A
60220	TOT THYROID LOBEC UNILAT; W/WO ISTHMUSECTOMY	No pre-authorization is required for all providers.	N/A
60225	TOT THYROID LOBEC UNILAT; W/CONTRALAT SUBTL LOBE	No pre-authorization is required for all providers.	N/A
60240	THYROIDECTOMY TOT/COMPLT	No pre-authorization is required for all providers.	N/A
60252	THYROIDECTOMY TOT/SUBTL-MALIG; W/LTD NECK DISSEC	No pre-authorization is required for all providers.	N/A
60254	THYROIDECTOMY TOT/SUBTL-MALIG; W/RAD NECK DISSEC	No pre-authorization is required for all providers.	N/A
60260	THYROIDECTOMY-REMOV REMAIN TISS-PREV REMOV PORTN	No pre-authorization is required for all providers.	N/A
60270	THYROIDECTOMY INCL SUBSTERNL GLAND; STERNL SPLIT	No pre-authorization is required for all providers.	N/A
60271	THYROIDECTOMY INCL SUBSTERNL GLAND; CERV APPROA	No pre-authorization is required for all providers.	N/A
60280	EXC THYROID GLAND DUCT CYST/SINUS	No pre-authorization is required for all providers.	N/A
60281	EXC THYROID GLAND DUCT CYST/SINUS; RECURRENT	No pre-authorization is required for all providers.	N/A
60300	ASPIR/INJ THYROID CYST	No pre-authorization is required for all providers.	N/A
60500	PARATHYROIDECTOMY/EXPLOR PARATHYROID	No pre-authorization is required for all providers.	N/A
60502	PARATHYROIDECTOMY/EXPLOR PARATHYROID; RE-EXPLOR	No pre-authorization is required for all providers.	N/A
60505	PARATHYROIDECTOMY; W/MEDIASTINAL EXPLOR	No pre-authorization is required for all providers.	N/A
60512	PARATHYROID AUTOTRANSPL	No pre-authorization is required for all providers.	N/A
60520	THYMECTOMY PART/TOT; TRANSCERV (SEPART PROC)	No pre-authorization is required for all providers.	N/A
60521	THYMECTOMY PART/TOT; STERN SPLIT (SEPART PROC)	No pre-authorization is required for all providers.	N/A

60522	THYMECTOMY; W/RADICAL MEDIASTIN DISSEC (SEP PRO)	No pre-authorization is required for all providers.	N/A
60540	ADRENALECTOMY/EXPLOR ADRENAL GLAND (SEPART PROC)	No pre-authorization is required for all providers.	N/A
60545	ADRENALECTOMY (SEP PRO); W/EXC RETROPERIT TUMOR	No pre-authorization is required for all providers.	N/A
60600	EXC CAROTID BODY TUMOR; WO EXC CAROTID ART	No pre-authorization is required for all providers.	N/A
60605	EXC CAROTID BODY TUMOR; W/EXC CAROTID ART	No pre-authorization is required for all providers.	N/A
60650	LAPAROSCOPY W/ADRENALECTOMY PARTIAL OR COMPLETE	No pre-authorization is required for all providers.	N/A
60659	UNLISTED LAPAROSCOPY PROCEDURE, ENDOCRINE SYSTEM	No pre-authorization is required for all providers.	N/A
60699	UNLISTED PROC ENDOCRINE SYST	No pre-authorization is required for all providers.	N/A
61000	SUBDURAL TAP-FONTANELLE INFANT UNI/BILAT; INIT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
61001	SUBDURAL TAP-FONTANELLE INFANT; SUBSQ TAPS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
61020	VENTRICULAR PUNCT-PREV BURR HOLE/SUTURE; WO INJ	No pre-authorization is required for all providers.	N/A
61026	VENTRICULAR PUNCT-THRU SUTURE; W/INJ DRUG-DX/TX	No pre-authorization is required for all providers.	N/A
61050	CISTERNAL/LAT CERV PUNCT; WO INJ (SEPART PROC)	No pre-authorization is required for all providers.	N/A
61055	INJECTION INTO BRAIN CANAL	No pre-authorization is required for all providers.	N/A
61070	PUNCT SHUNT TUBING/RESERVOIR-ASPIRAT/INJ PROC	No pre-authorization is required for all providers.	N/A
61105	TWIST DRILL HOLE SUBDURAL/VENT PUNCT;	No pre-authorization is required for all providers.	N/A
61107	TWIST DRILL HOLE(S) FOR SUBDUR,INTRACERAB OR VENTR PUNCTURE,FOR IMPLANT	No pre-authorization is required for all providers.	N/A
61108	TWIST DRILL HOLE; EVACUAT &/OR DRAIN HEMATOMA	No pre-authorization is required for all providers.	N/A
61120	BURR HOLE VENT PUNCT	No pre-authorization is required for all providers.	N/A
61140	BURR HOLE/TREPHINE; W/BX-BRAIN/INTRACRAN LES	No pre-authorization is required for all providers.	N/A
61150	BURR HOLE/TREPHINE; W/DRAIN BRAIN ABSCESS/CYST	No pre-authorization is required for all providers.	N/A
61151	BURR HOLE; W/SUBSQ TAPPING INTRACRAN ABSCESS	No pre-authorization is required for all providers.	N/A
61154	BURR HOLE W/EVACUATION &/OR DRAIN HEMATOMA	No pre-authorization is required for all providers.	N/A
61156	BURR HOLE; W/ASPIRAT HEMATOMA/CYST INTRACEREBRAL	No pre-authorization is required for all providers.	N/A
61210	BURR HOLE IMPLANT VENTRICULAR CATH/OTHER DEVICE	No pre-authorization is required for all providers.	N/A
61215	INSRT SUBQ RESERVOIR/PUMP-CONNECT TO VENT CATH	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
61250	BURR HOLE/TREPHINE-SUPRATENTOR-NO OTHER SURG	No pre-authorization is required for all providers.	N/A
61253	BURR HOLE/TREPHINE-INFRA TENTORIAL-UNILAT/BILAT	No pre-authorization is required for all providers.	N/A
61304	CRANIECTOMY/CRANIOTOMY EXPLOR; SUPRATENTORIAL	No pre-authorization is required for all providers.	N/A
61305	CRANIECTOMY/CRANIOTOMY EXPLOR; INFRATENTORIAL	No pre-authorization is required for all providers.	N/A
61312	CRANIECTOMY-HEMATOMA-SUPRATENT; EXTRA/SUBDURAL	No pre-authorization is required for all providers.	N/A
61313	CRANIECTOMY-HEMATOMA-SUPRATENT; INTRACEREBRAL	No pre-authorization is required for all providers.	N/A
61314	CRANIECTOMY-HEMATOMA-INFRA TENT; EXTRA/SUBDURAL	No pre-authorization is required for all providers.	N/A
61315	CRANIECTOMY-HEMATOMA-INFRA TENT; INTRACEREBELLAR	No pre-authorization is required for all providers.	N/A
61316	INCI & SUBQ PLGMT CRANIAL BONE GFT	No pre-authorization is required for all providers.	N/A
61320	CRANIECTOMY DRAIN INTRACRAN ABSCESS; SUPRATENT	No pre-authorization is required for all providers.	N/A
61321	CRANIECTOMY DRAIN INTRACRAN ABSCESS; INFRATENT	No pre-authorization is required for all providers.	N/A
61322	CRANI/CRNIOT NO EVAC HEMAT;NO LOBCT	No pre-authorization is required for all providers.	N/A
61323	CRANI/CRANIOT NO EVAC HEMAT; LOBECT	No pre-authorization is required for all providers.	N/A
61330	DECOMP ORBIT ONLY TRANSCRANIAL APPROACH	No pre-authorization is required for all providers.	N/A
61332	EXPLOR ORBIT; W/BX	This is no longer a valid code.	N/A
61333	EXPLOR ORBIT; W/REMOV LES	No pre-authorization is required for all providers.	N/A
61334	EXPLOR ORBIT; W/REMOV FB	This is no longer a valid code.	N/A
61340	SUBTEMPORAL CRANIAL DECOMPRESSION	No pre-authorization is required for all providers.	N/A
61343	CRANIECTOMY-SUBOCCIPIT W/LAMINEC W/WO DURAL GFT	No pre-authorization is required for all providers.	N/A
61345	OTHER CRANIAL DECOMP POST FOSSA	No pre-authorization is required for all providers.	N/A
61440	CRANIOTOMY-SECT TENTORIUM CEREBELLI (SEP PRO)	This is no longer a valid code.	N/A
61450	CRANIECTOMY-SUBTEMPORAL-SECT GASSERIAN GANGLION	No pre-authorization is required for all providers.	N/A
61458	CRANIECTOMY SUBOCCIPITAL; EXPLOR CRANIAL NERV	No pre-authorization is required for all providers.	N/A
61460	CRANIECTOMY SUBOCCIPIT; SECT-1/MORE CRANIAL NERV	No pre-authorization is required for all providers.	N/A
61470	CRANIECTOMY SUBOCCIPITAL; MEDULLARY TRACTOTOMY	This is no longer a valid code.	N/A
61480	CRANIECTOMY SUBOCCIPITAL; PEDUNCULOTOMY	This is no longer a valid code.	N/A
61490	CRANIOTOMY LOBOTOMY INCL CINGULOTOMY	This is no longer a valid code.	N/A
61500	CRANIECTOMY; W/EXC TUMOR/OTHER BONE LES-SKULL	No pre-authorization is required for all providers.	N/A
61501	CRANIECTOMY; OSTEOMYELITIS	No pre-authorization is required for all providers.	N/A
61510	CRANIECTOMY; EXC BRAIN TUMOR-SUPRATENTORIAL	No pre-authorization is required for all providers.	N/A
61512	CRANIECTOMY; EXC MENINGOMA-SUPRATENTORIAL	No pre-authorization is required for all providers.	N/A
61514	CRANIECTOMY; EXC BRAIN ABSCESS-SUPRATENTORIAL	No pre-authorization is required for all providers.	N/A
61516	CRANIECTOMY; EXC/FENESTRATION CYST-SUPRATENT	No pre-authorization is required for all providers.	N/A
61517	IMPL BRAIN INTRACAVITARY CHEMO AGT	No pre-authorization is required for all providers.	N/A
61518	CRANIECTOMY-EXC TUMOR-POST FOSSA; EX MENINGIOMA	No pre-authorization is required for all providers.	N/A
61519	CRANIECTOMY-EXC TUMOR-POST FOSSA; MENINGIOMA	No pre-authorization is required for all providers.	N/A
61520	CRANIECTOMY-POST FOSSA; CEREBELLOPONTINE ANGLE	No pre-authorization is required for all providers.	N/A
61521	CRANIECTOMY-EXC TUMOR; MIDLINE TUMOR @ BASE SKUL	No pre-authorization is required for all providers.	N/A
61522	CRANIECTOMY INFRATENTORIAL; EXC BRAIN ABSCESS	No pre-authorization is required for all providers.	N/A
61524	CRANIECTOMY INFRATENTORIAL; EXC/FENESTRAT CYST	No pre-authorization is required for all providers.	N/A
61526	CRANIECTOMY-TRANSTEMPORAL-EXC CEREBELLOPONTINE	No pre-authorization is required for all providers.	N/A
61530	CRANIECTOMY; COMBO W/POST FOSSA CRANIOTOMY	No pre-authorization is required for all providers.	N/A
61531	SUBDURAL IMPLNT STRIP ELECTRODES THRU BURR HOLE	No pre-authorization is required for all providers.	N/A
61533	CRANIOTOMY W/ELEVAT FLAP; IMPLNT ELECTRODE ARRAY	No pre-authorization is required for all providers.	N/A
61534	CRANIOTOMY W/ELEV FLAP; EXC EPILEPTOGENIC FOCUS	No pre-authorization is required for all providers.	N/A
61535	CRANIOTOMY W/FLAP; REMOV ELECT ARRAY (SEP PRO)	No pre-authorization is required for all providers.	N/A
61536	CRANIOTOMY W/FLAP; EXC CEREBRAL EPILEPTOGENIC	No pre-authorization is required for all providers.	N/A
61537	CRANIOT LOBECT TEMPORL W/O ECOG	No pre-authorization is required for all providers.	N/A
61538	CRANIOT W/FLAP LOBECTOMY TEMP LOBE	No pre-authorization is required for all providers.	N/A
61539	CRANIOT W/FLAP LOBECT-NOT TEMP LOBE	No pre-authorization is required for all providers.	N/A
61540	CRANIOT LOBECT NO TEMPORL NO ECOG	No pre-authorization is required for all providers.	N/A
61541	CRANIOTOMY W/FLAP; TRANSECTION CORPUS CALLOSUM	No pre-authorization is required for all providers.	N/A
61542	CRANIOTOMY W/FLAP; TOT HEMISPHERECTOMY	This is no longer a valid code.	N/A
61543	CRANIOTOMY PART HEMISPHERECTOMY	No pre-authorization is required for all providers.	N/A
61544	CRANIOTOMY W/FLAP; COAGULATION CHOROID PLEXUS	No pre-authorization is required for all providers.	N/A
61545	CRANIOTOMY W/FLAP; EXC CRANIOPHARYNGIOMA	No pre-authorization is required for all providers.	N/A
61546	CRANIOTOMY-HYPOPHYSECTOMY-INTRACRAN APPROACH	No pre-authorization is required for all providers.	N/A
61548	HYPOPHYSECTOMY-TRANSNASAL NONSTEREOTACTIC	No pre-authorization is required for all providers.	N/A
61550	CRANIECTOMY-CRANIOSYNOSTOSIS; 1 CRANIAL SUTURE	No pre-authorization is required for all providers.	N/A
61552	CRANIECTOMY-CRANIOSYNOSTOSIS; MX CRANIAL SUTURES	No pre-authorization is required for all providers.	N/A
61556	CRANIOTOMY-CRANIOSYNOSTOSIS; FRONTAL BONE FLAP	No pre-authorization is required for all providers.	N/A
61557	CRANIOTOMY CRANIOSYNOSTOSIS; BIFRONTAL BONE FLAP	No pre-authorization is required for all providers.	N/A
61558	EXTEN CRANIECTOMY-CRANIOSYNOSTOSIS; NOT REQ GFT	No pre-authorization is required for all providers.	N/A
61559	EXTEN CRANIECTOMY; RECONTOUR W/OSTEOTOM/AUTOGFT	No pre-authorization is required for all providers.	N/A
61563	EXC INTRA & EXTRACRAN BEN TUMOR; WO OPTIC NERV	No pre-authorization is required for all providers.	N/A
61564	EXC INTRA & EXTRACRAN BEN TUMOR; W/OPTIC NERV	No pre-authorization is required for all providers.	N/A
61566	CRANIOT SELCTV AMYGDALOHIPPOCAMPECT	No pre-authorization is required for all providers.	N/A
61567	CRANIOT MX SUBPIAL TRANSECT W/ECOG	No pre-authorization is required for all providers.	N/A
61570	CRANIECTOMY/CRANIOTOMY; W/EXC FB FROM BRAIN	No pre-authorization is required for all providers.	N/A
61571	CRANIECT/CRANIOT; W/TX PENETRATING WOUND BRAIN	No pre-authorization is required for all providers.	N/A
61575	TRANSORAL APPROACH SKULL BASE-BX/DECOMP/EXC LES	No pre-authorization is required for all providers.	N/A
61576	TRANSORAL APPROACH SKULL BASE; W/SPLIT TONGUE	No pre-authorization is required for all providers.	N/A
61580	CRANIOFAC-ANT CRAN FOSSA; XTRDURL WO MAXILLECTMY	No pre-authorization is required for all providers.	N/A
61581	CRANIOFAC-ANT CRAN FOSSA; XTRDURL INCL MAXILLECT	No pre-authorization is required for all providers.	N/A
61582	CRANIOFAC APPROACH; XTRDURL ELEVAT FRONTAL LOBE	No pre-authorization is required for all providers.	N/A
61583	CRANIOFAC APPROACH; XTRDURL RESECT FRONTAL LOBE	No pre-authorization is required for all providers.	N/A
61584	ORBITOCRANIAL APPROACH; WO ORBITAL EXENTERATION	No pre-authorization is required for all providers.	N/A
61585	ORBITOCRANIAL APPROACH; W/ORBITAL EXENTERATION	No pre-authorization is required for all providers.	N/A
61586	BICORONAL/TRANSZYGO/LEFORT APPRCH-ANT CRAN FOSSA	No pre-authorization is required for all providers.	N/A
61590	INFRA TEMP APPROACH-MID FOSSA INCL PAROTIDECTOMY	No pre-authorization is required for all providers.	N/A
61591	INFRA TEMP APPROACH-MID FOSSA INCL MASTOIDECTOMY	No pre-authorization is required for all providers.	N/A
61592	ORBITOCRAN ZYGOMATIC APPROACH INCL OSTEOTOMY ZYG	No pre-authorization is required for all providers.	N/A
61595	TRANSTEMP APPROACH-POST FOSSA INCL MASTOIDECT	No pre-authorization is required for all providers.	N/A
61596	TRANSCOCHLEAR APPROACH INCL LABYRINTHECTOMY	No pre-authorization is required for all providers.	N/A
61597	TRANSCONDYL APPROACH INCL RESECT C1-C3 BODY(S)	No pre-authorization is required for all providers.	N/A

61598	TRANSPETROSAL APPROACH INCL LIG SUPERIOR SINUS	No pre-authorization is required for all providers.	N/A
61600	RESECT/EXC LES BASE ANT CRAN FOSSA; EXTRADURAL	No pre-authorization is required for all providers.	N/A
61601	RESECT/EXC LES BASE ANT CRAN FOSSA; INTRADURAL	No pre-authorization is required for all providers.	N/A
61605	RESECT/EXC LES INFRATEMPORAL FOSSA; EXTRADURAL	No pre-authorization is required for all providers.	N/A
61606	RESECT/EXC LES INFRATEMPORAL FOSSA; INTRADURAL	No pre-authorization is required for all providers.	N/A
61607	RESECT/EXC LES PARASELLAR AREA; EXTRADURAL	No pre-authorization is required for all providers.	N/A
61608	RESECT/EXC LES PARASELLAR; INTRADURAL INCL REPR	No pre-authorization is required for all providers.	N/A
61609	TRANSECT/LIG CAROTID ART-CAVERNUS SINUS; WO REPR	This is no longer a valid code.	N/A
61610	TRANSECT/LIG CAROTID ART; W/REPR-ANASTOM/GFT	This is no longer a valid code.	N/A
61611	TRANSECT/LIG CAROTID ART-PETROUS CANAL; WO REPR	No pre-authorization is required for all providers.	N/A
61612	TRANSECT CAROTID ART-PETROUS CANAL; W/REPR-GFT	This is no longer a valid code.	N/A
61613	OBLIT CAROTID ANEURY/AV MALFORM/FIST-DISSECTION	No pre-authorization is required for all providers.	N/A
61615	RESECT/EXC LES POST CRAN FOSSA; EXTRADURAL	No pre-authorization is required for all providers.	N/A
61616	RESECT/EXC LES POST CRAN FOSSA; INTRADURAL W/REP	No pre-authorization is required for all providers.	N/A
61618	SECNDRY REPR DURA FOLLOWING SURG; FREE TISS GFT	No pre-authorization is required for all providers.	N/A
61619	SECNDRY REPR DURA; LOCAL/REGION PEDICL/MYOQ FLAP	No pre-authorization is required for all providers.	N/A
61623	ENDOVASC TMP BALLN ART OCCL HEAD/NCK	No pre-authorization is required for all providers.	N/A
61624	TRNSCATH PERM OCCL/EMBOLIZ PERQ; CNS	No pre-authorization is required for all providers.	N/A
61626	TRNSCATH PERM OCCL PERQ; NON-CNS	No pre-authorization is required for all providers.	N/A
61630	BALO ANGIOIP ICRA PRQ	This service is not covered by Superior HealthPlan.	N/A
61635	TCAT PLMT IV STENT ICRA W/BALO ANGIOIP IF PFRMD	This service is not covered by Superior HealthPlan.	N/A
61640	BALO DILAT ICRA PRQ 1ST VSL	This service is not covered by Superior HealthPlan.	N/A
61641	PERQ BALO DILA IC VSPSM EA VSL SM VASC TER	This service is not covered by Superior HealthPlan.	N/A
61642	PERQ BALO DILA IC VSPSM EA VSL DIFF VASC TER	This service is not covered by Superior HealthPlan.	N/A
61645	PERQ ART M-THROMBECT & NFS	No pre-authorization is required for all providers.	N/A
61650	EVASC PRLNG ADMN RX AGNT 1ST	No pre-authorization is required for all providers.	N/A
61651	EVASC PRLNG ADMN RX AGNT ADD	No pre-authorization is required for all providers.	N/A
61680	SURG INTRACRAN AV MALFORM; SUPRATENTORIAL SIMPL	No pre-authorization is required for all providers.	N/A
61682	SURG INTRACRAN AV MALFORM; SUPRATENTORIAL COMPLX	No pre-authorization is required for all providers.	N/A
61684	SURG INTRACRAN AV MALFORM; INFRATENTORIAL SIMPL	No pre-authorization is required for all providers.	N/A
61686	SURG INTRACRAN AV MALFORM; INFRATENTORIAL COMPLX	No pre-authorization is required for all providers.	N/A
61690	SURG INTRACRAN AV MALFORM; DURAL SIMPL	No pre-authorization is required for all providers.	N/A
61692	SURG INTRACRAN AV MALFORM; DURAL COMPLX	No pre-authorization is required for all providers.	N/A
61697	COMPLX ANEUR INTRACRAN; CAROTD CIRC 87.85	No pre-authorization is required for all providers.	N/A
61698	COMPLX ANEUR INTRACRAN; VERTEB-BASL 84.56	No pre-authorization is required for all providers.	N/A
61700	SURG ANEURY INTRACRAN APPROACH; CAROTID CIRCULAT	No pre-authorization is required for all providers.	N/A
61702	SURG ANEURY INTRACRAN; VERTEBRAL-BASILAR CIRCULA	No pre-authorization is required for all providers.	N/A
61703	SURG INTRACRAN ANEURY-CERV-APPLIC CLAMP-CAROTID	No pre-authorization is required for all providers.	N/A
61705	SURG ANEURY; INTRACRAN & CERV OCCLUD CAROTID ART	No pre-authorization is required for all providers.	N/A
61708	SURG ANEURY; INTRACRAN ELECTROTHROMBOSIS	No pre-authorization is required for all providers.	N/A
61710	SURG ANEURY; INTRA-ART EMBOLIZATION/BALLOON CATH	No pre-authorization is required for all providers.	N/A
61711	ANASTOM ART EXTRACRANIAL-INTRACRAN ART	No pre-authorization is required for all providers.	N/A
61720	CREAT LES-STEREOTACTIC METHD; GLOBUS PALLIDUS	No pre-authorization is required for all providers.	N/A
61735	CREAT LES-STEREOTACTIC; SUBCORTICAL STRUCT	No pre-authorization is required for all providers.	N/A
61750	STEREOTACTIC BX/ASPIRAT/EXC INTRACRAN LES	No pre-authorization is required for all providers.	N/A
61751	STREOTAC BX ASPIR/EXC IC LES; CT&MR	No pre-authorization is required for all providers.	N/A
61760	STEREOTACTIC IMPLNT DEPTH ELECTRODES-CEREBRUM	No pre-authorization is required for all providers.	N/A
61770	STEREOTACTIC LOCALIZ W/INSRT CATH BRACHYTHERAPY	No pre-authorization is required for all providers.	N/A
61781	SCAN PROC CRANIAL INTRA	No pre-authorization is required for all providers.	N/A
61782	SCAN PROC CRANIAL EXTRA	No pre-authorization is required for all providers.	N/A
61783	SCAN PROC SPINAL	No pre-authorization is required for all providers.	N/A
61790	CREAT LES-STEREOTAC PERCUT; GASSERIAN GANGLION	No pre-authorization is required for all providers.	N/A
61791	CREAT LES-STEREOTAC; TRIGEMINAL MEDULLARY TRACT	No pre-authorization is required for all providers.	N/A
61796	SRS CRANIAL LESION SIMPLE	No pre-authorization is required for all providers.	N/A
61797	SRS CRAN LES SIMPLE ADDL	No pre-authorization is required for all providers.	N/A
61798	SRS CRANIAL LESION COMPLEX	No pre-authorization is required for all providers.	N/A
61799	SRS CRAN LES COMPLEX ADDL	No pre-authorization is required for all providers.	N/A
61800	APPLY SRS HEADFRAME ADD-ON	No pre-authorization is required for all providers.	N/A
61850	TWIST DRILL-IMPLNT NEUROSTIM ELECTRODE; CORTICAL	No pre-authorization is required for all providers.	N/A
61860	CRANIECTOMY IMPLNT ELECTROD CEREBRAL; CORTICAL	No pre-authorization is required for all providers.	N/A
61863	TWST DRL BURR CRANIOT NO REC 1 ARAY	No pre-authorization is required for all providers.	N/A
61864	TWST DRL BURR CRANIOT NO REC EA ADD	No pre-authorization is required for all providers.	N/A
61867	TWST DRL BURR CRANIOT W/REC 1 ARRAY	No pre-authorization is required for all providers.	N/A
61868	TWST DRL BURR CRANIOT W/REC EA ADD	No pre-authorization is required for all providers.	N/A
61870	CRANIECTOMY IMPLNT ELECTROD CEREBELLAR; CORTICAL	No pre-authorization is required for all providers.	N/A
61875	CRANIECTOMY IMPLNT ELECTROD CEREBELLAR; SUBCORTI	This is no longer a valid code.	N/A
61880	REVIS/REMOV INTRACRAN NEUROSTIMULATOR ELECTRODES	No pre-authorization is required for all providers.	N/A
61885	INCS & SUBQ PLCMT CRANIAL NEUROSTIM GEN/RECEIVER	No pre-authorization is required for all providers.	N/A
61886	INCISION & SUBCUTANEOUS PLACEMENT OF PULSE GENERATOR W/CONNECTION	No pre-authorization is required for all providers.	N/A
61888	REVIS/REMOV CRANIAL NEUROSTIM PULSE GEN/RECEIVER	No pre-authorization is required for all providers.	N/A
62000	ELEVATION DEPRESSED SKULL FX; SIMPL EXTRADURAL	No pre-authorization is required for all providers.	N/A
62005	ELEVAT SKULL FX; COMPOUND/COMMINUTED EXTRADURAL	No pre-authorization is required for all providers.	N/A
62010	ELEVAT SKULL FX; W/REPR DURA &/OR DEBRID BRAIN	No pre-authorization is required for all providers.	N/A
62100	CRANIOT-REPR DURAL/CSF LEAK INCL SURG-OTORRHEA	No pre-authorization is required for all providers.	N/A
62115	REDUCT CRANIOMEGALIC SKULL; NOT REQ BONE GFT	No pre-authorization is required for all providers.	N/A
62116	REDUCT CRANIOMEGALIC SKULL; W/SIMPL CRANIOPLASTY	This is no longer a valid code.	N/A
62117	REDUCT CRANIOMEGALIC SKULL; W/CRANIOT & RECON	No pre-authorization is required for all providers.	N/A
62120	REPR ENCEPHALOCELE SKULL VAULT INCL CRANIOPLASTY	No pre-authorization is required for all providers.	N/A
62121	CRANIOTOMY REPR ENCEPHALOCELE SKULL BASE	No pre-authorization is required for all providers.	N/A
62140	CRANIOPLASTY SKULL DEFECT; UP TO 5 CM DIAMETER	No pre-authorization is required for all providers.	N/A
62141	CRANIOPLASTY SKULL DEFECT; > 5 CM DIAMETER	No pre-authorization is required for all providers.	N/A
62142	REMOV BONE FLAP/PROSTH PLATE-SKULL	No pre-authorization is required for all providers.	N/A
62143	REPLAC BONE FLAP/PROSTH PLATE-SKULL	No pre-authorization is required for all providers.	N/A
62145	CRANIOPLASTY-SKULL DEFECT W/REPARATIVE BRAIN SURG	No pre-authorization is required for all providers.	N/A
62146	CRANIOPLASTY W/AUTOGFT; UP TO 5 CM DIAMETER	No pre-authorization is required for all providers.	N/A
62147	CRANIOPLASTY W/AUTOGFT; > 5 CM DIAMETER	No pre-authorization is required for all providers.	N/A
62148	INCI&RETREV SUBQ CRANL BG CRANIPLST	No pre-authorization is required for all providers.	N/A
62160	NEUROENDO IC PLCMT VENT CATH SHNT	No pre-authorization is required for all providers.	N/A
62161	NEUROENDO IC; DISSCT ADHS FENS SEPTM	No pre-authorization is required for all providers.	N/A
62162	NEUROENDO IC; EXC COLLOID CYST CATH	No pre-authorization is required for all providers.	N/A
62163	NEUROENDO INTRACRAN; W/RETRIEVAL FB	No pre-authorization is required for all providers.	N/A
62164	NEUROENDO IC; EXC BRAIN TUMR CATH	No pre-authorization is required for all providers.	N/A
62165	NEUROENDO IC; EXC PITUIT TUMR	No pre-authorization is required for all providers.	N/A
62180	VENTRICULOCISTERNOSTOMY	No pre-authorization is required for all providers.	N/A
62190	CREAT SHUNT; SUBARACHNOID/SUBDURAL-ATRIAL	No pre-authorization is required for all providers.	N/A
62192	CREAT SHUNT; SUBARACHNOID/SUBDURAL-PERITONEAL	No pre-authorization is required for all providers.	N/A
62194	REPLAC/IRRIGA SUBARACHNOID/SUBDURAL CATH	No pre-authorization is required for all providers.	N/A
62200	VENTRICULOCISTERNOSTOMY THIRD VENTRICLE	No pre-authorization is required for all providers.	N/A
62201	VENTRICULOCISTRNOST 3RD VENT; STEREOT	No pre-authorization is required for all providers.	N/A
62220	CREAT SHUNT; VENTRICULO-ATRIAL/JUGULAR-AURICUL	No pre-authorization is required for all providers.	N/A
62223	CREAT SHUNT; VENTRICULO-PERITONEAL-PLEURAL	No pre-authorization is required for all providers.	N/A
62225	REPLAC/IRRIGA VENTRICULAR CATH	No pre-authorization is required for all providers.	N/A
62230	REPLAC/REVIS CSF SHUNT/OBSTRUC VALV/DISTAL CATH	No pre-authorization is required for all providers.	N/A
62252	REPROGRAM PROGRAMMABLE CSF SHUNT 2.18	No pre-authorization is required for all providers.	N/A
62256	REMOV COMPLT CSF SHUNT SYST; WO REPLAC	No pre-authorization is required for all providers.	N/A
62258	REMOV COMPLT CSF SHUNT; W/REPLAC-SIMILAR SHUNT	No pre-authorization is required for all providers.	N/A
62263	PERQ LYSIS EPID ADHES MX; 2/3 DAY	No pre-authorization is required for all providers.	N/A
62264	PERQ LYSIS EPIDURL ADHES MX; 1 DAY	No pre-authorization is required for all providers.	N/A
62267	INTERDISCAL PERQ ASPIR DX	No pre-authorization is required for all providers.	N/A
62268	PERCUT ASPIRAT SPINAL CORD CYST/SYRINX	No pre-authorization is required for all providers.	N/A
62269	BX SPINAL CORD PERCUT NEEDLE	No pre-authorization is required for all providers.	N/A

62270	DIAGNOSTIC LUMBAR SPINAL PUNCTURE	No pre-authorization is required for all providers.	N/A
62272	THERAPEUTIC SPINAL PUNCTURE DRAINAGE CSF	No pre-authorization is required for all providers.	N/A
62273	*INJ LUMBAR EPIDURAL BLD/CLOT PATCH	No pre-authorization is required for all providers.	N/A
62280	INJ NEUROLYTIC SUBSTANCE; SUBARACHNOID	No pre-authorization is required for all providers.	N/A
62281	INJ NEUROLYTIC SUBSTANCE; EPIDURAL/CERV/THORACIC	No pre-authorization is required for all providers.	N/A
62282	INJ NEUROLYTIC SUBSTANCE; EPIDURAL/LUMBAR/CAUDAL	No pre-authorization is required for all providers.	N/A
62284	INJECTION FOR MYELOGRAM	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
62287	PERCUTANEOUS DISKECTOMY	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
62290	NJX PX DISCOGRAPHY LUMBAR	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
62291	NJX PX DISCOGRAPHY CRV/THRC	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
62292	INJ PROC-CHEMONUCLEOLYSIS-DISK; 1/MX LUMBAR	This service is not covered by Superior HealthPlan.	N/A
62294	INJ PROC ART-OCCLUD AV MALFORM SPINAL	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
62302	MYELOGRAPHY LUMBAR INJECTION	No pre-authorization is required for all providers.	N/A
62303	MYELOGRAPHY LUMBAR INJECTION	No pre-authorization is required for all providers.	N/A
62304	MYELOGRAPHY LUMBAR INJECTION	No pre-authorization is required for all providers.	N/A
62305	MYELOGRAPHY LUMBAR INJECTION	No pre-authorization is required for all providers.	N/A
62310	INJECT SPINE C/T	This is no longer a valid code.	N/A
62311	INJECTION LUMBAR, SACRAL (CAUDAL)	This is no longer a valid code.	N/A
62318	INJECT SPINE W/CATH C/T	This is no longer a valid code.	N/A
62319	INJECT SPINE W/CATH L/S (CD)	This is no longer a valid code.	N/A
62320	NJX DX/THER SBST INTRLMNR CRV/THRC W/O IMG GDN	Pre-authorization is required for all providers.	Prior to 09/01/2019
62321	NJX DX/THER SBST INTRLMNR CRV/THRC W/IMG GDN	Pre-authorization is required for all providers.	Prior to 09/01/2019
62322	NJX DX/THER SBST INTRLMNR LMBR/SAC W/O IMG GDN	Pre-authorization is required for all providers.	Prior to 09/01/2019
62323	NJX DX/THER SBST INTRLMNR LMBR/SAC W/IMG GDN	Pre-authorization is required for all providers.	Prior to 09/01/2019
62324	NJX DX/THER SBST INTRLMNR CRV/THRC W/O IMG GDN	Pre-authorization is required for all providers.	Prior to 09/01/2019
62325	NJX DX/THER SBST INTRLMNR CRV/THRC W/IMG GDN	Pre-authorization is required for all providers.	Prior to 09/01/2019
62326	NJX DX/THER SBST INTRLMNR LMBR/SAC W/O IMG GDN	Pre-authorization is required for all providers.	Prior to 09/01/2019
62327	NJX DX/THER SBST INTRLMNR LMBR/SAC W/IMG GDN	Pre-authorization is required for all providers.	Prior to 09/01/2019
62328	DIAGNOSTIC LUMBAR SPINAL PUNCTURE W/FLUOR OR CT	No pre-authorization is required for all providers.	N/A
62329	THERAPEUTIC SPINAL PNXR DRAINAGE CSF W/FLUOR/CT	No pre-authorization is required for all providers.	N/A
62350	IMPLNT/REVIS THECAL/EPIDUR CATH; WO LAMINECT	Pre-authorization is required for all providers.	11/01/2019
62351	IMPLNT/REVIS INTHECAL/EPIDUR CATH; W/LAMINECT	Pre-authorization is required for all providers.	11/01/2019
62355	REMOV PREV IMPLNT INTRATHECAL/EPIDURAL CATH	Pre-authorization is required for all providers.	11/01/2019
62360	IMPLNT/REPLAC DEVIC-EPIDUR DRUG INFUS; SUBQ RESV	Pre-authorization is required for all providers.	11/01/2019
62361	IMPLNT/REPLAC DEVIC-EPIDUR INFUS; NONPROGRM PUMP	Pre-authorization is required for all providers.	11/01/2019
62362	IMPLNT/REPLAC DEVIC-EPIDUR INFUS; PROGRMBLE PUMP	Pre-authorization is required for all providers.	11/01/2019
62365	REMOV PREV IMPLNT SUBQ RESERVOIR/PUMP	Pre-authorization is required for all providers.	11/01/2019
62367	ANALYZE SPINE INFUS PUMP	Pre-authorization is required for all providers.	11/01/2019
62368	ELEC ANALYS PROGRAMBLE IMPLNT PUMP; W/REPROGRAM	Pre-authorization is required for all providers.	11/01/2019
62369	ANAL SP INF PMP W/REPRG&FILL	No pre-authorization is required for all providers.	N/A
62370	ANL SP INF PMP W/MDREPRG&FIL	No pre-authorization is required for all providers.	N/A
62380	NDSC DCMPRN SPINAL CORD 1 W/LAMOT NTRSPC LUMBAR	No pre-authorization is required for all providers.	N/A
63001	LAMINECT W/EXPLOR WO FACETECT 1-2 VERTEB; CERV	Pre-authorization is required for all providers.	11/01/2019
63003	LAMINECT W/EXPLOR WO FACETECT 1-2 VERTEB; THORAC	Pre-authorization is required for all providers.	11/01/2019
63005	LAMINECT W/EXPLOR 1-2 VERTEB; LUMBAR EX SPONDYLO	Pre-authorization is required for all providers.	11/01/2019
63011	LAMINECTOMY W/EXPLOR 1-2 VERTEB SEGMT; SACRAL	Pre-authorization is required for all providers.	11/01/2019
63012	LAMINECT W/REMOV ABNL FACETS-SPONDYLOLIST LUMBAR	Pre-authorization is required for all providers.	11/01/2019
63015	LAMINECTOMY W/EXPLOR > 2 VERTEBRAL SEGMT; CERV	Pre-authorization is required for all providers.	11/01/2019
63016	LAMINECT W/EXPLOR > 2 VERTEBRAL SEGMT; THORACIC	Pre-authorization is required for all providers.	11/01/2019
63017	LAMINECTOMY W/EXPLOR > 2 VERTEBRAL SEGMT; LUMBAR	Pre-authorization is required for all providers.	11/01/2019
63020	NECK SPINE DISK SURGERY	Pre-authorization is required for all providers.	11/01/2019
63030	LOW BACK DISK SURGERY	Pre-authorization is required for all providers.	11/01/2019
63035	SPINAL DISK SURGERY ADD-ON	Pre-authorization is required for all providers.	11/01/2019
63040	LAMINOTOMY W/DECOMP NERV ROOT RE-EXPLOR; CERV	Pre-authorization is required for all providers.	11/01/2019
63042	LAMINOTOMY W/DECOMP NERV ROOT RE-EXPLOR; LUMBAR	Pre-authorization is required for all providers.	11/01/2019
63043	LAMINOTOMY ADDL CERVICAL	Pre-authorization is required for all providers.	11/01/2019
63044	LAMINOTOMY ADDL LUMBAR	Pre-authorization is required for all providers.	11/01/2019
63045	LAMINECTOMY SNGL VERTEBRAL SEGMT-UNI/BIL; CERV	Pre-authorization is required for all providers.	11/01/2019
63046	LAMINECTOMY SNGL VERTEBRAL SEGMT-UNI/BIL; THORAC	Pre-authorization is required for all providers.	11/01/2019
63047	LAMINECTOMY SNGL VERTEBRAL SEGMT-UNI/BIL; LUMBAR	Pre-authorization is required for all providers.	11/01/2019
63048	LAMINECTMY 1 SEGMT-UNI/BIL; EA ADD CERV/THOR/LUM	Pre-authorization is required for all providers.	11/01/2019
63050	LAMINOPLASTY CERV W/DECOMP SP CRD 2/> VERT SEG;	Pre-authorization is required for all providers.	11/01/2019
63051	LAMINOPLASTY CERV 2/> SEG; RECON POST BONY ELEM	Pre-authorization is required for all providers.	11/01/2019
63055	TRANSPEDICULAR APPROACH SNGL SEGMT; THORACIC	Pre-authorization is required for all providers.	11/01/2019
63056	TRANSPEDICULAR APPROACH SNGL SEGMT; LUMBAR	Pre-authorization is required for all providers.	11/01/2019
63057	TRANSPEDICULAR APPROACH SNGL SEGMT; EA ADD SEGMT	Pre-authorization is required for all providers.	11/01/2019
63064	COSTOVERTEBRAL W/DECOMP THORACIC; SNGL SEGMT	Pre-authorization is required for all providers.	11/01/2019
63066	COSTOVERTEBRAL W/DECOMP THORACIC; EA ADD SEGMT	Pre-authorization is required for all providers.	11/01/2019
63075	DISKECTOMY ANT W/DECOMP; CERV SNGL INTERSPACE	Pre-authorization is required for all providers.	11/01/2019
63076	DISKECTOMY ANT W/DECOMP; CERV EA ADD INTERSPACE	Pre-authorization is required for all providers.	11/01/2019
63077	DISKECTOMY ANT W/DECOMP; THORACIC 1 INTERSPACE	Pre-authorization is required for all providers.	11/01/2019
63078	DISKECTOMY ANT; THORACIC EA ADD INTERSPACE	Pre-authorization is required for all providers.	11/01/2019
63081	VERTEBRAL CORPECTOMY-ANT W/DECOMP; CERV 1 SEGMT	Pre-authorization is required for all providers.	11/01/2019
63082	VERTEBRAL CORPECTOMY-ANT; CERV EA ADD SEGMT	Pre-authorization is required for all providers.	11/01/2019
63085	VERTEBRAL CORPECT TRANSTHORACIC; THORACIC 1 SEGM	Pre-authorization is required for all providers.	11/01/2019
63086	VERTEBRAL CORPECT TRANSTHOR; THORACIC EA AD SEGM	Pre-authorization is required for all providers.	11/01/2019
63087	VERTEBRAL CORPECTOMY LOW THORACIC/LUMBAR; 1 SEGM	Pre-authorization is required for all providers.	11/01/2019
63088	VERTEBRAL CORPECTOMY LOW THORACIC/LUMBAR; EA ADD	Pre-authorization is required for all providers.	11/01/2019
63090	VERTEBRAL CORPECTOMY TRANSPERITON LUMB/SACRAL; 1	Pre-authorization is required for all providers.	11/01/2019
63091	VERTEBRAL CORPECTOMY LUMBAR/SACRAL; EA ADD SEGMT	Pre-authorization is required for all providers.	11/01/2019
63101	VERT CORPCT SC&NRV ROOT THOR 1 SEG	Pre-authorization is required for all providers.	11/01/2019
63102	VERT CORPCT SC&NRV ROOT LUMB 1 SEG	Pre-authorization is required for all providers.	11/01/2019
63103	VERT CORPCT SC&NRV ROOT T/L EA ADD	Pre-authorization is required for all providers.	11/01/2019
63170	LAMINECTOMY W/MYELOTOMY CERV/THORACIC/THORACOLUM	Pre-authorization is required for all providers.	11/01/2019
63172	LAMINECTOMY W/DRAIN CYST; TO SUBARACHNOID SPACE	Pre-authorization is required for all providers.	11/01/2019
63173	LAMINECT DRAIN CYSTPERITON/PLEURAL	Pre-authorization is required for all providers.	11/01/2019
63180	LAMINECTOMY & SECT DENTATE LIGAMNT CERV; 1-2 SEG	Pre-authorization is required for all providers.	11/01/2019
63182	LAMINECTOMY & SECT DENTATE LIGAMNT CERV; >2 SEGM	Pre-authorization is required for all providers.	11/01/2019
63185	LAMINECTOMY W/RHIZOTOMY; 1 OR 2 SEGMT	Pre-authorization is required for all providers.	11/01/2019
63190	LAMINECTOMY W/RHIZOTOMY; MORE THAN 2 SEGMT	Pre-authorization is required for all providers.	11/01/2019
63191	LAMINECTOMY W/SECT SPINAL ACCES NERV	Pre-authorization is required for all providers.	11/01/2019
63194	LAMINECTOMY W/SECT 1 SPINOTHALAMIC TRACT; CERV	Pre-authorization is required for all providers.	11/01/2019
63195	LAMINECTOMY W/SECT 1 SPINOTHALAM TRACT; THORACIC	Pre-authorization is required for all providers.	11/01/2019
63196	LAMINECTOMY W/SECT BOTH SPINOTHALAMIC; CERV	Pre-authorization is required for all providers.	11/01/2019
63197	LAMINECTOMY W/SECT BOTH SPINOTHALAMIC; THORACIC	Pre-authorization is required for all providers.	11/01/2019
63198	LAMINECTOMY-2 STAGES WITHIN 14 DA; CERV	Pre-authorization is required for all providers.	11/01/2019
63199	LAMINECTOMY-2 STAGES WITHIN 14 DA; THORACIC	Pre-authorization is required for all providers.	11/01/2019
63200	LAMINECTOMY W/RELEASE TETHERED CORD LUMBAR	Pre-authorization is required for all providers.	11/01/2019
63250	LAMINECTOMY-EXC/OCCLUD AV MALFORM CORD; CERV	Pre-authorization is required for all providers.	11/01/2019
63251	LAMINECTOMY-EXC/OCCLUD AV MALFORM CORD; THORACIC	Pre-authorization is required for all providers.	11/01/2019
63252	LAMINECTOMY-EXC AV MALFORM CORD; THORACOLUMBAR	Pre-authorization is required for all providers.	11/01/2019
63265	LAMINECTOMY-EXC INTRASPINAL LES-EXTRADURAL; CERV	Pre-authorization is required for all providers.	11/01/2019
63266	LAMINECTOMY-EXC LES-EXTRADURAL; THORACIC	Pre-authorization is required for all providers.	11/01/2019
63267	LAMINECTOMY-EXC LES-EXTRADURAL; LUMBAR	Pre-authorization is required for all providers.	11/01/2019
63268	LAMINECTOMY-EXC LES-EXTRADURAL; SACRAL	Pre-authorization is required for all providers.	11/01/2019
63270	LAMINECTOMY-EXC INTRASPINAL LES-INTRADURAL; CERV	Pre-authorization is required for all providers.	11/01/2019
63271	LAMINECTOMY-EXC LES-INTRADURAL; THORACIC	Pre-authorization is required for all providers.	11/01/2019
63272	LAMINECTOMY-EXC LES INTRADURAL; LUMBAR	Pre-authorization is required for all providers.	11/01/2019
63273	LAMINECTOMY-EXC LES-INTRADURAL; SACRAL	Pre-authorization is required for all providers.	11/01/2019
63275	LAMINECTOMY BX/EXC NEOPLSM; EXTRADURAL-CERV	Pre-authorization is required for all providers.	11/01/2019
63276	LAMINECTOMY BX/EXC NEOPLSM; EXTRADURAL-THORACIC	Pre-authorization is required for all providers.	11/01/2019

63277	LAMINECTOMY BX/EXC NEOPLSM; EXTRADURAL-LUMBAR	Pre-authorization is required for all providers.	11/01/2019
63278	LAMINECTOMY BX/EXC NEOPLSM; EXTRADURAL-SACRAL	Pre-authorization is required for all providers.	11/01/2019
63280	LAMINECTOMY-NEOPLSM; INTRADURAL EXTRAMEDUL CERV	Pre-authorization is required for all providers.	11/01/2019
63281	LAMINECTOMY-NEOPLSM; INTRADUR EXTRAMEDUL THORAC	Pre-authorization is required for all providers.	11/01/2019
63282	LAMINECTOMY-NEOPLSM; INTRADUR EXTRAMEDUL LUMBAR	Pre-authorization is required for all providers.	11/01/2019
63283	LAMINECTOMY-BX/EXC NEOPLSM; INTRADURAL SACRAL	Pre-authorization is required for all providers.	11/01/2019
63285	LAMINECTOMY; INTRADURAL INTRAMEDULLARY CERV	Pre-authorization is required for all providers.	11/01/2019
63286	LAMINECTOMY; INTRADURAL INTRAMEDULLARY THORACIC	Pre-authorization is required for all providers.	11/01/2019
63287	LAMINECT; INTRADURAL INTRAMEDULLARY THORACOLUMB	Pre-authorization is required for all providers.	11/01/2019
63290	LAMINECTOMY; COMBO EXTRA-INTRADURL LES ANY LEVEL	Pre-authorization is required for all providers.	11/01/2019
63295	OSTEOPLASTIC RECON DORS SP FLW PRIM INTRASP PROC	Pre-authorization is required for all providers.	11/01/2019
63300	VERTEBRAL CORPECTOMY 1 SEGMT; EXTRADURAL CERV	Pre-authorization is required for all providers.	11/01/2019
63301	VERTEB CORPECT; EXTRADURAL THORAC-TRANSTHORACIC	Pre-authorization is required for all providers.	11/01/2019
63302	VERTEB CORPECT; EXTRADURAL THORAC-THORACOLUMBAR	Pre-authorization is required for all providers.	11/01/2019
63303	VERTEB CORPECT; LUMBAR/SACRAL TRANSPERITONEAL	Pre-authorization is required for all providers.	11/01/2019
63304	VERTEBRAL CORPECTOMY 1 SEGMT; INTRADURAL CERV	Pre-authorization is required for all providers.	11/01/2019
63305	VERTEB CORPECT; INTRADURAL THORAC-TRANSTHORACIC	Pre-authorization is required for all providers.	11/01/2019
63306	VERTEB CORPECT; INTRADURAL THORAC-THORACOLUMBAR	Pre-authorization is required for all providers.	11/01/2019
63307	VERTEB CORPECT; INTRADUR LUMB/SACRAL-TRANSPERITO	Pre-authorization is required for all providers.	11/01/2019
63308	VERTEBRAL CORPECTOMY 1 SEGMT; EA ADD SEGMT	Pre-authorization is required for all providers.	11/01/2019
63600	CREAT LES-SPINAL CORD-STEREOTACTIC METHD PERCUT	No pre-authorization is required for all providers.	N/A
63610	STEREOTACTIC STIM-CORD-PERCUT SEP PRO WO SURG	No pre-authorization is required for all providers.	N/A
63615	STEREOTACTIC BX/ASPIRAT/EXC LES SPINAL CORD	This is no longer a valid code.	N/A
63620	SRS SPINAL LESION	No pre-authorization is required for all providers.	N/A
63621	SRS SPINAL LESION ADDL	No pre-authorization is required for all providers.	N/A
63650	PERCUT IMPLNT ELECTRODE ARRAY; EPIDURAL	Pre-authorization is required for all providers.	11/01/2019
63655	LAMINECT IMPLNT ELECTRODE/PLATE/PADDLE EPIDURAL	Pre-authorization is required for all providers.	11/01/2019
63661	REMOVE SPINE ELTRD PERQ ARAY	Pre-authorization is required for all providers.	11/01/2019
63662	REMOVE SPINE ELTRD PLATE	Pre-authorization is required for all providers.	11/01/2019
63663	REVISE SPINE ELTRD PERQ ARAY	Pre-authorization is required for all providers.	11/01/2019
63664	REVISE SPINE ELTRD PLATE	Pre-authorization is required for all providers.	11/01/2019
63685	INCS & SUBQ PLCMT SPINAL NEUROSTIM PULSE GEN	Pre-authorization is required for all providers.	11/01/2019
63688	REVIS/REMOV IMPLNT SPINAL NEUROSTIM PULSE GEN	Pre-authorization is required for all providers.	11/01/2019
63700	REPR MENINGOCELE; LESS THAN 5 CM DIAMETER	No pre-authorization is required for all providers.	N/A
63702	REPR MENINGOCELE; LARGER THAN 5 CM DIAMETER	No pre-authorization is required for all providers.	N/A
63704	REPR MYELOMENINGOCELE; LESS THAN 5 CM DIAMETER	No pre-authorization is required for all providers.	N/A
63706	REPR MYELOMENINGOCELE; LARGER THAN 5 CM DIAMETER	No pre-authorization is required for all providers.	N/A
63707	REPR DURAL/CSF LEAK NOT REQUIRING LAMINECTOMY	No pre-authorization is required for all providers.	N/A
63709	REPR DURAL/CSF LEAK/PSEUDOMENINGOCELE W/LAMINECT	No pre-authorization is required for all providers.	N/A
63710	DURAL GFT SPINAL	No pre-authorization is required for all providers.	N/A
63740	CREAT SHUNT LUMBAR SUBARACH-PERITON; W/LAMINECT	No pre-authorization is required for all providers.	N/A
63741	CREAT SHUNT LUMBAR; PERCUT WO LAMINECTOMY	No pre-authorization is required for all providers.	N/A
63744	REPLAC IRRIGA/REVIS LUMBOSUBARACHNOID SHUNT	No pre-authorization is required for all providers.	N/A
63746	REMOV LUMBOSUBARACHNOID SHUNT SYST WO REPLAC	No pre-authorization is required for all providers.	N/A
64400	INJECTION AA AND /STRD TRIGEMINAL NERVE EACH BRANCH	No pre-authorization is required for all providers.	N/A
64402	INJ ANES AGENT; FACIAL NERV	No pre-authorization is required for all providers.	N/A
64405	INJECTION AA AND /STRD GREATER OCCIPITAL NERVE	No pre-authorization is required for all providers.	N/A
64408	INJECTION AA AND /STRD VAGUS NERVE	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64410	INJ ANES AGENT; PHRENIC NERV	No pre-authorization is required for all providers.	N/A
64412	INJ ANES AGENT; SPINAL ACCES NERV	This is no longer a valid code.	N/A
64413	INJ ANES AGENT; CERV PLEXUS	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64415	INJECTION AA AND /STRD BRACHIAL PLEXUS	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64416	INJECTION AA AND /STRD BRACHIAL PLEXUS CONT NFS CATH	No pre-authorization is required for all providers.	N/A
64417	INJECTION AA AND /STRD AXILLARY NERVE	No pre-authorization is required for all providers.	N/A
64418	INJECTION AA AND /STRD SUPRASCAPULAR NERVE	No pre-authorization is required for all providers.	N/A
64420	INJECTION AA AND /STRD INTERCOSTAL NRV SINGLE LVL	No pre-authorization is required for all providers.	N/A
64421	INJECTION AA AND /STRD INTERCOSTAL NRV EA ADDL LVL	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64425	INJECTION AA AND /STRD ILIOINGUINAL IH NERVES	No pre-authorization is required for all providers.	N/A
64430	INJECTION AA AND /STRD PUDENDAL NERVE	No pre-authorization is required for all providers.	N/A
64435	INJECTION AA AND /STRD PARACERVICAL NERVE	No pre-authorization is required for all providers.	N/A
64445	INJECTION AA AND /STRD SCIATIC NERVE	No pre-authorization is required for all providers.	N/A
64446	INJECTION AA AND /STRD SCIATIC NERVE CONT NFS CATH	No pre-authorization is required for all providers.	N/A
64447	INJECTION AA AND /STRD FEMORAL NERVE	No pre-authorization is required for all providers.	N/A
64448	INJECTION AA AND /STRD FEMORAL NERVE CONT NFS CATH	No pre-authorization is required for all providers.	N/A
64449	INJECTION AA AND /STRD LUMBAR PLEXUS CONT NFS CATH	No pre-authorization is required for all providers.	N/A
64450	INJECTION AA AND /STRD OTHER PERIPHERAL NERVE/BRANCH	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64451	INJECTION AA AND /STRD NERVES NRVTG SI JOINT W/IMG	Pre-authorization required for all providers.	Prior to 09/01/2019
64454	INJECTION AA AND /STRD GENICULAR NRV BRANCHES W/IMG	Pre-authorization required for all providers.	Prior to 09/01/2019
64455	N BLOCK INJ PLANTAR DIGIT	No pre-authorization is required for all providers.	N/A
64461	PVB THORACIC SINGLE INJ SITE	Pre-authorization required for all providers.	Prior to 09/01/2019
64462	PVB THORACIC 2ND+ INJ SITE	Pre-authorization required for all providers.	Prior to 09/01/2019
64463	PVB THORACIC CONT INFUSION	Pre-authorization required for all providers.	Prior to 09/01/2019
64479	INJ FORAMEN EPIDURAL C/T	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64480	INJ FORAMEN EPIDURAL ADD-ON	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64483	INJ FORAMEN EPIDURAL L/S	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64484	INJ FORAMEN EPIDURAL ADD-ON	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64486	TAP BLOCK UNIL BY INJECTION	This service is not covered by Superior HealthPlan.	N/A
64487	TAP BLOCK UNI BY INFUSION	This service is not covered by Superior HealthPlan.	N/A
64488	TAP BLOCK BI INJECTION	This service is not covered by Superior HealthPlan.	N/A
64489	TAP BLOCK BI BY INFUSION	This service is not covered by Superior HealthPlan.	N/A
64490	INJ PARAVERT F JNT C/T 1 LEV	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64491	INJ PARAVERT F JNT C/T 2 LEV	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64492	INJ PARAVERT F JNT C/T 3 LEV	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64493	INJ PARAVERT F JNT L/S 1 LEV	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64494	INJ PARAVERT F JNT L/S 2 LEV	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64495	INJ PARAVERT F JNT L/S 3 LEV	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64505	INJ ANES AGENT; SPHENOPALATINE GANGLION	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64508	INJ ANES AGENT; CAROTID SINUS (SEPART PROC)	This is no longer a valid code.	N/A
64510	INJ ANES AGENT; STELLATE GANGLION	No pre-authorization is required for all providers.	N/A
64517	INJ ANES AGT SUP HYPOGASTR PLEXUS	No pre-authorization is required for all providers.	N/A
64520	INJ ANES AGENT; LUMBAR/THORACIC	No pre-authorization is required for all providers.	N/A
64530	INJ ANES AGENT; CELIAC PLEXUS W/WO RAD MONITOR	Pre-authorization is required for all providers.	Prior to 09/01/2019
64550	APPL SURFACE NEUROSTIMULATOR	This is no longer a valid code.	N/A
64553	IMPLANT NEUROELECTRODES	No pre-authorization is required for all providers.	N/A
64555	IMPLANT NEUROELECTRODES	No pre-authorization is required for all providers.	N/A
64561	IMPLANT NEUROELECTRODES	No pre-authorization is required for all providers.	N/A
64565	IMPLANT NEUROELECTRODES	This is no longer a valid code.	N/A
64566	NEUROELTRD STIM POST TIBIAL	This service is not covered by Superior HealthPlan.	N/A
64568	INC FOR VAGUS N ELECT IMPL	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64569	REVISE/REPL VAGUS N ELTRD	No pre-authorization is required for all providers.	N/A
64570	REMOVE VAGUS N ELTRD	No pre-authorization is required for all providers.	N/A
64575	IMPLANT NEUROELECTRODES	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64580	IMPLANT NEUROELECTRODES	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64581	IMPLANT NEUROELECTRODES	No pre-authorization is required for all providers.	N/A
64585	REVISE/REMOVE NEUROELECTRODE	No pre-authorization is required for all providers.	N/A
64590	INSERTOR REPLACE PERIPHERAL OR GASTRIC NEUROSTIM PULSE GEN OR RECEIVER	Pre-authorization is required for all providers.	Prior to 09/01/2019
64595	REVISION OR REMOVAL OF PERIPHERAL OR GASTRIC NEUROSTIM PULSE GEN OR REC	Pre-authorization is required for all providers.	Prior to 09/01/2019
64600	DESTRCT TRIGEMINAL; SUPRAORBITAL/INFRAORBITAL	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64605	DESTRCT TRIGEMINAL; 2ND & 3RD DIV @ FORAMEN OVAL	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64610	DESTRCT TRIGEMINAL; 2ND & 3RD DIV W/RADIOLOGIC	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64611	CHEMODENERV SALIV GLANDS	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019

64612	DESTROY NERVE FACE MUSCLE	No pre-authorization is required for all providers.	N/A
64613	DESTRCT BY NEUROLYTIC AGENT; CERV SPINAL MUSCL	This is no longer a valid code.	N/A
64614	DESTROY NERVE EXTREM MUSC	This is no longer a valid code.	N/A
64615	CHEMODENERV MUSC MIGRAINE	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64616	CHEMODENERV MUSC NECK DYSTON	No pre-authorization is required for all providers.	N/A
64617	CHEMODENER MUSCLE LARYNX EMG	No pre-authorization is required for all providers.	N/A
64620	DESTRCT BY NEUROLYTIC AGENT; INTERCOSTAL NERV	No pre-authorization is required for all providers.	N/A
64624	DESTRUCTION NEUROLYTIC AGT GENICULAR NERVE W/IMG	Pre-authorization required for all providers.	Prior to 09/01/2019
64625	RADIOFREQUENCY ABLTJ NRV NRVTG SI JT W/IMG GDN	Pre-authorization required for all providers.	Prior to 09/01/2019
64630	DESTRCT BY NEUROLYTIC AGENT; PUDENDAL NERV	No pre-authorization is required for all providers.	N/A
64632	N BLOCK INJ COMMON DIGIT	No pre-authorization is required for all providers.	N/A
64633	DESTROY CERV/THOR FACET JNT	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64634	DESTROY C/TH FACET JNT ADDL	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64635	DESTROY LUMB/SAC FACET JNT	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64636	DESTROY L/S FACET JNT ADDL	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64640	DESTRCT; OTHER PERIPHERAL NERV/BRANCH	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
64642	CHEMODENERV 1 EXTREMITY 1-4	No pre-authorization is required for all providers.	N/A
64643	CHEMODENERV 1 EXTREM 1-4 EA	No pre-authorization is required for all providers.	N/A
64644	CHEMODENERV 1 EXTREM 5/> MUS	No pre-authorization is required for all providers.	N/A
64645	CHEMODENERV 1 EXTREM 5/> EA	No pre-authorization is required for all providers.	N/A
64646	CHEMODENERV TRUNK MUSC 1-5	No pre-authorization is required for all providers.	N/A
64647	CHEMODENERV TRUNK MUSC 6/>	No pre-authorization is required for all providers.	N/A
64650	CHEMODNRVTJ ECCRINE GLNDS BTH AX	No pre-authorization is required for all providers.	N/A
64653	CHEMODNRVTJ ECCRINE GLNDS OTH AREA PR D	No pre-authorization is required for all providers.	N/A
64680	DESTRCT W/WO RAD MON CELIAC PLEXUS	No pre-authorization is required for all providers.	N/A
64681	DESTRUC NEURLYT SUP HYPOGASTRC PLEX	No pre-authorization is required for all providers.	N/A
64702	NEUROPLASTY; DIGITAL 1/BOTH SAME DIGIT	No pre-authorization is required for all providers.	N/A
64704	NEUROPLASTY; NERV HAND/FT	No pre-authorization is required for all providers.	N/A
64708	REVISE ARM/LEG NERVE	No pre-authorization is required for all providers.	N/A
64712	REVISION OF SCIATIC NERVE	No pre-authorization is required for all providers.	N/A
64713	REVISION OF ARM NERVE(S)	No pre-authorization is required for all providers.	N/A
64714	REVISE LOW BACK NERVE(S)	No pre-authorization is required for all providers.	N/A
64716	NEUROPLASTY &/OR TRANSPOSITION; CRANIAL NERV	No pre-authorization is required for all providers.	N/A
64718	NEUROPLASTY &/OR TRANSPOSIT; ULNAR NERV @ ELBOW	No pre-authorization is required for all providers.	N/A
64719	NEUROPLASTY &/OR TRANSPOSIT; ULNAR NERV @ WRIST	No pre-authorization is required for all providers.	N/A
64721	NEUROPLASTY &/OR TRANSP; MEDIAN @ CARPAL TUNNEL	No pre-authorization is required for all providers.	N/A
64722	DECOMP; UNSPECIFIED NERV (SPECIFY)	No pre-authorization is required for all providers.	N/A
64726	DECOMP; PLANTAR DIGITAL NERV	No pre-authorization is required for all providers.	N/A
64727	INT NEUROLYSIS REQUIRING USE OR MICRO	No pre-authorization is required for all providers.	N/A
64732	TRANSECTION/AVULSION SUPRAORBITAL NERV	No pre-authorization is required for all providers.	N/A
64734	TRANSECTION/AVULSION INFRAORBITAL NERV	No pre-authorization is required for all providers.	N/A
64736	TRANSECTION/AVULSION MENTAL NERV	No pre-authorization is required for all providers.	N/A
64738	TRANSECT/AVULSION INFERIOR ALVEOLAR NERV-OSTEOT	No pre-authorization is required for all providers.	N/A
64740	TRANSECTION/AVULSION LINGUAL NERV	No pre-authorization is required for all providers.	N/A
64742	TRANSECT/AVULSION FACIAL NERV DIFF/COMPLT	No pre-authorization is required for all providers.	N/A
64744	TRANSECTION/AVULSION GREATER OCCIPT NERV	No pre-authorization is required for all providers.	N/A
64746	TRANSECTION/AVULSION PHRENIC NERV	No pre-authorization is required for all providers.	N/A
64752	TRANSECTION/AVULSION VAGUS NERV TRANSTHORACIC	This is no longer a valid code.	N/A
64755	TRANSECTION/AVULSION VAGI LTD TO PROX STOMACH	No pre-authorization is required for all providers.	N/A
64760	TRANSECTION/AVULSION VAGUS NERV ABD	No pre-authorization is required for all providers.	N/A
64761	TRANSECTION/AVULSION PUDENDAL NERV	This is no longer a valid code.	N/A
64763	TRANSECT/AVULSION OBTURATOR NERV EXTRAPELVIC	No pre-authorization is required for all providers.	N/A
64766	TRANSECT/AVULSION OBTURATOR NERV INTRAPELVIC	No pre-authorization is required for all providers.	N/A
64771	TRANSECT/AVULSION OTHER CRANIAL NERV EXTRADURAL	No pre-authorization is required for all providers.	N/A
64772	TRANSECT/AVULSION OTHER SPINAL NERV EXTRADURAL	No pre-authorization is required for all providers.	N/A
64774	EXC NEUROMA; CUT NERV SURGICALLY IDENT	No pre-authorization is required for all providers.	N/A
64776	EXC NEUROMA; DIGITAL NERV 1/BOTH SAME DIGIT	No pre-authorization is required for all providers.	N/A
64778	EXC NEUROMA; DIGITAL NERV EA ADD DIGIT	No pre-authorization is required for all providers.	N/A
64782	EXC NEUROMA; HAND/FT EX DIGITAL NERV	No pre-authorization is required for all providers.	N/A
64783	EXC NEUROMA; HAND/FT EA ADD NERV EX SAME DIGIT	No pre-authorization is required for all providers.	N/A
64784	EXC NEUROMA; MAJOR PERIPHERAL NERV EX SCIATIC	No pre-authorization is required for all providers.	N/A
64786	EXC NEUROMA; SCIATIC NERV	No pre-authorization is required for all providers.	N/A
64787	IMPLNT NERV END INTO BONE/MUSCL	No pre-authorization is required for all providers.	N/A
64788	EXC NEUROFIBROMA/NEUROLEMMOMA; CUT NERV	No pre-authorization is required for all providers.	N/A
64790	EXC NEUROFIBROMA/NEUROLEMMOMA; MAJ PERIPHERAL	No pre-authorization is required for all providers.	N/A
64792	EXC NEUROFIBROMA/NEUROLEMMOMA; EXTEN	No pre-authorization is required for all providers.	N/A
64795	BX NERV	No pre-authorization is required for all providers.	N/A
64802	SYMPATHECTOMY CERV	No pre-authorization is required for all providers.	N/A
64804	SYMPATHECTOMY CERVICOTHORACIC	No pre-authorization is required for all providers.	N/A
64809	SYMPATHECTOMY THORACOLUMBAR	No pre-authorization is required for all providers.	N/A
64818	SYMPATHECTOMY LUMBAR	No pre-authorization is required for all providers.	N/A
64820	SYMPATHECTOMY DIG ARTS W/MAGNIFICA-EA DIGIT	No pre-authorization is required for all providers.	N/A
64821	SYMPATHECTOMY	No pre-authorization is required for all providers.	N/A
64822	SYMPATHECTOMY	No pre-authorization is required for all providers.	N/A
64823	SYMPATHECTOMY	No pre-authorization is required for all providers.	N/A
64831	SUTURE DIGITAL NERV HAND/FT; 1 NERV	No pre-authorization is required for all providers.	N/A
64832	SUTURE DIGITAL NERV HAND/FT; EA ADD DIGITAL NERV	No pre-authorization is required for all providers.	N/A
64834	SUTURE 1 NERVE HAND/FOOT COMMON SENSORY NERVE	No pre-authorization is required for all providers.	N/A
64835	SUTURE 1 NERVE MEDIAN MOTOR THENAR	No pre-authorization is required for all providers.	N/A
64836	SUTURE 1 NERVE ULNAR MOTOR	No pre-authorization is required for all providers.	N/A
64837	SUTURE EA ADD NERV HAND/FT	No pre-authorization is required for all providers.	N/A
64840	SUTURE POST TIBIAL NERV	No pre-authorization is required for all providers.	N/A
64856	SUTURE MAJ NERV ARM/LEG EX-SCIATIC; W/TRANSPPOSIT	No pre-authorization is required for all providers.	N/A
64857	SUTURE MAJ NERV ARM/LEG; WO TRANSPPOSIT	No pre-authorization is required for all providers.	N/A
64858	SUTURE SCIATIC NERV	No pre-authorization is required for all providers.	N/A
64859	SUTURE EA ADD MAJOR PERIPHERAL NERV	No pre-authorization is required for all providers.	N/A
64861	SUTURE BRACHIAL PLEXUS	No pre-authorization is required for all providers.	N/A
64862	SUTURE LUMBAR PLEXUS	No pre-authorization is required for all providers.	N/A
64864	SUTURE FACIAL NERV; EXTRACRANIAL	No pre-authorization is required for all providers.	N/A
64865	SUTURE FACIAL NERV; INFRATEMPORAL W/WO GFT	No pre-authorization is required for all providers.	N/A
64866	ANASTOM; FACIAL-SPINAL ACCES	No pre-authorization is required for all providers.	N/A
64868	ANASTOM; FACIAL-HYPOGLOSSAL	No pre-authorization is required for all providers.	N/A
64870	ANASTOM; FACIAL-PHRENIC	This is no longer a valid code.	N/A
64872	SUTURE NERV; REQUIRING SECNDRY/DELAYED SUTURE	No pre-authorization is required for all providers.	N/A
64874	SUTURE NERV; REQ EXTEN MOBILIZAT/TRANSPPOSIT NERV	No pre-authorization is required for all providers.	N/A
64876	SUTURE NERV; REQUIRING SHORTENING BONE EXTREM	No pre-authorization is required for all providers.	N/A
64885	NERV GFT HEAD/NECK; UP TO 4 CM LENGTH	No pre-authorization is required for all providers.	N/A
64886	NERV GFT HEAD/NECK; MORE THAN 4 CM LENGTH	No pre-authorization is required for all providers.	N/A
64890	NERV GFT 1 STRAND HAND/FT; UP TO 4 CM LENGTH	No pre-authorization is required for all providers.	N/A
64891	NERV GFT 1 STRAND HAND/FT; > 4 CM LENGTH	No pre-authorization is required for all providers.	N/A
64892	NERV GFT 1 STRAND ARM/LEG; UP TO 4 CM LENGTH	No pre-authorization is required for all providers.	N/A
64893	NERV GFT 1 STRAND ARM/LEG; > 4 CM LENGTH	No pre-authorization is required for all providers.	N/A
64895	NERV GFT MX STRAND HAND/FT; UP TO 4 CM LENGTH	No pre-authorization is required for all providers.	N/A
64896	NERV GFT MX STRAND HAND/FT; > 4 CM LENGTH	No pre-authorization is required for all providers.	N/A
64897	NERV GFT MX STRAND ARM/LEG; UP TO 4 CM LENGTH	No pre-authorization is required for all providers.	N/A
64898	NERV GFT MX STRAND ARM/LEG; > 4 CM LENGTH	No pre-authorization is required for all providers.	N/A
64901	NERV GFT EA ADD NERV; SNGL STRAND	No pre-authorization is required for all providers.	N/A
64902	NERV GFT EA ADD NERV; MX STRANDS	No pre-authorization is required for all providers.	N/A
64905	NERV PEDICLE TRANSF; FIRST STAGE	No pre-authorization is required for all providers.	N/A
64907	NERV PEDICLE TRANSF; SECOND STAGE	No pre-authorization is required for all providers.	N/A
64910	NERVE RPAIR WITH SYNTHETIC CONDUIT OR VEIN ALLOGRAFT	No pre-authorization is required for all providers.	N/A

64911	WITH AUTOGENOUS VEIN GRAFT	No pre-authorization is required for all providers.	N/A
64912	NRV RPR W/NRV ALGRFT 1ST	No pre-authorization is required for all providers.	N/A
64913	NRV RPR W/NRV ALGRFT EA ADDL	No pre-authorization is required for all providers.	N/A
64999	UNLISTED PROC NERV SYST	No pre-authorization is required for all providers.	N/A
65091	EVISCERATION OCULAR CONTENTS; WO IMPLNT	No pre-authorization is required for all providers.	N/A
65093	EVISCERATION OCULAR CONTENTS; W/IMPLNT	No pre-authorization is required for all providers.	N/A
65101	ENUCLEATION EYE; WO IMPLNT	No pre-authorization is required for all providers.	N/A
65103	ENUCLEAT EYE; W/IMPLNT MUSCL NOT ATTACHED-IMPLNT	No pre-authorization is required for all providers.	N/A
65105	ENUCLEATION EYE; W/IMPLNT MUSCL ATTACHED-IMPLNT	No pre-authorization is required for all providers.	N/A
65110	EXENTERATION ORBIT REMOV ORBITAL CONTENTS; ONLY	No pre-authorization is required for all providers.	N/A
65112	EXENTERATION ORBITAL CONTENTS; W/REMOV BONE	No pre-authorization is required for all providers.	N/A
65114	EXENTERAT ORBITAL CONTENTS; W/MUSCL/MYOCUT FLAP	No pre-authorization is required for all providers.	N/A
65125	MODIF OCULAR IMPLNT W/PLC/REPLC PEGS (SEP PROC)	No pre-authorization is required for all providers.	N/A
65130	INSRT OCULAR IMPLNT SECNDRY; AFTER EVISCERATION	No pre-authorization is required for all providers.	N/A
65135	INSRT OCULAR IMPLNT SECNDRY; AFTER ENUCLEATION	No pre-authorization is required for all providers.	N/A
65140	INSRT OCULAR IMPLNT; ENUCLEAT-MUSCL ATTACH-IMPLT	No pre-authorization is required for all providers.	N/A
65150	REINSRT OCULAR IMPLNT; W/WO CONJUNC GFT	No pre-authorization is required for all providers.	N/A
65155	REINSRT OCULAR IMPLNT; W/FOREIGN MAT REINFORCE	No pre-authorization is required for all providers.	N/A
65175	REMOV OCULAR IMPLNT	No pre-authorization is required for all providers.	N/A
65205	REMOV FB EXT EYE; CONJUNC SUPERF	No pre-authorization is required for all providers.	N/A
65210	REMOV FB EXT EYE; CONJUNC EMBEDDED/SUBCONJUNC	No pre-authorization is required for all providers.	N/A
65220	REMOV FB EXT EYE; CORNEAL WO SLIT LAMP	No pre-authorization is required for all providers.	N/A
65222	REMOV FB EXT EYE; CORNEAL W/SLIT LAMP	No pre-authorization is required for all providers.	N/A
65235	REMOV FB IO; FROM ANT CHAMBER/LENS	No pre-authorization is required for all providers.	N/A
65260	REMOV FB IO; POST SEGMT-MAGNETIC EXTRACTION	No pre-authorization is required for all providers.	N/A
65265	REMOV FB IO; POST SEGMT NONMAGNETIC EXTRACTION	No pre-authorization is required for all providers.	N/A
65270	REPR LACERAT; CONJUNC W/WO LACERAT SCLERA	No pre-authorization is required for all providers.	N/A
65272	REPR LACERAT; CONJUNC BY MOBILIZA WO HOSP	No pre-authorization is required for all providers.	N/A
65273	REPR LACERAT; CONJUNC BY MOBILIZA W/HOSP	No pre-authorization is required for all providers.	N/A
65275	REPR LACERAT; CORNEA NONPERFORAT W/WO REMOV FB	No pre-authorization is required for all providers.	N/A
65280	REPR LACERAT; CORNEA PERFORATING WO UVEAL TISS	No pre-authorization is required for all providers.	N/A
65285	REPR LACERAT; CORNEA W/REPOSIT/RESECT UVEAL TISS	No pre-authorization is required for all providers.	N/A
65286	REPR LACERAT; APPLIC TISS GLUE WOUNDS CORNEA	No pre-authorization is required for all providers.	N/A
65290	REPR WOUND EXTRAOCULAR MUSCL/TENDON &/OR TENON'S	No pre-authorization is required for all providers.	N/A
65400	EXC LES CORNEA EX PTERYGIUM	No pre-authorization is required for all providers.	N/A
65410	BX CORNEA	No pre-authorization is required for all providers.	N/A
65420	EXC/TRANSPOSITION PTERYGIUM; WO GFT	No pre-authorization is required for all providers.	N/A
65426	EXC/TRANSPOSITION PTERYGIUM; W/GFT	No pre-authorization is required for all providers.	N/A
65430	SCRAPING CORNEA DX SMEAR &/OR CULTURE	No pre-authorization is required for all providers.	N/A
65435	REMOV CORNEAL EPITHELIUM; W/WO CHEMOCAUTERIZAT	No pre-authorization is required for all providers.	N/A
65436	REMOV CORNEAL EPITHELIUM; W/APPLIC CHELAT AGENT	No pre-authorization is required for all providers.	N/A
65450	DESTRCT LES CORNEA-CRYOTHERAPY/PHOTOCOAGULATION	No pre-authorization is required for all providers.	N/A
65600	MX PUNCTURES ANT CORNEA	No pre-authorization is required for all providers.	N/A
65710	CORNEAL TRANSPLANT	No pre-authorization is required for all providers.	N/A
65730	CORNEAL TRANSPLANT	No pre-authorization is required for all providers.	N/A
65750	KERATOPLASTY; PENETRATING (APHAKIA)	No pre-authorization is required for all providers.	N/A
65755	KERATOPLASTY; PENETRATING (PSEUDOAPHAKIA)	No pre-authorization is required for all providers.	N/A
65756	CORNEAL TRNSPL ENDOTHELIAL	No pre-authorization is required for all providers.	N/A
65757	PREP CORNEAL ENDO ALLOGRAFT	No pre-authorization is required for all providers.	N/A
65760	KERATOMILEUSIS	No pre-authorization is required for all providers.	N/A
65765	KERATOPHAKIA	No pre-authorization is required for all providers.	N/A
65767	EPIKERATOPLASTY	This service is not covered by Superior HealthPlan.	N/A
65770	KERATOPROSTHESIS	No pre-authorization is required for all providers.	N/A
65771	RADIAL KERATOTOMY	This service is not covered by Superior HealthPlan.	N/A
65772	CORNEAL RELAXING INCS CORRECT INDUCE ASTIGMATISM	No pre-authorization is required for all providers.	N/A
65775	CORNEAL WEDGE RESECT CORRECT INDUCED ASTIGMATISM	No pre-authorization is required for all providers.	N/A
65778	COVER EYE W/MEMBRANE	No pre-authorization is required for all providers.	N/A
65779	COVER EYE W/MEMBRANE SUTURE	No pre-authorization is required for all providers.	N/A
65780	OCULAR RECONST TRANSPLANT	No pre-authorization is required for all providers.	N/A
65781	OCULR RECNSR LIMBL STEM CELL ALLGFT	This service is not covered by Superior HealthPlan.	N/A
65782	OCULR RECNSR LIMBL CONJUNCT AUTOGFT	This service is not covered by Superior HealthPlan.	N/A
65785	IMPLTJ NTRSTRML CRNL RING SEG	No pre-authorization is required for all providers.	N/A
65800	DRAINAGE OF EYE	No pre-authorization is required for all providers.	N/A
65810	PARACENTESIS (SEPART PROC); W/REMOV VITREOUS	No pre-authorization is required for all providers.	N/A
65815	PARACENTESIS (SEPART PROC); W/REMOV BLD	No pre-authorization is required for all providers.	N/A
65820	GONIOTOMY	No pre-authorization is required for all providers.	N/A
65850	TRABECULOTOMY AB EXT	No pre-authorization is required for all providers.	N/A
65855	TRABECULOPLASTY LASER SURG	No pre-authorization is required for all providers.	N/A
65860	SEVERING ADHESIONS ANT SEGMT LASER (SEPART PROC)	No pre-authorization is required for all providers.	N/A
65865	SEVERING ADHESIONS (SEP PRO); GONIOSYNECHIAE	No pre-authorization is required for all providers.	N/A
65870	SEVERING ADHESIONS (SEPART PROC); ANT SYNECHIAE	No pre-authorization is required for all providers.	N/A
65875	SEVERING ADHESIONS (SEPART PROC); POST SYNECHIAE	No pre-authorization is required for all providers.	N/A
65880	SEVERING ADHESIONS (SEPART PROC); CORNEOVITREAL	No pre-authorization is required for all providers.	N/A
65900	REMOV EPITHELIAL DOWNGROWTH ANT CHAMBER EYE	No pre-authorization is required for all providers.	N/A
65920	REMOV IMPLNT MAT ANT SEGMT EYE	No pre-authorization is required for all providers.	N/A
65930	REMOV BLD CLOT ANT SEGMT EYE	No pre-authorization is required for all providers.	N/A
66020	INJ ANT CHAMBER (SEPART PROC); AIR/LIQUID	No pre-authorization is required for all providers.	N/A
66030	INJ ANT CHAMBER (SEPART PROC); MEDS	No pre-authorization is required for all providers.	N/A
66130	EXC LES SCLERA	No pre-authorization is required for all providers.	N/A
66150	FISTULIZAT SCLERA-GLAU; TREPHINAT W/IRIDECTOMY	No pre-authorization is required for all providers.	N/A
66155	FISTULIZAT SCLERA; THERMOCAUTERIZATION W/IRIDECT	No pre-authorization is required for all providers.	N/A
66160	FISTULIZAT SCLERA; SCLERECTOMY W/PUNCH W/IRIDECT	No pre-authorization is required for all providers.	N/A
66165	FISTULIZAT SCLERA; IRIDENCLISIS/IRIDOTASIS	This is no longer a valid code.	N/A
66170	FISTULIZAT SCLER;TRABECULECT AB EXT-NO OTHR SURG	No pre-authorization is required for all providers.	N/A
66172	FISTULIZAT SCLERA; TRABECULECT AB EXT W/SCARRING	No pre-authorization is required for all providers.	N/A
66174	TRANSLUM DIL EYE CANAL	This service is not covered by Superior HealthPlan.	N/A
66175	TRNSLUM DIL EYE CANAL W/STN	This service is not covered by Superior HealthPlan.	N/A
66179	AQUEOUS SHUNT EYE W/O GRAFT	No pre-authorization is required for all providers.	N/A
66180	AQUEOUS SHUNT EYE W/GRAFT	No pre-authorization is required for all providers.	N/A
66183	INSERT ANT DRAINAGE DEVICE	No pre-authorization is required for all providers.	N/A
66184	REVISION OF AQUEOUS SHUNT	No pre-authorization is required for all providers.	N/A
66185	REVISE AQUEOUS SHUNT EYE	No pre-authorization is required for all providers.	N/A
66220	REPR SCLERAL STAPHYLOMA; WO GFT	This is no longer a valid code.	N/A
66225	REPR SCLERAL STAPHYLOMA; W/GFT	No pre-authorization is required for all providers.	N/A
66250	REVIS/REPR OPERATIVE WOUND ANT SEGMT	No pre-authorization is required for all providers.	N/A
66500	IRIDOTOMY-STAB INCS (SEP PRO); EX TRANSFIXION	No pre-authorization is required for all providers.	N/A
66505	IRIDOTOMY-STAB INCS (SEP PRO); W/TRANSFIXION	No pre-authorization is required for all providers.	N/A
66600	IRIDECTOMY W/CORNEOSCLERAL SECT; REMOV LES	No pre-authorization is required for all providers.	N/A
66605	IRIDECTOMY W/CORNEOSCLERAL SECT; W/CYCLECTOMY	No pre-authorization is required for all providers.	N/A
66625	IRIDECTOMY; PERIPHERAL GLAU (SEPART PROC)	No pre-authorization is required for all providers.	N/A
66630	IRIDECTOMY; SECTOR GLAU (SEPART PROC)	No pre-authorization is required for all providers.	N/A
66635	IRIDECTOMY; 'OPTICAL' (SEPART PROC)	No pre-authorization is required for all providers.	N/A
66680	REPR IRIS CILIARY BODY	No pre-authorization is required for all providers.	N/A
66682	SUTURE IRIS CILIARY BODY (SEPART PROC)	No pre-authorization is required for all providers.	N/A
66700	CILIARY BODY DESTRCT; DIATHERMY	No pre-authorization is required for all providers.	N/A
66710	CILIARY BODY DESTRCT; CYCLOPHOTOCOAGULATION	No pre-authorization is required for all providers.	N/A
66711	ECP CILIARY BODY DSTRJ W/O RMLV CRYSTALLINE LENS	No pre-authorization is required for all providers.	N/A
66720	CILIARY BODY DESTRCT; CRYOTHERAPY	No pre-authorization is required for all providers.	N/A
66740	DESTRUCTION CILIARY BODY	No pre-authorization is required for all providers.	N/A
66761	REVISION OF IRIS	No pre-authorization is required for all providers.	N/A
66762	IRIDOPLASTY BY PHOTOCOAGULATION	No pre-authorization is required for all providers.	N/A

66770	DESTRCT CYST/LES IRIS/CILIARY BODY	No pre-authorization is required for all providers.	N/A
66820	DISCISSION SECNDRY MEMBRN CATARACT; STAB INCS	No pre-authorization is required for all providers.	N/A
66821	DISCISSION SECNDRY MEMBRN CATARACT; LASER SURG	No pre-authorization is required for all providers.	N/A
66825	REPOSIT IO LENS PROSTH REQ INCS (SEPART PROC)	No pre-authorization is required for all providers.	N/A
66830	REMOV 2ND MEMBRN CATARACT W/CORNEO-SCLERAL SECT	No pre-authorization is required for all providers.	N/A
66840	REMOV LENS MAT; ASPIRAT TECH 1/MORE STAGES	No pre-authorization is required for all providers.	N/A
66850	REMOV LENS MAT; PHACOFRAGMENTAT TECH W/ASPIRAT	No pre-authorization is required for all providers.	N/A
66852	REMOV LENS MAT; PARS PLANA APPROACH W/WO VITRECT	No pre-authorization is required for all providers.	N/A
66920	REMOV LENS MAT; INTRACAPSULAR	No pre-authorization is required for all providers.	N/A
66930	REMOV LENS MAT; INTRACAPSULAR DISLOC LENS	No pre-authorization is required for all providers.	N/A
66940	REMOV LENS MAT; EXTRACAPSULAR	No pre-authorization is required for all providers.	N/A
66982	XCAPSL CTRC RMVL INSJ IO LENS PROSTH CPLX WO ECP	No pre-authorization is required for all providers.	N/A
66983	INTRACAPSULAR CATARACT EXTRAC W/INSRT IOL PROSTH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
66984	XCAPSL CTRC RMVL INSJ IO LENS PROSTH W/O ECP	No pre-authorization is required for all providers.	N/A
66985	INSRT IOL PROSTH (SECNDRY IMPLNT)	No pre-authorization is required for all providers.	N/A
66986	EXCHG IO LENS	No pre-authorization is required for all providers.	N/A
66987	XCAPSL CTRC RMVL INSJ IO LENS PROSTH CPLX W/ECP	No pre-authorization is required for all providers.	N/A
66988	XCAPSL CTRC RMVL INSJ IO LENS PROSTH W/ECP	No pre-authorization is required for all providers.	N/A
66990	USE OF OPHTHALMIC ENDOSCOPE	No pre-authorization is required for all providers.	N/A
66999	UNLISTED PROC ANT SEGMENT EYE	No pre-authorization is required for all providers.	N/A
67005	REMOV VITREOUS ANT APPROACH; PART REMOV	No pre-authorization is required for all providers.	N/A
67010	REMOV VITREOUS ANT; SUBTL REMOV W/MECH VITRECT	No pre-authorization is required for all providers.	N/A
67015	ASPIRAT/RELEASE VITREOUS/SUBRETINAL FLUID	No pre-authorization is required for all providers.	N/A
67025	INJ VITREOUS SUBSTITUTE-W/WO ASPIRAT (SEP PRO)	No pre-authorization is required for all providers.	N/A
67027	IMPLNT INTRAVITREAL DRUG DELIV SYST	No pre-authorization is required for all providers.	N/A
67028	INTRAVITREAL INJ-PHARMACOLOGIC AGENT (SEP PRO)	No pre-authorization is required for all providers.	N/A
67030	DISCISSION VITREOUS STRANDS PARS PLANA APPROACH	No pre-authorization is required for all providers.	N/A
67031	SEVERING VITREOUS STRANDS/MEMBRN-LASER SURG	No pre-authorization is required for all providers.	N/A
67036	VITRECTOMY MECH PARS PLANA APPROACH	No pre-authorization is required for all providers.	N/A
67039	VITRECTOMY MECH; W/FOCAL ENDOLASER PHOTOCOAGULAT	No pre-authorization is required for all providers.	N/A
67040	VITRECTOMY MECH; W/ENDOLASER PANRETINAL PHOTOCOA	No pre-authorization is required for all providers.	N/A
67041	VIT FOR MACULAR PUCKER	No pre-authorization is required for all providers.	N/A
67042	VIT FOR MACULAR HOLE	No pre-authorization is required for all providers.	N/A
67043	VIT FOR MEMBRANE DISSECT	No pre-authorization is required for all providers.	N/A
67101	REPAIR DETACHED RETINA CRTX	No pre-authorization is required for all providers.	N/A
67105	REPAIR DETACHED RETINA PC	No pre-authorization is required for all providers.	N/A
67107	REPAIR DETACHED RETINA	No pre-authorization is required for all providers.	N/A
67108	REPR RETINAL DETACHMENT; W/VITRECTOMY ANY METHD	No pre-authorization is required for all providers.	N/A
67110	REPR RETINAL DETACHMENT; INJ AIR/OTHER GAS	No pre-authorization is required for all providers.	N/A
67112	REPR RETINAL DETACHMENT; PREV OPERATED UPON	This is no longer a valid code.	N/A
67113	REPAIR RETINAL DETACH CPLX	No pre-authorization is required for all providers.	N/A
67115	RELEASE ENCIRCLING MAT	No pre-authorization is required for all providers.	N/A
67120	REMOV IMPLNT MAT POST SEGMENT; EXTRAOCULAR	No pre-authorization is required for all providers.	N/A
67121	REMOV IMPLNT MAT POST SEGMENT; IO	No pre-authorization is required for all providers.	N/A
67141	PROPHYLAXIS RETINAL DETACH WO DRAIN; CRYOTHERAPY	No pre-authorization is required for all providers.	N/A
67145	PROPHYLAXIS RETINAL DETACH; PHOTOCOAGULATION	No pre-authorization is required for all providers.	N/A
67208	DESTRCT LOCALIZ LES RETINA; CRYOTHERAPY/DIATHERM	No pre-authorization is required for all providers.	N/A
67210	DESTRCT LOCALIZ LES RETINA; PHOTOCOAGULATION	No pre-authorization is required for all providers.	N/A
67218	DESTRCT LOCALIZ LES RETINA; RADIATION-IMPLNT	No pre-authorization is required for all providers.	N/A
67220	DESTRUC LOCALIZ LES CHOROID-1/> SESSIONS-LASER	No pre-authorization is required for all providers.	N/A
67221	DESTRUC LES CHOROID; PHOTODYNA THPY 8.91	No pre-authorization is required for all providers.	N/A
67225	OCULAR PHOTODYNAMIC THERAPY	No pre-authorization is required for all providers.	N/A
67227	DSTRJ EXTENSIVE RETINOPATHY	No pre-authorization is required for all providers.	N/A
67228	TREATMENT X10SV RETINOPATHY	No pre-authorization is required for all providers.	N/A
67229	TR RETINAL LES PRETERM INF	No pre-authorization is required for all providers.	N/A
67250	SCLERAL REINFORCEMENT (SEPART PROC); WO GFT	No pre-authorization is required for all providers.	N/A
67255	SCLERAL REINFORCEMENT (SEPART PROC); W/GFT	No pre-authorization is required for all providers.	N/A
67299	UNLISTED PROC POST SEGMENT	No pre-authorization is required for all providers.	N/A
67311	STRABISMUS SURG; 1 HORIZONTAL MUSCL	No pre-authorization is required for all providers.	N/A
67312	STRABISMUS SURG; 2 HORIZONTAL MUSCL	No pre-authorization is required for all providers.	N/A
67314	STRABISMUS SURG; 1 VERTICAL MUSCL	No pre-authorization is required for all providers.	N/A
67316	STRABISMUS SURG; 2/MORE VERTICAL MUSCL	No pre-authorization is required for all providers.	N/A
67318	STRABISMUS SURG ANY PROC SUPER OBLIQ MUSCL	No pre-authorization is required for all providers.	N/A
67320	TRANSPOSITION PROC-ANY EXTRAOCULAR MUSCL	No pre-authorization is required for all providers.	N/A
67331	STRABISMUS SURG-PT W/PREV EYE SURG	No pre-authorization is required for all providers.	N/A
67332	STRABISMUS SURG-PT W/SCARRING EXTRAOCULAR MUSCL	No pre-authorization is required for all providers.	N/A
67334	STRABISMUS SURG-POST FIXA SUTURE TECH W/WO MUSCL	No pre-authorization is required for all providers.	N/A
67335	PLCMT ADJUSTABLE SUTURE-DURING STRABISMUS SURG	No pre-authorization is required for all providers.	N/A
67340	STRABISMUS SURG EXPLOR &/OR REPR DETACHED MUSCL	No pre-authorization is required for all providers.	N/A
67343	RELEASE EXTEN SCAR TISS WO DETACHING (SEP PRO)	No pre-authorization is required for all providers.	N/A
67345	CHEMODENERVATION EXTRAOCULAR MUSCL	No pre-authorization is required for all providers.	N/A
67346	BIOPSY OF EXTRAOCULAR MUSCLE	No pre-authorization is required for all providers.	N/A
67399	UNLISTED PX EXTRAOCULAR MUSC	No pre-authorization is required for all providers.	N/A
67400	ORBITOTOMY WO BONE FLAP; EXPLOR W/WO BX	No pre-authorization is required for all providers.	N/A
67405	ORBITOTOMY WO BONE FLAP; W/DRAINAGE ONLY	No pre-authorization is required for all providers.	N/A
67412	ORBITOTOMY WO BONE FLAP; W/REMOV LES	No pre-authorization is required for all providers.	N/A
67413	ORBITOTOMY WO BONE FLAP; W/REMOV FB	No pre-authorization is required for all providers.	N/A
67414	ORBITOTOMY WO BONE FLAP; W/REMOV BONE DECOMP	No pre-authorization is required for all providers.	N/A
67415	FINE NEEDLE ASPIRAT ORBITAL CONTENTS	No pre-authorization is required for all providers.	N/A
67420	ORBITOTOMY W/BONE FLAP/WINDOW; W/REMOV LES	No pre-authorization is required for all providers.	N/A
67430	ORBITOTOMY W/BONE FLAP/WINDOW; W/REMOV FB	No pre-authorization is required for all providers.	N/A
67440	ORBITOTOMY W/BONE FLAP/WINDOW; W/DRAIN	No pre-authorization is required for all providers.	N/A
67445	ORBITOTOMY W/BONE FLAP/WINDOW; W/REMOV BONE	No pre-authorization is required for all providers.	N/A
67450	ORBITOTOMY W/BONE FLAP/WINDOW; EXPLOR W/WO BX	No pre-authorization is required for all providers.	N/A
67500	RETROBULBAR INJ; MEDS	No pre-authorization is required for all providers.	N/A
67505	RETROBULBAR INJ; ALCOHOL	No pre-authorization is required for all providers.	N/A
67515	INJ THERAP AGENT INTO TENON'S CAPSULE	No pre-authorization is required for all providers.	N/A
67550	ORBITAL IMPLNT; INSRT	No pre-authorization is required for all providers.	N/A
67560	ORBITAL IMPLNT; REMOV/REVIS	No pre-authorization is required for all providers.	N/A
67570	OPTIC NERV DECOMP	No pre-authorization is required for all providers.	N/A
67599	UNLISTED PROC ORBIT	No pre-authorization is required for all providers.	N/A
67700	BLEPHAROTOMY DRAINAGE ABSCESS EYELID	No pre-authorization is required for all providers.	N/A
67710	SEVERING TARSORRHAPHY	No pre-authorization is required for all providers.	N/A
67715	CANTHOTOMY (SEPART PROC)	Pre-authorization is required for all providers.	Prior to 09/01/2019
67800	EXC CHALAZION; SNGL	No pre-authorization is required for all providers.	N/A
67801	EXC CHALAZION; MX SAME LID	Pre-authorization is required in an outpatient and ambulatory surgical center locations for members over 21 years of age.	Prior to 09/01/2019
67805	EXC CHALAZION; MX DIFF LIDS	No pre-authorization is required for all providers.	N/A
67808	EXC CHALAZION; GEN ANES &/OR REQ HOSP-1/MX	No pre-authorization is required for all providers.	N/A
67810	BIOPSY EYELID & LID MARGIN	No pre-authorization is required for all providers.	N/A
67820	CORRECT TRICHIASIS; EPILATION BY FORCEPS ONLY	No pre-authorization is required for all providers.	N/A
67825	CORRECT TRICHIASIS; EPILATION-OTH THAN FORCEPS	No pre-authorization is required for all providers.	N/A
67830	CORRECT TRICHIASIS; INCS LID MARGIN	No pre-authorization is required for all providers.	N/A
67835	CORRECT TRICHIASIS; INCS LID MARGIN W/MEMBRN GFT	No pre-authorization is required for all providers.	N/A
67840	EXC LES EYELID WO CLO OR W/SIMPL DIRECT CLO	No pre-authorization is required for all providers.	N/A
67850	DESTRCT LES LID MARGIN	No pre-authorization is required for all providers.	N/A
67875	TEMPORARY CLO EYELIDS BY SUTURE	No pre-authorization is required for all providers.	N/A
67880	CONSTRUCT INTERMARGINAL ADHESIONS	No pre-authorization is required for all providers.	N/A
67882	CONSTRCT INTERMARG ADHESIONS; W/TRANSPOSIT TARSL	No pre-authorization is required for all providers.	N/A
67900	REPR BROW PTOSIS	Pre-authorization is required for all providers.	Prior to 09/01/2019
67901	REPR BLEPHAROPTOSIS; W/SUTUE/OTHER MAT	Pre-authorization is required for all providers.	Prior to 09/01/2019
67902	REPR BLEPHAROPTOSIS; W/FASCIAL SLING	Pre-authorization is required for all providers.	Prior to 09/01/2019

67903	REPR BLEPHAROPTOSIS; LEVATOR RESECT-INT APPROACH	Pre-authorization is required for all providers.	Prior to 09/01/2019
67904	REPR BLEPHAROPTOSIS; LEVATOR RESECT-EXT APPROACH	Pre-authorization is required for all providers.	Prior to 09/01/2019
67906	REPR BLEPHAROPTOSIS; SUPER RECTUS TECH-FASCIAL	Pre-authorization is required for all providers.	Prior to 09/01/2019
67908	REPR BLEPHAROPTOSIS; CONJUNC-TARSO-MULLER'S	Pre-authorization is required for all providers.	Prior to 09/01/2019
67909	REDUCTION OVERCORRECTION PTOSIS	Pre-authorization is required for all providers.	Prior to 09/01/2019
67911	CORRECT LID RETRACTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
67912	CORR LAGOPHTHALMOS IMPL UP EYELD	No pre-authorization is required for all providers.	N/A
67914	REPR ECTROPION; SUTURE	Pre-authorization is required for all providers.	Prior to 09/01/2019
67915	REPR ECTROPION; THERMOCAUTERIZATION	Pre-authorization is required for all providers.	Prior to 09/01/2019
67916	REPAIR ECTROPION EXC TARSAL WEDGE	Pre-authorization is required for all providers.	Prior to 09/01/2019
67917	REPAIR OF ECTROPION EXTENSIVE	Pre-authorization required for all providers.	Prior to 09/01/2019
67921	REPR ENTROPION; SUTURE	Pre-authorization is required for all providers.	Prior to 09/01/2019
67922	REPR ENTROPION; THERMOCAUTERIZATION	Pre-authorization is required for all providers.	Prior to 09/01/2019
67923	REPAIR ENTROPION EXC TARSAL WEDGE	Pre-authorization is required for all providers.	Prior to 09/01/2019
67924	REPAIR OF ENTROPION EXTENSIVE	Pre-authorization is required for all providers.	Prior to 09/01/2019
67930	SUTURE RECENT WOUND EYELID DIR CLO; PART THICK	No pre-authorization is required for all providers.	N/A
67935	SUTURE RECENT WOUND EYELID DIR CLO; FULL THICK	No pre-authorization is required for all providers.	N/A
67938	REMOV EMBEDDED FB EYELID	No pre-authorization is required for all providers.	N/A
67950	CANTHOPLASTY	Pre-authorization is required for all providers.	Prior to 09/01/2019
67961	EXC & REPR EYELID; UP TO 1/4 LID MARGIN	Pre-authorization is required for all providers.	Prior to 09/01/2019
67966	EXC & REPR EYELID > 1/4 LID MARGIN	Pre-authorization is required for all providers.	Prior to 09/01/2019
67971	RECON EYELID FULL THICK; UP TO 2/3 LID 1 STAGE	Pre-authorization is required for all providers.	Prior to 09/01/2019
67973	RECON EYELID; TOT LID LOWER 1 STAGE/1ST STAGE	Pre-authorization is required for all providers.	Prior to 09/01/2019
67974	RECON EYELID; TOT LID UPPER 1 STAGE/1ST STAGE	Pre-authorization is required for all providers.	Prior to 09/01/2019
67975	RECON EYELID FULL THICK-TRANSF FLAP; 2ND STAGE	Pre-authorization is required for all providers.	Prior to 09/01/2019
67999	UNLISTED PROC EYELIDS	No pre-authorization is required for all providers.	N/A
68020	INCS CONJUNC DRAINAGE CYST	No pre-authorization is required for all providers.	N/A
68040	EXPRESSION CONJUNC FOLLICLES EG TRACHOMA	No pre-authorization is required for all providers.	N/A
68100	BX CONJUNC	No pre-authorization is required for all providers.	N/A
68110	EXC LES CONJUNC; UP TO 1 CM	No pre-authorization is required for all providers.	N/A
68115	EXC LES CONJUNC; OVER 1 CM	No pre-authorization is required for all providers.	N/A
68130	EXC LES CONJUNC; W/ADJACENT SCLERA	No pre-authorization is required for all providers.	N/A
68135	DESTRUCT LES CONJUNC	No pre-authorization is required for all providers.	N/A
68200	SUBCONJUNCTIVAL INJ	No pre-authorization is required for all providers.	N/A
68320	CONJUNCTIVOPLASTY; W/CONJUNC GFT/EXTEN REARRANG	No pre-authorization is required for all providers.	N/A
68325	CONJUNCTIVOPLASTY; W/BUCCAL MUCOS MEMBRN GFT	No pre-authorization is required for all providers.	N/A
68326	CONJUNCTIVOPLASTY RECON CUL-DE-SAC; W/GFT	No pre-authorization is required for all providers.	N/A
68328	CONJUNCTIVOPLASTY RECON CUL-DE-SAC; W/BUCCAL GFT	No pre-authorization is required for all providers.	N/A
68330	REPR SYMBLEPHARON; CONJUNCTIVOPLASTY WO GFT	No pre-authorization is required for all providers.	N/A
68335	REPR SYMBLEPHARON; W/FREE GFT CONJUNC/BUCCAL	No pre-authorization is required for all providers.	N/A
68340	REPR SYMBLEPHARON; DIVIS SYMBLEPHARON W/WO INSR	No pre-authorization is required for all providers.	N/A
68360	CONJUNC FLAP; BRIDGE/PART (SEPART PROC)	No pre-authorization is required for all providers.	N/A
68362	CONJUNC FLAP; TOT	No pre-authorization is required for all providers.	N/A
68371	HARV CONJUNCT ALLOGFT LIVING DONR	No pre-authorization is required for all providers.	N/A
68399	UNLISTED PROC CONJUNC	No pre-authorization is required for all providers.	N/A
68400	INCS DRAINAGE LACRIMAL GLAND	No pre-authorization is required for all providers.	N/A
68420	INCS DRAINAGE LACRIMAL SAC	No pre-authorization is required for all providers.	N/A
68440	SNIP INCS LACRIMAL PUNCTUM	No pre-authorization is required for all providers.	N/A
68500	EXC LACRIMAL GLAND EX TUMOR; TOT	No pre-authorization is required for all providers.	N/A
68505	EXC LACRIMAL GLAND EX TUMOR; PART	No pre-authorization is required for all providers.	N/A
68510	BX LACRIMAL GLAND	No pre-authorization is required for all providers.	N/A
68520	EXC LACRIMAL SAC	No pre-authorization is required for all providers.	N/A
68525	BX LACRIMAL SAC	No pre-authorization is required for all providers.	N/A
68530	REMOV FB/DACRYOLITH LACRIMAL PASSAGES	No pre-authorization is required for all providers.	N/A
68540	EXC LACRIMAL GLAND TUMOR; FRONTAL APPROACH	No pre-authorization is required for all providers.	N/A
68550	EXC LACRIMAL GLAND TUMOR; INVOLV OSTEOTOMY	No pre-authorization is required for all providers.	N/A
68700	PLASTIC REPR CANALICULI	No pre-authorization is required for all providers.	N/A
68705	CORRECT EVERTED PUNCTUM CAUT	No pre-authorization is required for all providers.	N/A
68720	DACRYOCYSTORRHINOSTOMY	No pre-authorization is required for all providers.	N/A
68745	CONJUNCTIVORRHINOSTOMY; WO TUBE	No pre-authorization is required for all providers.	N/A
68750	CONJUNCTIVORRHINOSTOMY; W/INSRT TUBE/STENT	No pre-authorization is required for all providers.	N/A
68760	CLO LACRIMAL PUNCTUM; THERMOCAUT/LIG/LASER SURG	No pre-authorization is required for all providers.	N/A
68761	CLO LACRIMAL PUNCTUM; BY PLUG EA	No pre-authorization is required for all providers.	N/A
68770	CLO LACRIMAL FISTULA (SEPART PROC)	No pre-authorization is required for all providers.	N/A
68801	DILAT LACRIMAL PUNCTUM W/WO IRRIGA	No pre-authorization is required for all providers.	N/A
68810	PROBING NASOLACRIMAL DUCT W/WO IRRIGA;	No pre-authorization is required for all providers.	N/A
68811	PROBE NASOLACRIMAL DUCT W/WO IRRIG; REQ GEN ANES	No pre-authorization is required for all providers.	N/A
68815	PROBE NASOLACRIM DUCT W/WO IRRIG; W/INSERT TUBE	No pre-authorization is required for all providers.	N/A
68816	PROBE NL DUCT W/BALLOON	No pre-authorization is required for all providers.	N/A
68840	PROBING LACRIMAL CANALICULI W/WO IRRIGA	No pre-authorization is required for all providers.	N/A
68850	INJ CONTRAST MEDIUM DACRYOCYSTOGRAPHY	No pre-authorization is required for all providers.	N/A
68899	UNLISTED PROC LACRIMAL SYST	No pre-authorization is required for all providers.	N/A
69000	DRAINAGE EXT EAR ABSCESS/HEMATOMA; SIMPL	No pre-authorization is required for all providers.	N/A
69005	DRAINAGE EXT EAR ABSCESS/HEMATOMA; COMPLIC	No pre-authorization is required for all providers.	N/A
69020	DRAINAGE EXT AUDITORY CANAL ABSCESS	No pre-authorization is required for all providers.	N/A
69090	EAR PIERCING	This service is not covered by Superior HealthPlan.	N/A
69100	BX EXT EAR	No pre-authorization is required for all providers.	N/A
69105	BX EXT AUDITORY CANAL	No pre-authorization is required for all providers.	N/A
69110	EXC EXT EAR; PART SIMPL REPR	No pre-authorization is required for all providers.	N/A
69120	EXC EXT EAR; COMPLT AMPUTA	No pre-authorization is required for all providers.	N/A
69140	EXC EXOSTOSIS EXT AUDITORY CANAL	No pre-authorization is required for all providers.	N/A
69145	EXC SOFT TISS LES EXT AUDITORY CANAL	No pre-authorization is required for all providers.	N/A
69150	RAD EXC EXT AUDITORY CANAL LES; WO NECK DISSECT	No pre-authorization is required for all providers.	N/A
69155	RAD EXC EXT AUDITORY CANAL LES; W/NECK DISSECT	No pre-authorization is required for all providers.	N/A
69200	REMOV FB-EXT AUDITORY CANAL; WO GEN ANES	No pre-authorization is required for all providers.	N/A
69205	REMOV FB-EXT AUDITORY CANAL; W/GEN ANES	No pre-authorization is required for all providers.	N/A
69209	REMOVE IMPACTED EAR WAX UNI	No pre-authorization is required for all providers.	N/A
69210	REMOVE IMPACTED EAR WAX UNI	No pre-authorization is required for all providers.	N/A
69220	DEBRID MASTOIDEAL CAVITY SIMPL	No pre-authorization is required for all providers.	N/A
69222	DEBRID MASTOIDEAL CAVITY COMPLX	No pre-authorization is required for all providers.	N/A
69300	OTOPLASTY PROTRUDING EAR W/WO SIZE REDUCTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
69310	RECON EXT AUDITORY CANAL (SEPART PROC)	No pre-authorization is required for all providers.	N/A
69320	RECON EXT AUDITORY CANAL CONGEN ATRESIA; 1 STAGE	No pre-authorization is required for all providers.	N/A
69399	UNLISTED PROC EXT EAR	No pre-authorization is required for all providers.	N/A
69400	EUSTACHIAN TUBE INFLATION TRANSNASAL; W/CATH	This is no longer a valid code.	N/A
69401	EUSTACHIAN TUBE INFLATION TRANSNASAL; WO CATH	This is no longer a valid code.	N/A
69405	EUSTACHIAN TUBE CATH TRANSTYMPANIC	This is no longer a valid code.	N/A
69420	MYRINGOTOMY INCL ASPIRAT &/OR EUSTACHIAN INFLAT	No pre-authorization is required for all providers.	N/A
69421	MYRINGOTOMY INCL ASPIRAT REQ GEN ANES	No pre-authorization is required for all providers.	N/A
69424	VENTILATING TUBE REMV RQR GEN ANES	No pre-authorization is required for all providers.	N/A
69433	TYMPANOSTOMY LOCAL/TOPICAL ANES	No pre-authorization is required for all providers.	N/A
69436	TYMPANOSTOMY GEN ANES	No pre-authorization is required for all providers.	N/A
69440	MID EAR EXPLOR-POSTAURICULAR/EAR CANAL INCS	No pre-authorization is required for all providers.	N/A
69450	TYMPANOLYSIS TRANSCANAL	No pre-authorization is required for all providers.	N/A
69501	TRANSMASTOID ANTROTOMY	No pre-authorization is required for all providers.	N/A
69502	MASTOIDEAL; COMPLT	No pre-authorization is required for all providers.	N/A
69505	MASTOIDEAL; MODIF RADICAL	No pre-authorization is required for all providers.	N/A
69511	MASTOIDEAL; RADICAL	No pre-authorization is required for all providers.	N/A
69530	PETROUS APICECTOMY INCL RADICAL MASTOIDEAL	No pre-authorization is required for all providers.	N/A
69535	RESECT TEMPORAL BONE EXT APPROACH	No pre-authorization is required for all providers.	N/A
69540	EXC AURAL POLYP	No pre-authorization is required for all providers.	N/A

69550	EXC AURAL GLOMUS TUMOR; TRANSCANAL	No pre-authorization is required for all providers.	N/A
69552	EXC AURAL GLOMUS TUMOR; TRANSMASTOID	No pre-authorization is required for all providers.	N/A
69554	EXC AURAL GLOMUS TUMOR; EXTEN	No pre-authorization is required for all providers.	N/A
69601	REVIS MASTOIDE; RESULTING-COMPLT MASTOIDE	No pre-authorization is required for all providers.	N/A
69602	REVIS MASTOIDE; RESULT-MODIF RAD MASTOIDE	No pre-authorization is required for all providers.	N/A
69603	REVIS MASTOIDE; RESULTING-RADICAL MASTOIDE	No pre-authorization is required for all providers.	N/A
69604	REVIS MASTOIDE; RESULTING-TYMPANOPLASTY	No pre-authorization is required for all providers.	N/A
69605	REVIS MASTOIDE; W/APICECTOMY	No pre-authorization is required for all providers.	N/A
69610	TYMPANIC MEMBRN REPR W/WO SITE PREP W/WO PATCH	No pre-authorization is required for all providers.	N/A
69620	MYRINGOPLASTY	No pre-authorization is required for all providers.	N/A
69631	TYMPANOPLASTY WO MASTOIDE; WO OSSICULAR CHAIN	No pre-authorization is required for all providers.	N/A
69632	TYMPANOPLASTY WO MASTOIDE; W/OSSICULAR CHAIN	No pre-authorization is required for all providers.	N/A
69633	TYMPANOPLASTY WO MASTOIDE; W/CHAIN & PROSTH	No pre-authorization is required for all providers.	N/A
69635	TYMPANOPLASTY W/ANTROTOMY; WO OSSICULAR CHAIN	No pre-authorization is required for all providers.	N/A
69636	TYMPANOPLASTY W/ANTROTOMY; W/OSSICULAR CHAIN	No pre-authorization is required for all providers.	N/A
69637	TYMPANOPLASTY W/ANTROTOMY; W/CHAIN & PROSTH	No pre-authorization is required for all providers.	N/A
69641	TYMPANOPLASTY W/MASTOIDE; WO OSSICULAR CHAIN	No pre-authorization is required for all providers.	N/A
69642	TYMPANOPLASTY W/MASTOIDE; W/OSSICULAR CHAIN	No pre-authorization is required for all providers.	N/A
69643	TYMPANOPLASTY W/MASTOIDE; W/INTACT/RECON WALL	No pre-authorization is required for all providers.	N/A
69644	TYMPANOPLASTY W/MASTOIDE; W/RECON CANAL WALL	No pre-authorization is required for all providers.	N/A
69645	TYMPANOPLASTY W/MASTOIDE; RADICAL/COMPLT	No pre-authorization is required for all providers.	N/A
69646	TYMPANOPLASTY W/MASTOIDE; RAD W/CHAIN RECON	No pre-authorization is required for all providers.	N/A
69650	STAPES MOBILIZATION	No pre-authorization is required for all providers.	N/A
69660	STAPEDECTOMY/STAPEDOTOMY W/REESTABLISHMENT	No pre-authorization is required for all providers.	N/A
69661	STAPEDECTOMY/STAPEDOTOMY; W/FOOTPLATE DRILL OUT	No pre-authorization is required for all providers.	N/A
69662	REVIS STAPEDECTOMY/STAPEDOTOMY	No pre-authorization is required for all providers.	N/A
69666	REPR OVAL WINDOW FISTULA	No pre-authorization is required for all providers.	N/A
69667	REPR ROUND WINDOW FISTULA	No pre-authorization is required for all providers.	N/A
69670	MASTOID OBLIT (SEPART PROC)	No pre-authorization is required for all providers.	N/A
69676	TYMPANIC NEURECTOMY	No pre-authorization is required for all providers.	N/A
69700	CLO POSTAURICULAR FISTULA MASTOID (SEPART PROC)	No pre-authorization is required for all providers.	N/A
69710	IMPLNT/REPLAC ELECTROMAGNETIC BONE HEARING DEVIC	No pre-authorization is required for all providers.	N/A
69711	REMOV/REPR ELECTROMAGNETIC BONE HEARING DEVICE	No pre-authorization is required for all providers.	N/A
69714	OSSEO IMPLNT-TEMP BONE; WO MASTOID 23.68	No pre-authorization is required for all providers.	N/A
69715	OSSEO IMPLNT-TEMP BONE; W/MASTOIDE 29.99	No pre-authorization is required for all providers.	N/A
69717	REPLAC OSSEO IMPLNT; WO MASTOIDE 24.39	No pre-authorization is required for all providers.	N/A
69718	REPLAC OSSEO IMPLNT; W/MASTOIDE 30.35	No pre-authorization is required for all providers.	N/A
69720	DECOMP FACIAL NERV INTRATEMPORAL; LAT-GENICULATE	No pre-authorization is required for all providers.	N/A
69725	DECOMP FACIAL NERV; INCL MEDIAL-GENICULATE GANGL	No pre-authorization is required for all providers.	N/A
69740	SUTURE FACIAL NERV W/WO GFT; LAT-GENICULATE	No pre-authorization is required for all providers.	N/A
69745	SUTURE FACIAL NERV; INCL MEDIAL-GENICULATE GANGL	No pre-authorization is required for all providers.	N/A
69799	UNLISTED PROC MID EAR	No pre-authorization is required for all providers.	N/A
69801	INCISE INNER EAR	No pre-authorization is required for all providers.	N/A
69805	ENDOLYMPHATIC SAC OR; WO SHUNT	No pre-authorization is required for all providers.	N/A
69806	ENDOLYMPHATIC SAC OR; W/SHUNT	No pre-authorization is required for all providers.	N/A
69820	FENESTRATION SEMICIRCULAR CANAL	This is no longer a valid code.	N/A
69840	REVIS FENESTRATION OR	This is no longer a valid code.	N/A
69905	LABYRINTHECTOMY; TRANSCANAL	No pre-authorization is required for all providers.	N/A
69910	LABYRINTHECTOMY; W/MASTOIDE	No pre-authorization is required for all providers.	N/A
69915	VESTIBULAR NERV SECT TRANSLABYRINTHINE APPROACH	No pre-authorization is required for all providers.	N/A
69930	COCHLEAR DEVICE IMPLNT W/WO MASTOIDE	Pre-authorization is required for all providers.	Prior to 09/01/2019
69949	UNLISTED PROC INNER EAR	No pre-authorization is required for all providers.	N/A
69950	VESTIBULAR NERV SECT-TRANSCRANIAL APPROACH	No pre-authorization is required for all providers.	N/A
69955	TOT FACIAL NERV DECOMP &/OR REPR	No pre-authorization is required for all providers.	N/A
69960	DECOMP INT AUDITORY CANAL	No pre-authorization is required for all providers.	N/A
69970	REMOV TUMOR TEMPORAL BONE	No pre-authorization is required for all providers.	N/A
69979	UNLISTED PROC TEMPORAL BONE-MID FOSSA APPROACH	No pre-authorization is required for all providers.	N/A
69990	USE OPER MICROSCOPE	No pre-authorization is required for all providers.	N/A
70010	MYELOGRAPHY POST FOSSA-RAD S & I	No pre-authorization is required for all providers.	N/A
70015	CISTERNOGRAPHY POS CONTRAST-RAD S & I	No pre-authorization is required for all providers.	N/A
70030	RAD EXAM EYE DETECTION FB	No pre-authorization is required for all providers.	N/A
70100	RAD EXAM MANDIB; PART LESS THAN 4 VIEWS	No pre-authorization is required for all providers.	N/A
70110	RAD EXAM MANDIB; COMPLT MINI 4 VIEWS	No pre-authorization is required for all providers.	N/A
70120	RAD EXAM MASTOIDS; LESS THAN 3 VIEWS PER SIDE	No pre-authorization is required for all providers.	N/A
70130	RAD EXAM MASTOIDS; COMPLT MINI 3 VIEWS-SIDE	No pre-authorization is required for all providers.	N/A
70134	RAD EXAM INT AUDITORY MEATI COMPLT	No pre-authorization is required for all providers.	N/A
70140	RAD EXAM FACIAL BONES; LESS THAN 3 VIEWS	No pre-authorization is required for all providers.	N/A
70150	RAD EXAM FACIAL BONES; COMPLT MINI 3 VIEWS	No pre-authorization is required for all providers.	N/A
70160	RAD EXAM NASAL BONES COMPLT MINI 3 VIEWS	No pre-authorization is required for all providers.	N/A
70170	DACRYOCYSTOGRAPHY NASOLACRIMAL DUCT-RAD S & I	No pre-authorization is required for all providers.	N/A
70190	RAD EXAM; OPTIC FORAMINA	No pre-authorization is required for all providers.	N/A
70200	RAD EXAM; ORBITS COMPLT MINI 4 VIEWS	No pre-authorization is required for all providers.	N/A
70210	RAD EXAM SINUSES PARANASAL LESS THAN 3 VIEWS	No pre-authorization is required for all providers.	N/A
70220	RAD EXAM SINUSES PARANASAL COMPLT MINI 3 VIEWS	No pre-authorization is required for all providers.	N/A
70240	RAD EXAM SELLA TURCICA	No pre-authorization is required for all providers.	N/A
70250	RAD EXAM SKULL LESS THAN 4 VIEWS	No pre-authorization is required for all providers.	N/A
70260	RAD EXAM SKULL Cmpl MINI 4 VIEWS	No pre-authorization is required for all providers.	N/A
70300	RAD EXAM TEETH; SNGL VIEW	No pre-authorization is required for all providers.	N/A
70310	RAD EXAM TEETH; PART EXAM LESS THAN FULL MOUTH	No pre-authorization is required for all providers.	N/A
70320	RAD EXAM TEETH; COMPLT FULL MOUTH	No pre-authorization is required for all providers.	N/A
70328	RAD EXAM TMJ OPEN & CLO MOUTH; UNILAT	No pre-authorization is required for all providers.	N/A
70330	RAD EXAM TMJ OPEN & CLO MOUTH; BILAT	No pre-authorization is required for all providers.	N/A
70332	TMJ ARTHROGRAPHY-RAD S & I	No pre-authorization is required for all providers.	N/A
70336	MRI TEMPOROMANDIBULAR JT	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70350	CEPHALOGRAM ORTHODONTIC	No pre-authorization is required for all providers.	N/A
70355	PANORAMIC X-RAY OF JAWS	No pre-authorization is required for all providers.	N/A
70360	RAD EXAM; NECK SOFT TISS	No pre-authorization is required for all providers.	N/A
70370	RAD EXAM; PHARYNX/LARYNX INCL FLUORO &/OR MAGNIF	No pre-authorization is required for all providers.	N/A
70371	COMPLX DYNAMIC PHARYNGEAL & SPEECH EVAL	No pre-authorization is required for all providers.	N/A
70373	LARYNGOGRAPHY CONTRAST-RAD S & I	This is no longer a valid code.	N/A
70380	RAD EXAM SALIVARY GLAND CALCU	No pre-authorization is required for all providers.	N/A
70390	SIALOGRAPHY-RAD S & I	No pre-authorization is required for all providers.	N/A
70450	CT HEAD/BRAIN; W/O CONTRAST MATL	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70460	CT HEAD/BRAIN; W/CONTRAST MATL	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70470	CT HEAD/BRAIN; W/O & W/CONTRST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70480	CT ORBIT SELLA/EAR; W/O CONTRST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70481	CT ORBIT SELLA/EAR; W/CONTRST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70482	CT ORBIT SELLA/EAR; W/O&W/CONTRST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70486	CT MAXLOFCE AREA; W/O CONTRAST MATL	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70487	CT MAXILLOFACIAL AREA; W/CONTRAST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70488	CT MAXILLOFACIAL; W/O&W/CONTRST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70490	CT SOFT TISS NECK; W/O CONTRST MATL	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70491	CT SOFT TISSUE NECK; W/CONTRST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70492	CT SFT TISS NCK; W/O&W/CONTRST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70496	CTA HEAD C-/C+	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70498	CTA NCK C-/C+ POST-PXESSING	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70540	MRI ORBIT, FACE AND OR NECK, WITHOUT CONTRACT MATERIALS	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70542	MRI ORBIT FACE & NECK; W/CONTRAST 15.36	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70543	MRI ORBIT FACE & NECK; W/ & WO CONT 27.61	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70544	MRA HEAD; WO CONTRAST MAT 13.32	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70545	MRA HEAD; W/CONTRAST MAT 13.32	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019

70546	MRA HEAD; W/ & WO CONTRAST MAT 25.25	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70547	MRA NECK; WO CONTRAST MAT 13.32	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70548	MRA NECK; W/CONTRAST MAT 13.32	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70549	MRA NECK; W/ & WO CONTRAST MAT 25.25	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70551	MRI BRAIN; WO CONTRAST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70552	MRI BRAIN; W/CONTRAST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70553	MRI BRAIN; WO CONTRAST FOLLOWED BY CONTRAST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70554	MAGNETIC RESONANCE IMAGING, BRAIN	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70555	MRI, BRAIN, FXNL, REQ PHYSIC/ PSYCHOL ADMIN	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
70557	MRI BRAIN DUR INTRACRAN NO CONTRST	No pre-authorization is required for all providers.	N/A
70558	MRI BRAIN DUR INTRACRAN W/CONTRST	No pre-authorization is required for all providers.	N/A
70559	MRI BRAIN NO CONTRST FLWED CONTRST	No pre-authorization is required for all providers.	N/A
71010	RAD EXAM CHEST; SNGL VIEW FRONTAL	This is no longer a valid code.	N/A
71015	RAD EXAM CHEST; STEREO FRONTAL	This is no longer a valid code.	N/A
71020	RAD EXAM CHEST 2 VIEWS FRONTAL & LAT	This is no longer a valid code.	N/A
71021	RAD EXAM CHEST-FRONT & LAT; W/APICAL LORDOTIC	This is no longer a valid code.	N/A
71022	RAD EXAM CHEST-FRONT & LAT; W/OBLIQ PROJ	This is no longer a valid code.	N/A
71023	RAD EXAM CHEST, FRONT & LAT; W/FLUOROSCOPY	This is no longer a valid code.	N/A
71030	RAD EXAM CHEST COMPLT MINI 4 VIEWS	This is no longer a valid code.	N/A
71034	RAD EXAM CHEST COMPLT MINI 4 VIEWS; W/FLUOROSCPY	This is no longer a valid code.	N/A
71035	RAD EXAM CHEST SPECIAL VIEWS	This is no longer a valid code.	N/A
71038	FLUOROSCOPIC LOCALIZ TRANSBRONCHIAL BX/BRUSHING	No pre-authorization is required for all providers.	N/A
71045	X-RAY EXAM CHEST 1 VIEW	No pre-authorization is required for all providers.	N/A
71046	X-RAY EXAM CHEST 2 VIEWS	No pre-authorization is required for all providers.	N/A
71047	X-RAY EXAM CHEST 3 VIEWS	No pre-authorization is required for all providers.	N/A
71048	X-RAY EXAM CHEST 4+ VIEWS	No pre-authorization is required for all providers.	N/A
71100	RAD EXAM RIBS UNILAT; 2 VIEWS	No pre-authorization is required for all providers.	N/A
71101	RAD EXAM RIBS UNILAT; W/PA CHEST MINI 3 VIEWS	No pre-authorization is required for all providers.	N/A
71110	RAD EXAM RIBS BILAT; 3 VIEWS	No pre-authorization is required for all providers.	N/A
71111	RAD EXAM RIBS BILAT; W/PA CHEST MINI 4 VIEWS	No pre-authorization is required for all providers.	N/A
71120	RAD EXAM; STERNUM MINI 2 VIEWS	No pre-authorization is required for all providers.	N/A
71130	RAD EXAM; STERNOCLAVICULAR JT/JTS MINI 3 VIEWS	No pre-authorization is required for all providers.	N/A
71250	CMPT TOMOGRPH THORAX; W/O CONTRST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
71260	CMPT TOMOGRPH THORAX; W/CONTRST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
71270	CT THORAX; W/O&W/CONTRST&OTH SECT	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
71275	CTA CH C-/C+ POST-PXESSING	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
71550	MRI CHEST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
71551	MRI CHEST; W/CONTRAST MAT 15.58	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
71552	MRI CHEST; W/ & WO CONTRAST MAT 27.64	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
71555	MRI ANGIO CHEST W/WO CONTRAST MAT	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72010	RAD EXAM SPINE-ENTIRE-SURVEY STUDY AP & LAT	This is no longer a valid code.	N/A
72020	RAD EXAM SPINE SNGL VIEW SPEC LEVEL	No pre-authorization is required for all providers.	N/A
72040	X-RAY EXAM NECK SPINE 3/<VWS	No pre-authorization is required for all providers.	N/A
72050	X-RAY EXAM NECK SPINE 4/5VWS	No pre-authorization is required for all providers.	N/A
72052	X-RAY EXAM NECK SPINE 6/>VWS	No pre-authorization is required for all providers.	N/A
72069	RAD EXAM SPINE THORACOLUMBAR STANDING	This is no longer a valid code.	N/A
72070	RAD EXAM SPINE; THORACIC ANTEROPOSTERIOR & LAT	No pre-authorization is required for all providers.	N/A
72072	RAD EXAM SPINE; THORACIC AP & LAT W/SWIM VIEW	No pre-authorization is required for all providers.	N/A
72074	RAD EXAM SPINE; THORACIC COMPLT W/OBLIQ MINI 4	No pre-authorization is required for all providers.	N/A
72080	X-RAY EXAM THORACOLMB 2/> VW	No pre-authorization is required for all providers.	N/A
72081	X-RAY EXAM ENTIRE SPI 1 VW	No pre-authorization is required for all providers.	N/A
72082	X-RAY EXAM ENTIRE SPI 2/3 VW	No pre-authorization is required for all providers.	N/A
72083	X-RAY EXAM ENTIRE SPI 4/5 VW	No pre-authorization is required for all providers.	N/A
72084	X-RAY EXAM ENTIRE SPI 6/> VW	No pre-authorization is required for all providers.	N/A
72090	RAD EXAM SPINE; SCOLIOSIS STUDY W/SUPINE & ERECT	This is no longer a valid code.	N/A
72100	RAD EXAM SPINE LUMBOSACRAL; AP & LAT	No pre-authorization is required for all providers.	N/A
72110	RAD EXAM SPINE LUMBOSACRAL; COMPLT W/OBLIQ VIEWS	No pre-authorization is required for all providers.	N/A
72114	X-RAY EXAM OF LOWER SPINE	No pre-authorization is required for all providers.	N/A
72120	X-RAY EXAM OF LOWER SPINE	No pre-authorization is required for all providers.	N/A
72125	CT CERV SPINE; W/O CONTRST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72126	CMPT TOMOGRPH CERV SPINE; W/CONTRST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72127	CT C-SPINE; W/O&W/CONTRST&OTH SECT	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72128	CT T-SPINE; W/O CONTRST MATL	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72129	CMPT TOMOGRPH T-SPINE; W/CONTRST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72130	CT T-SPINE; W/O&W/CONTRST&OTH SECT	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72131	CT LUMBAR SPINE; W/O CONTRST MATL	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72132	CT LUMBAR SPINE; W/CONTRST MATL	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72133	CT LUMB SP; W/O&W/CONTRST&OTH SECT	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72141	MRI SPINAL CANAL & CONTENTS CERV; WO CONTRAST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72142	MRI SPINAL CANAL & CONTENTS CERV; W/CONTRAST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72146	MRI SPINAL CANAL & CONTENTS THORACIC; WO CONTRST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72147	MRI SPINAL CANAL & CONTENTS THORACIC; W/CONTRAST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72148	MRI SPINAL CANAL & CONTENTS LUMBAR; WO CONTRAST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72149	MRI SPINAL CANAL & CONTENTS LUMBAR; W/CONTRAST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72156	MRI SPINAL CANAL WO THEN W/CONTRAST CERV	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72157	MRI SPINAL CANAL WO THEN W/CONTRAST; THORACIC	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72158	MRI SPINAL CANAL WO THEN W/CONTRAST; LUMBAR	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72159	MRI ANGIO SPINAL CANAL & CONTENTS W/WO CONTRAST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72170	RAD EXAM PELVIS; ANTEROPOSTERIOR ONLY	No pre-authorization is required for all providers.	N/A
72190	RAD EXAM PELVIS; COMPLT MINI 3 VIEWS	No pre-authorization is required for all providers.	N/A
72191	CTA PELVIS C-/C+ POST-PXESSING	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72192	CT PELVIS; W/O CONTRAST MATERIAL	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72193	CT PELVIS; W/CONTRAST MATERIAL	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72194	CT PELV; W/O & W/CONTRST&OTH SECT	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72195	MRI PELVIS; WO CONTRAST MAT 13.03	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72196	MRI PELVIS	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72197	MRI PELVIS; W/ & WO CONTRAST 27.86	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72198	MRI ANGIO PELVIS W/WO CONTRAST MAT	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
72200	RAD EXAM SACROILIAC JT; LESS THAN 3 VIEWS	No pre-authorization is required for all providers.	N/A
72202	RAD EXAM SACROILIAC JT; 3/MORE VIEWS	No pre-authorization is required for all providers.	N/A
72220	RAD EXAM SACRUM & COCCYX MINI 2 VIEWS	No pre-authorization is required for all providers.	N/A
72240	MYELOGRAPHY CERV-RAD S & I	No pre-authorization is required for all providers.	N/A
72255	MYELOGRAPHY THORACIC-RAD S & I	No pre-authorization is required for all providers.	N/A
72265	MYELOGRAPHY LUMBOSACRAL-RAD S & I	No pre-authorization is required for all providers.	N/A
72270	MYELOGRAPHY 2/MORE REGIONS RAD S&I	No pre-authorization is required for all providers.	N/A
72275	EPIDUROGRAPHY	No pre-authorization is required for all providers.	N/A
72285	DISKOGRAPHY CERV-RAD S & I	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
72291	RADIOLOGICAL SUPERVISION AND INTERPRETATION	This is no longer a valid code.	N/A
72292	UNDER CT GUIDANCE	This is no longer a valid code.	N/A
72295	DISKOGRAPHY LUMBAR-RAD S & I	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
73000	RAD EXAM; CLAV COMPLT	No pre-authorization is required for all providers.	N/A
73010	RAD EXAM; SCAPULA COMPLT	No pre-authorization is required for all providers.	N/A
73020	RAD EXAM SHOULDER; 1 VIEW	No pre-authorization is required for all providers.	N/A
73030	RAD EXAM SHOULDER; COMPLT MINI 2 VIEWS	No pre-authorization is required for all providers.	N/A
73040	RAD EXAM SHOULDER ARTHROGRAPHY-RAD S & I	No pre-authorization is required for all providers.	N/A
73050	RAD EXAM; ACROMIOCLAV JT BILAT W/WO WT DISTRACT	No pre-authorization is required for all providers.	N/A
73060	RAD EXAM; HUMERUS MINI 2 VIEWS	No pre-authorization is required for all providers.	N/A
73070	RAD EXAM ELBOW; ANTEROPOSTERIOR & LAT VIEWS	No pre-authorization is required for all providers.	N/A
73080	RAD EXAM ELBOW; COMPLT MINI 3 VIEWS	No pre-authorization is required for all providers.	N/A
73085	RAD EXAM ELBOW ARTHROGRAPHY-RAD S & I	No pre-authorization is required for all providers.	N/A
73090	RAD EXAM; FOREARM ANTEROPOSTERIOR & LAT VIEWS	No pre-authorization is required for all providers.	N/A

73092	RAD EXAM; UPPER EXTREM INFANT MINI 2 VIEWS	No pre-authorization is required for all providers.	N/A
73100	RAD EXAM WRIST; ANTEROPOSTERIOR & LAT VIEWS	No pre-authorization is required for all providers.	N/A
73110	RAD EXAM WRIST; COMPLT MINI 3 VIEWS	No pre-authorization is required for all providers.	N/A
73115	RAD EXAM WRIST ARTHROGRAPHY-RAD S & I	No pre-authorization is required for all providers.	N/A
73120	RAD EXAM HAND; 2 VIEWS	No pre-authorization is required for all providers.	N/A
73130	RAD EXAM HAND; MINI 3 VIEWS	No pre-authorization is required for all providers.	N/A
73140	RAD EXAM FINGER(S) MINI 2 VIEWS	No pre-authorization is required for all providers.	N/A
73200	CT UPPER EXT; W/O CONTRAST MATL	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73201	CT UPPER EXT; W/CONTRST MATL	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73202	CT UP EXT; W/O & W/CONTRST&OTH SECT	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73206	CTA UXTR C-/C+ POST-PXESSING	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73218	MRI UP EXTREM OTH THAN JT WO CONTRA 12.82	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73219	MRI UP EXTREM NOT JT W/CONTRAST 15.36	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73220	MRI UPPER EXTREM OTHER THAN JT	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73221	MRI ANY JT UPPER EXTREM	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73222	MRI ANY JT UP EXTREM W/CONTRAST 15.36	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73223	MRI ANY JT UP EXTREM W/ & WO CONTRA 27.61	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73225	MRI ANGIO UPPER EXTREM W/WO CONTRAST MAT	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73500	RAD EXAM HIP; UNILAT 1 VIEW	This is no longer a valid code.	N/A
73501	X-RAY EXAM HIP UNI 1 VIEW	No pre-authorization is required for all providers.	N/A
73502	X-RAY EXAM HIP UNI 2-3 VIEWS	No pre-authorization is required for all providers.	N/A
73503	X-RAY EXAM HIP UNI 4/> VIEWS	No pre-authorization is required for all providers.	N/A
73510	RAD EXAM HIP; COMPLT MINI 2 VIEWS	This is no longer a valid code.	N/A
73520	RAD EXAM HIPS BILAT MIN 2 VIEWS W/AP VIEW PELVIS	This is no longer a valid code.	N/A
73521	X-RAY EXAM HIPS BI 2 VIEWS	No pre-authorization is required for all providers.	N/A
73522	X-RAY EXAM HIPS BI 3-4 VIEWS	No pre-authorization is required for all providers.	N/A
73523	X-RAY EXAM HIPS BI 5/> VIEWS	No pre-authorization is required for all providers.	N/A
73525	RAD EXAM HIP ARTHROGRAPHY-RAD S & I	No pre-authorization is required for all providers.	N/A
73530	RAD EXAM HIP DURING OR PROC	This is no longer a valid code.	N/A
73540	RAD EXAM PELVIS & HIPS INFANT/CHILD MINI 2 VIEWS	This is no longer a valid code.	N/A
73550	RAD EXAM FEMUR ANTEROPOSTERIOR & LAT VIEWS	This is no longer a valid code.	N/A
73551	X-RAY EXAM OF FEMUR 1	No pre-authorization is required for all providers.	N/A
73552	X-RAY EXAM OF FEMUR 2/>	No pre-authorization is required for all providers.	N/A
73560	RAD EXAM KNEE; ONE/TWO VIEWS	No pre-authorization is required for all providers.	N/A
73562	RAD EXAM KNEE; THREE VIEWS	No pre-authorization is required for all providers.	N/A
73564	RAD EXAM KNEE; COMPLT 4/MORE VIEWS	No pre-authorization is required for all providers.	N/A
73565	RAD EXAM KNEE; BOTH KNEES STANDING AP	No pre-authorization is required for all providers.	N/A
73580	RAD EXAM KNEE ARTHROGRAPHY-RAD S & I	No pre-authorization is required for all providers.	N/A
73590	RAD EXAM; TIB & FIB AP & LAT VIEWS	No pre-authorization is required for all providers.	N/A
73592	RAD EXAM; LOWER EXTREM INFANT MINI 2 VIEWS	No pre-authorization is required for all providers.	N/A
73600	RAD EXAM ANK; ANTEROPOSTERIOR & LAT VIEWS	No pre-authorization is required for all providers.	N/A
73610	RAD EXAM ANK; COMPLT MINI 3 VIEWS	No pre-authorization is required for all providers.	N/A
73615	RAD EXAM ANK ARTHROGRAPHY-RAD S & I	No pre-authorization is required for all providers.	N/A
73620	RAD EXAM FT; ANTEROPOSTERIOR & LAT VIEWS	No pre-authorization is required for all providers.	N/A
73630	RAD EXAM FT; COMPLT MINI 3 VIEWS	No pre-authorization is required for all providers.	N/A
73650	RAD EXAM; CALCAN MINI 2 VIEWS	No pre-authorization is required for all providers.	N/A
73660	RAD EXAM; TOE(S) MINI 2 VIEWS	No pre-authorization is required for all providers.	N/A
73700	CT LOWER EXT; W/O CONTRST MATL	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73701	CMPT TOMOGRPH LOWER EXT; W/CONTRAST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73702	CT LW EXT; W/O & W/CONTRST&OTH SECT	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73706	CTA LXTR C-/C+ POST-PXESSING	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73718	MRI LOW EXTREM NOT JT WO CONTRAST 12.82	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73719	MRI LOW EXTREM W/CONTRAST MAT 15.36	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73720	MRI LOWER EXTREM OTHER THAN JT	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73721	MRI ANY JT LOWER EXTREM	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73722	MRI ANY JT LOW EXTREM; W/CONTRAST 15.36	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73723	MRI ANY JT LO EXTREM W/ & WO CONTRS 27.61	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
73725	MRI ANGIO LOWER EXTREM W/WO CONTRAST MAT	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
74000	RAD EXAM ABD; SNGL ANTEROPOSTERIOR VIEW	This is no longer a valid code.	N/A
74010	RAD EXAM ABD; AP & ADD OBLIQ & CONE VIEWS	This is no longer a valid code.	N/A
74018	X-RAY EXAM ABDOMEN 1 VIEW	No pre-authorization is required for all providers.	N/A
74019	X-RAY EXAM ABDOMEN 2 VIEWS	No pre-authorization is required for all providers.	N/A
74020	RAD EXAM ABD; COMPLT INCL DECUBITUS &/OR ERECT	This is no longer a valid code.	N/A
74021	X-RAY EXAM ABDOMEN 3+ VIEWS	No pre-authorization is required for all providers.	N/A
74022	RADIOLOGIC EXAM COMPLETE ACUTE ABDOMEN SERIES	No pre-authorization is required for all providers.	N/A
74150	CMPT TOMOGRPH ABD; W/O CONTRST MATL	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
74160	CMPT TOMOGRPH ABD; W/CONTRST MATL	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
74170	CT ABD; W/O & W/CONTRST&OTH SECT	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
74174	CT ANGIO ABD&PELV W/O&W/DYE	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
74175	CTA ABD C-/C+ POST-PXESSING	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
74176	CT ABD & PELVIS W/O CONTRAST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
74177	CT ABD & PELV W/CONTRAST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
74178	CT ABD & PELV 1/> REGNS	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
74181	MRI ABD	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
74182	MRI ABD W/CONTRAST MAT 15.58	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
74183	MRI ABD W/ & WO CONTRAST 27.86	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
74185	MRI ANGIO ABD W/WO CONTRAST MAT	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
74190	PERITONEOGRAM-RAD S & I	No pre-authorization is required for all providers.	N/A
74210	RADIOLOGIC EXAM PHRNX AND /CRV ESOPH CONTRAST STUDY	No pre-authorization is required for all providers.	N/A
74220	RADIOLOGIC EXAM ESOPHAGUS SINGLE CONTRAST STUDY	No pre-authorization is required for all providers.	N/A
74221	RADIOLOGIC EXAM ESOPHAGUS DOUBLE CONTRAST STUDY	No pre-authorization is required for all providers.	N/A
74230	RADIOLOGIC EXAM SWALLOW FUNCTION CONTRAST STUDY	No pre-authorization is required for all providers.	N/A
74235	REMOV FB ESOPH W/USE BALLOON CATH-RAD S & I	No pre-authorization is required for all providers.	N/A
74240	RADIOLOGIC EXAM UPGR GI TRC SINGLE CONTRAST STUDY	No pre-authorization is required for all providers.	N/A
74241	X-RAY UPPER GI DELAY W/KUB	No pre-authorization is required for all providers.	N/A
74245	X-RAY UPPER GI&SMALL INTEST	No pre-authorization is required for all providers.	N/A
74246	RADIOLOGIC EXAM UPGR GI TRC DOUBLE CONTRAST STUDY	No pre-authorization is required for all providers.	N/A
74247	CONTRST X-RAY UPGR GI TRACT	No pre-authorization is required for all providers.	N/A
74248	RADIOLOGIC SMALL INTESTINE FOLLOW-THROUGH STUDY	No pre-authorization is required for all providers.	N/A
74249	RAD EXAM GI TRACT UPPER-AIR CONTRAST; W/SM BOWEL	No pre-authorization is required for all providers.	N/A
74250	RADIOLOGIC EXAM SMALL INT SINGLE CONTRAST STUDY	No pre-authorization is required for all providers.	N/A
74251	RADIOLOGIC EXAM SMALL INT DOUBLE CONTRAST STUDY	No pre-authorization is required for all providers.	N/A
74260	DUODENOGRAPHY HYPOTONIC	No pre-authorization is required for all providers.	N/A
74261	CT COLONOGRAPHY, W/O DYE	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
74262	CT COLONOGRAPHY, W/DYE	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
74263	CT COLONOGRAPHY, SCREEN	No pre-authorization is required for all providers.	N/A
74270	RADIOLOGIC EXAM COLON SINGLE CONTRAST STUDY	No pre-authorization is required for all providers.	N/A
74280	RADIOLOGIC EXAM COLON DOUBLE CONTRAST STUDY	No pre-authorization is required for all providers.	N/A
74283	THERAP ENEMA-CM/AIR-REDUC INTUSSUSCEP/OTH OBSTR	No pre-authorization is required for all providers.	N/A
74290	CHOLECYSTOGRAPHY ORAL CONTRAST	No pre-authorization is required for all providers.	N/A
74291	CHOLECYSTOGRAPHY ORAL CONTRAST; ADD/REPEAT EXAM	This is no longer a valid code.	N/A
74300	CHOLANGIOGRAPHY; INTRAOP-RAD S & I	No pre-authorization is required for all providers.	N/A
74301	CHOLANGIOGRAPHY; ADD SET INTRAOP-RAD S & I	No pre-authorization is required for all providers.	N/A
74305	CHOLANGIOGRAPHY; POSTOP-RAD S & I	This is no longer a valid code.	N/A
74320	CHOLANGIOGRAPHY PERCUT TRANSHEPATIC-RAD S & I	This is no longer a valid code.	N/A
74327	POSTOP BILI DUCT STONE REMOV-RAD S & I	This is no longer a valid code.	N/A
74328	ENDO CATH-BILI DUCTAL SYST-RAD S & I	No pre-authorization is required for all providers.	N/A
74329	ENDO CATH-PANCREATIC DUCTAL SYST-RAD S & I	No pre-authorization is required for all providers.	N/A
74330	COMBO ENDO CATH-BILI & PANCREAT DUCTAL-RAD S & I	No pre-authorization is required for all providers.	N/A
74340	X-RAY GUIDE FOR GI TUBE	No pre-authorization is required for all providers.	N/A
74355	PERCUT PLCMT ENTEROCYCLYSIS TUBE-RAD S & I	No pre-authorization is required for all providers.	N/A

74360	INTRALUMINAL DILAT STRICT &/OR OBSTRUC-RAD S & I	No pre-authorization is required for all providers.	N/A
74363	PERCUT TRANSHEPATIC DILAT BILI STRICT-RAD S & I	No pre-authorization is required for all providers.	N/A
74400	UROGRAPHY IV W/WO KUB W/WO TOMOGRAPHY	No pre-authorization is required for all providers.	N/A
74410	UROGRAPHY INFUSION DRIP TECH &/OR BOLUS TECH	No pre-authorization is required for all providers.	N/A
74415	UROGRAPHY INFUSION DRIP &/OR BOLUS; W/NEPHROTOM	No pre-authorization is required for all providers.	N/A
74420	UROGRAPHY RETROGRADE W/WO KUB	No pre-authorization is required for all providers.	N/A
74425	UROGRAPHY ANTEGRADE-RAD S & I	No pre-authorization is required for all providers.	N/A
74430	CYSTOGRAPHY MINI 3 VIEWS-RAD S & I	No pre-authorization is required for all providers.	N/A
74440	VASOGRPHY/VESICULOGRPHY/EPIDIDYMOGRPHY-RAD S & I	No pre-authorization is required for all providers.	N/A
74445	CORPORA CAVERNOSOGRAPHY-RAD S & I	No pre-authorization is required for all providers.	N/A
74450	URETHROCYSTOGRAPHY RETROGRADE-RAD S & I	No pre-authorization is required for all providers.	N/A
74455	URETHROCYSTOGRAPHY VOIDING-RAD S & I	No pre-authorization is required for all providers.	N/A
74470	RAD EXAM-RENAL CYST STUDY-TRANSLUMBAR-RAD S & I	No pre-authorization is required for all providers.	N/A
74475	INTRO INTRACATH-RENAL PELVIS-PERCUT-RAD S & I	This is no longer a valid code.	N/A
74480	INTRO URETERAL CATH THRU RENAL PELVIS-RAD S & I	This is no longer a valid code.	N/A
74485	DILATION URETERS/URETHRA R S AND I	No pre-authorization is required for all providers.	N/A
74710	PELVIMETRY W/WO PLACENTAL LOCALIZ	No pre-authorization is required for all providers.	N/A
74712	MRI FETAL SNGL/1ST GESTATION	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
74713	MRI FETAL EA ADDL GESTATION	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
74740	HYSTEOSALPINGOGRAPHY-RAD S & I	No pre-authorization is required for all providers.	N/A
74742	TRANSCERV CATH FALLOPIAN TUBE-RAD S & I	This service is not covered by Superior HealthPlan.	N/A
74775	PERINEOGRAM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
75552	CARDIAC MRI-MORPHOLOGY; WO CONTRAST MAT	No pre-authorization is required for all providers.	N/A
75556	CARDIAC MRI VELOCITY-FLOW MAPPING	No pre-authorization is required for all providers.	N/A
75557	CARDIAC MRI FOR MORPH	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
75559	CARDIAC MRI W/STRESS IMG	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
75561	CARDIAC MRI FOR MORPH W/DYE	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
75563	CARD MRI W/STRESS IMG & DYE	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
75565	CARD MRI VEL FLW MAP ADD-ON	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
75571	CT HRT W/O DYE W/CA TEST	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
75572	CT HRT W/3D IMAGE	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
75573	CT HRT W/3D IMAGE, CONGEN	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
75574	CT ANGIO HRT W/3D IMAGE	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
75600	AORTOGRAPHY THORACIC WO SERIOLOGRAPHY-RAD S & I	No pre-authorization is required for all providers.	N/A
75605	AORTOGRAPHY THORACIC-SERIOLOGRAPHY-RAD S & I	No pre-authorization is required for all providers.	N/A
75625	AORTOGRAPHY ABD-SERIOLOGRAPHY-RAD S & I	No pre-authorization is required for all providers.	N/A
75630	AORTOGRAPHY ABD+BILAT ILIOFEM LOWER EXTREM-S & I	No pre-authorization is required for all providers.	N/A
75635	CTA AA&BI ILIOFEM LXTR RS&I C-/C+ POST-PXESSING	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
75658	ANGIO BRACHIAL RETROGRADE-RAD S & I	This is no longer a valid code.	N/A
75705	ANGIO SPINAL SELECT-RAD S & I	No pre-authorization is required for all providers.	N/A
75710	ANGIO EXTREM UNILAT-RAD S & I	No pre-authorization is required for all providers.	N/A
75716	ANGIO EXTREM BILAT-RAD S & I	No pre-authorization is required for all providers.	N/A
75726	ANGIO VISCERAL SELECT/SUPRASELECT-RAD S & I	No pre-authorization is required for all providers.	N/A
75731	ANGIO ADRENAL UNILAT SELECT-RAD S & I	No pre-authorization is required for all providers.	N/A
75733	ANGIO ADRENAL BILAT SELECT-RAD S & I	No pre-authorization is required for all providers.	N/A
75736	ANGIO PELVIC SELECT/SUPRASELECT-RAD S & I	No pre-authorization is required for all providers.	N/A
75741	ANGIO PULM UNILAT SELECT-RAD S & I	No pre-authorization is required for all providers.	N/A
75743	ANGIO PULM BILAT SELECT-RAD S & I	No pre-authorization is required for all providers.	N/A
75746	ANGIO PULM-NONSELECT CATH/VENOUS INJ-RAD S & I	No pre-authorization is required for all providers.	N/A
75756	ANGIO INT MAMMARY-RAD S & I	No pre-authorization is required for all providers.	N/A
75774	ANGIO SELECT EA ADD VESSEL-AFTER BASIC EXAM-S&I	No pre-authorization is required for all providers.	N/A
75791	AV DIALYSIS SHUNT IMAGING	This is no longer a valid code.	N/A
75801	LYMPHANGIOGRAPHY EXTREM ONLY UNILAT-RAD S & I	No pre-authorization is required for all providers.	N/A
75803	LYMPHANGIOGRAPHY EXTREM ONLY BILAT-RAD S & I	No pre-authorization is required for all providers.	N/A
75805	LYMPHANGIOGRAPHY PELVIC/ABD UNILAT-RAD S & I	No pre-authorization is required for all providers.	N/A
75807	LYMPHANGIOGRAPHY PELVIC/ABD BILAT-RAD S & I	No pre-authorization is required for all providers.	N/A
75809	SHUNTOGM INVESTIGAT PREV PLACED SHUNT-RAD S & I	No pre-authorization is required for all providers.	N/A
75810	SPLENOPTOGRAPHY-RAD S & I	No pre-authorization is required for all providers.	N/A
75820	VENOGRAPHY EXTREM UNILAT-RAD S & I	No pre-authorization is required for all providers.	N/A
75822	VENOGRAPHY EXTREM BILAT-RAD S & I	No pre-authorization is required for all providers.	N/A
75825	VENOGRAPHY CAVAL INFERIOR W/SERIOLOG-RAD S & I	No pre-authorization is required for all providers.	N/A
75827	VENOGRAPHY CAVAL SUPER W/SERIOLOGRAPHY-RAD S & I	No pre-authorization is required for all providers.	N/A
75831	VENOGRAPHY RENAL UNILAT SELECT-RAD S & I	No pre-authorization is required for all providers.	N/A
75833	VENOGRAPHY RENAL BILAT SELECT-RAD S & I	No pre-authorization is required for all providers.	N/A
75840	VENOGRAPHY ADRENAL UNILAT SELECT-RAD S & I	No pre-authorization is required for all providers.	N/A
75842	VENOGRAPHY ADRENAL BILAT SELECT-RAD S & I	No pre-authorization is required for all providers.	N/A
75860	VENGRPH VNUS SINUS/JUG CATH RAD S&I	No pre-authorization is required for all providers.	N/A
75870	VENOGRAPHY SUPER SAGITTAL SINUS-RAD S & I	No pre-authorization is required for all providers.	N/A
75872	VENOGRAPHY EPIDURAL-RAD S & I	No pre-authorization is required for all providers.	N/A
75880	VENOGRAPHY ORBITAL-RAD S & I	No pre-authorization is required for all providers.	N/A
75885	PERCUT TRANSHEPATIC PORTOGRAPHY W/EVAL-RAD S & I	No pre-authorization is required for all providers.	N/A
75887	PERCUT TRANSHEPATIC PORTOGRPHY WO EVAL-RAD S & I	No pre-authorization is required for all providers.	N/A
75889	HEPATIC VENOGRAPHY WEDGED/FREE W/EVAL-RAD S & I	No pre-authorization is required for all providers.	N/A
75891	HEPATIC VENOGRAPHY WEDGED/FREE WO EVAL-RAD S & I	No pre-authorization is required for all providers.	N/A
75893	VENOUS SAMPL THRU CATH W/WO ANGIO-RAD S & I	No pre-authorization is required for all providers.	N/A
75894	TRANSCATH THERAP EMBOLIZATION-RAD S & I	No pre-authorization is required for all providers.	N/A
75896	X-RAYS TRANSCATH THERAPY	This is no longer a valid code.	N/A
75898	FOLLOW-UP ANGIOGRAPHY	No pre-authorization is required for all providers.	N/A
75901	MECH REMV PERICATH OBST CV RAD S&I	No pre-authorization is required for all providers.	N/A
75902	MECH REMV OBST CV DEV LUMN RAD S&I	No pre-authorization is required for all providers.	N/A
75945	INTRAVASC US (NON-CORN) RAD S/I; INITIAL VESSEL	This is no longer a valid code.	N/A
75946	INTRAVASC US RAD S/I; EA ADD NON-CORNARY VESSEL	This is no longer a valid code.	N/A
75952	ENDOVASC REPR ABD AO ANEUR-RAD S&I 6.28	This is no longer a valid code.	N/A
75953	PLCMT EXT PROS REP ANEUR RAD S&I	This is no longer a valid code.	N/A
75954	ILIAC ANEURYSM ENDOVAS RPR	This is no longer a valid code.	N/A
75956	EVASC RPR DTA COVERAGE L SUBCLA ORIGIN RS&I	No pre-authorization is required for all providers.	N/A
75957	EVASC RPR DTA X COVERAGE L SUBCLA ORIGIN RS&I	No pre-authorization is required for all providers.	N/A
75958	PLMT PROX XTN PROSTH EVASC RPR DTA RS&I	No pre-authorization is required for all providers.	N/A
75959	PLMT DSTL XTN PROSTH AFTER EVASC RPR DTA RS&I	No pre-authorization is required for all providers.	N/A
75960	TRANSCATH IV STENT RS&I	This is no longer a valid code.	N/A
75962	REPAIR ARTERIAL BLOCKAGE	This is no longer a valid code.	N/A
75964	REPAIR ARTERY BLOCKAGE EACH	This is no longer a valid code.	N/A
75966	TRANSLUM BALOON ANGIOPL RENAL/VISCERAL ART-S & I	This is no longer a valid code.	N/A
75968	TRANSLUM BALLOON ANGIOPL EA ADD VISCERAL ART-S&I	This is no longer a valid code.	N/A
75970	TRANSCATH BX-RAD S & I	No pre-authorization is required for all providers.	N/A
75978	TRANSLUMINAL BALLOON ANGIOPL VENOUS-RAD S & I	This is no longer a valid code.	N/A
75980	PERCUT TRANSHEPATIC BILI DRAIN W/CONTRST-RAD S&I	This is no longer a valid code.	N/A
75982	PERCUT PLCMT DRAIN CATH-INOPER OBSTRCT-RAD S & I	This is no longer a valid code.	N/A
75984	CHNG PRQ TUBE/DRAINAGE CATH W CONTRAST RS&I	No pre-authorization is required for all providers.	N/A
75989	RAD GUID DRN PLCMT CATH RAD S&I	No pre-authorization is required for all providers.	N/A
75995	TRANSLUMINAL ATHERECTOMY VISCERAL-RAD S & I	No pre-authorization is required for all providers.	N/A
75996	TRANSLUM ATHERECT EA ADD VISCERAL ART-RAD S & I	No pre-authorization is required for all providers.	N/A
76000	FLUOROSCOPY <1 HR PHYS/QHP	No pre-authorization is required for all providers.	N/A
76001	FLUOROSCOPE EXAM EXTENSIVE	This is no longer a valid code.	N/A
76010	RAD EXAM NOSE TO RECTUM FOR FB SNGL FILM-CHILD	No pre-authorization is required for all providers.	N/A
76040	BONE LENGTH STUDIES	No pre-authorization is required for all providers.	N/A
76065	RAD EXAM OSSEOUS SURVEY INFANT	No pre-authorization is required for all providers.	N/A
76066	JT SURVEY SNGL VIEW 1/MORE JT	No pre-authorization is required for all providers.	N/A
76076	DEXA 1/MORE SITES; APPENDICULAR SKELETON	No pre-authorization is required for all providers.	N/A
76077	DXA BONE DENSITY STUDY 1/> SITES; VERT FX ASSESS	No pre-authorization is required for all providers.	N/A
76078	RADIOGRAPHIC ABSORPTIOMETRY 1/MORE SITES	No pre-authorization is required for all providers.	N/A

76080	RAD EXAM ABCS/FISTULA/SINUS TRACT STUDY-RAD S&I	No pre-authorization is required for all providers.	N/A
76082	CMPT AID DETECT MD INTEPR DX MAMMO	No pre-authorization is required for all providers.	N/A
76083	CMPT AID DETECT MD INTEPR SCR MAMMO	No pre-authorization is required for all providers.	N/A
76086	MAMMARY DUCTOGM/GALACTOGM-SNGL DUCT-RAD S & I	No pre-authorization is required for all providers.	N/A
76088	MAMMARY DUCTOGRAM/GALACTOGRAM-MX DUCTS-RAD S & I	No pre-authorization is required for all providers.	N/A
76090	MAMMO; UNILAT	No pre-authorization is required for all providers.	N/A
76091	MAMMO; BILAT	No pre-authorization is required for all providers.	N/A
76092	SCREENING MAMMO BILAT	No pre-authorization is required for all providers.	N/A
76093	MRI BREAST WO &/OR W/CONTRAST; UNILAT	No pre-authorization is required for all providers.	N/A
76094	MRI BREAST WO &/OR W/CONTRAST; BILAT	No pre-authorization is required for all providers.	N/A
76095	STEREOTACTIC LOCALIZ BREAST BX-EA LES-RAD S & I	No pre-authorization is required for all providers.	N/A
76096	PREOP PLCMT NEEDLE LOCALIZ WIRE BREAST-RAD S & I	No pre-authorization is required for all providers.	N/A
76098	RAD EXAM SURG SPECMN	No pre-authorization is required for all providers.	N/A
76100	RAD EXAM 1 PLANE BODY SECT OTHER THAN W/UROGRPHY	No pre-authorization is required for all providers.	N/A
76101	RAD EXAM COMPLX MOTION BODY SECT-NOT UROG; UNILA	No pre-authorization is required for all providers.	N/A
76102	RAD EXAM COMPLX MOTION BODY SECT-NOT UROG; BILAT	No pre-authorization is required for all providers.	N/A
76120	CINERADIOGRAPHY EX WHERE SPEC INCL	No pre-authorization is required for all providers.	N/A
76125	CINERADIOGRAPHY-COMPLEMENT ROUTINE EXAM	No pre-authorization is required for all providers.	N/A
76140	CONS X-RAY EXAM MADE ELSEWHERE WRITTEN REPORT	This service is not covered by Superior HealthPlan.	N/A
76350	SUBTRACTION CONJUNCTION W/CONTRAST STUDIES	No pre-authorization is required for all providers.	N/A
76355	CMPT TOMOGRAPHY GUID STEREOAC LOC	No pre-authorization is required for all providers.	N/A
76360	CT GUID NEEDLE PLACEMENT RAD S&I	No pre-authorization is required for all providers.	N/A
76362	CT GUID & MON VISCERAL TISS ABLAT	No pre-authorization is required for all providers.	N/A
76370	CMPT TOMOGRPH GUID PLCMT RTX FIELDS	No pre-authorization is required for all providers.	N/A
76376	3D RENDER W/INTRP POSTPROCES	No pre-authorization is required for all providers.	N/A
76377	3D RENDER W/INTRP POSTPROCES	No pre-authorization is required for all providers.	N/A
76380	CMPT TOMOGRAPHY LTD/LOC F/U STUDY	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
76390	MAGNETIC RESONANCE SPECTROSCOPY	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
76391	MAGNETIC RESONANCE ELASTOGRAPHY	No pre-authorization is required for all providers.	N/A
76393	MR GUID NEEDLE PLCMT RAD S&I 13.68	No pre-authorization is required for all providers.	N/A
76394	MR GUID&MON VISCERAL TISSUE ABLAT	No pre-authorization is required for all providers.	N/A
76400	MRI BONE MARROW BLD SUPPLY	No pre-authorization is required for all providers.	N/A
76490	US GUIDANCE FOR TISSUE ABLATION	No pre-authorization is required for all providers.	N/A
76496	UNLISTED FLUOROSCOPIC PROCEDURE	No pre-authorization is required for all providers.	N/A
76497	UNLISTED COMPUTED TOMOGRAPHY PROC	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
76498	UNLISTED MAGNETIC RESONANCE PROC	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
76499	UNLISTED DX RADIOGRAPHIC PROC	No pre-authorization is required for all providers.	N/A
76506	ECHOENCEPHALOGRAPHY REAL TIME IMAGING	No pre-authorization is required for all providers.	N/A
76510	OPHTHALMIC US DX; B-SCAN&QUAN A-SCAN SAME ENCNTN	No pre-authorization is required for all providers.	N/A
76511	OPHTH ULTRASOUND ECHO DX; A-SCAN ONLY	No pre-authorization is required for all providers.	N/A
76512	OPHTH ULTRASOUND ECHO DX; CONTACT B-SCAN	No pre-authorization is required for all providers.	N/A
76513	OPHTH ULTRASOUND ECHO DX; IMMERSION B-SCAN	No pre-authorization is required for all providers.	N/A
76514	OPHTHALMC US ECHO DX CORNL PACHYMTR	No pre-authorization is required for all providers.	N/A
76516	OPHTH BIOMETRY BY ULTRASOUND ECHO A-SCAN	No pre-authorization is required for all providers.	N/A
76519	OPHTH BIOMETRY A-SCAN; W/IO LENS POWER CALCULAT	No pre-authorization is required for all providers.	N/A
76529	OPHTH ULTRASONIC FB LOCALIZ	No pre-authorization is required for all providers.	N/A
76536	ULTRASOUND-SOFT TISSUE HEAD/NECK REAL TIME W/IMAGE DOCUMENTATION	No pre-authorization is required for all providers.	N/A
76604	ULTRASOUND-CHEST (INCLUDES MEDIASTINUM) REAL TIME W/IMAGE DOCUMENTATION	No pre-authorization is required for all providers.	N/A
76641	ULTRASOUND BREAST COMPLETE	No pre-authorization is required for all providers.	N/A
76642	ULTRASOUND BREAST LIMITED	No pre-authorization is required for all providers.	N/A
76645	ULTRASOUND-BREAST(S) (UNILATERAL/BILATERAL) RL TIME W/IMG DOCUMENTATION	This is no longer a valid code.	N/A
76700	ULTRASOUND-ABDOMINAL, REAL TIME W/IMAGE DOCUMENTATION, COMPLETE	No pre-authorization is required for all providers.	N/A
76705	ECHO ABD B-SCAN &/OR REAL TIME W/IMAGE DOC; LTD	No pre-authorization is required for all providers.	N/A
76706	US ABDOMINAL AORTA REAL TIME SCREEN STUDY AAA	Authorization is required for non-participating independent labs. For all other providers, no authorization is required.	Prior to 09/01/2019
76770	ULTRASOUND-RETROPERITONEAL, REAL TIME W/ IMAGE DOCUMENTATION, COMPLETE	No pre-authorization is required for all providers.	N/A
76775	ECHO RETROPERITON B-SCAN W/IMAGE DOCUMENT; LTD	No pre-authorization is required for all providers.	N/A
76776	ULTRASOUND, TRANSPLANTED KIDNEY	No pre-authorization is required for all providers.	N/A
76778	ECHO TRANSPL KIDNEY B-SCAN W/IMAGE DOCUMEN	No pre-authorization is required for all providers.	N/A
76800	ECHO SPINAL CANAL & CONTENTS	No pre-authorization is required for all providers.	N/A
76801	RTU PG UTRUS 1 TRI ABD;1/1 GEST	No pre-authorization is required for all providers.	N/A
76802	RTU PG UTRUS 1 TRI TRNSABD; EA GEST	No pre-authorization is required for all providers.	N/A
76805	RTU UTRUS AFTR 1 TRI ABD; 1/1 GEST	No pre-authorization is required for all providers.	N/A
76810	RTU UTRUS AFTR 1 TRI ABD; EA GEST	No pre-authorization is required for all providers.	N/A
76811	RTU PG UTRUS FETL ANAT ABD;1/1 GEST	No pre-authorization is required for all providers.	N/A
76812	RTU PG UTRUS FETL ANAT ABD; EA GEST	No pre-authorization is required for all providers.	N/A
76813	ULTRASOUND, PREGNANT UTERUS	No pre-authorization is required for all providers.	N/A
76814	EACH ADDITIONAL GESTATION	No pre-authorization is required for all providers.	N/A
76815	RTU PG UTRUS LTD 1/MORE FETUSES	No pre-authorization is required for all providers.	N/A
76816	RTU PG UTRUS F/U TRANSABD FETUS	No pre-authorization is required for all providers.	N/A
76817	RTU PG UTRUS W/IMAG DOC TRANSVAG	No pre-authorization is required for all providers.	N/A
76818	FETAL BIOPHYSICAL PROFILE	No pre-authorization is required for all providers.	N/A
76819	FETAL BIOPHYS PROFILE WO NONSTRESS 2.58	No pre-authorization is required for all providers.	N/A
76820	DOPPLER VELOCIMETRY FETAL; UMBILICAL ARTERY	No pre-authorization is required for all providers.	N/A
76821	DOPPLER VELOCIMETRY FETAL; MIDDLE CEREBRAL ART	No pre-authorization is required for all providers.	N/A
76825	ECHO FETAL-CV SYST-REAL TIME W/IMAGE DOCUMEN	No pre-authorization is required for all providers.	N/A
76826	ECHO FETAL-CV SYST-REAL TIME W/DOCUMENT; REPEAT	No pre-authorization is required for all providers.	N/A
76827	DOPPLER ECHO FETAL-CV SYST-PULSED WAVE; COMPLT	No pre-authorization is required for all providers.	N/A
76828	DOPPLER ECHO FETAL-CV SYST-PULSED WAVE; REPEAT	No pre-authorization is required for all providers.	N/A
76830	ECHO TRANSVAGINAL	No pre-authorization is required for all providers.	N/A
76831	SIS INCL COLOR DOPPLER WHEN PRFRMED	No pre-authorization is required for all providers.	N/A
76856	ULTRASOUND-PELVIC (NONOBSTETRIC), REAL TM W/IMAGE DOCUMENTATION, COMPL	No pre-authorization is required for all providers.	N/A
76857	ECHO PELVIC B-SCAN W/IMAGE DOCUMEN; LTD/F U	No pre-authorization is required for all providers.	N/A
76870	ECHO SCROTUM & CONTENTS	No pre-authorization is required for all providers.	N/A
76872	ULTRASOUND TRANSRECTAL	No pre-authorization is required for all providers.	N/A
76873	US TRNSREC PROSTATE TX PLAN-SP	No pre-authorization is required for all providers.	N/A
76881	US COMPL JOINT R-T W/IMG	No pre-authorization is required for all providers.	N/A
76882	US LMTD JT/NONVASC XTR STRUX	No pre-authorization is required for all providers.	N/A
76885	US EXAM INFANT HIPS DYNAMIC	No pre-authorization is required for all providers.	N/A
76886	US EXAM INFANT HIPS STATIC	No pre-authorization is required for all providers.	N/A
76930	ULTRASONIC GUIDANCE PERICARDIOCENTESIS-RAD S & I	No pre-authorization is required for all providers.	N/A
76932	ULTRASONIC GUIDANCE ENDOMYOCARDIAL BX-RAD S & I	No pre-authorization is required for all providers.	N/A
76936	US GUID COMPRESS REPR ART PSEUDO-ANEUR/AV FISTUL	No pre-authorization is required for all providers.	N/A
76937	US GUID VASC ACSS SITE PERM REC&RPT	No pre-authorization is required for all providers.	N/A
76940	ULTRASOUND GUIDANCE FOR/MONITORING OF/ PARENCHYMAL TISSUE ABLATION	No pre-authorization is required for all providers.	N/A
76941	US GUID IN UTERO FETAL TRNSFUS/CORDCENTESIS-S&I	No pre-authorization is required for all providers.	N/A
76942	ULTRASONIC GUIDANCE NEEDLE BX-RAD S & I	No pre-authorization is required for all providers.	N/A
76945	US GUID CHORIONIC VILLUS SAMPL-RAD S & I	No pre-authorization is required for all providers.	N/A
76946	ULTRASONIC GUIDANCE AMNIOCENTESIS-RAD S & I	No pre-authorization is required for all providers.	N/A
76948	ULTRASONIC GUIDANCE ASPIRAT OVA-RAD S & I	No pre-authorization is required for all providers.	N/A
76950	ECHO PLCMT RADIATION THERAP FIELDS B-SCAN	This is no longer a valid code.	N/A
76965	US GUID INTERST RADIOELEMENT APPLIC	No pre-authorization is required for all providers.	N/A
76970	ULTRASOUND STUDY F/U	No pre-authorization is required for all providers.	N/A
76975	GI ENDO ULTRASND-RAD S & I	No pre-authorization is required for all providers.	N/A
76977	US BONE DENSITY MEASUR & INTERP-PERIPH SITE(S)	No pre-authorization is required for all providers.	N/A
76978	ULTRASOUND TRGT DYNAMIC MICROBUBBLE 1ST LESION	No pre-authorization is required for all providers.	N/A
76979	ULTRASOUND TRGT DYNAMIC MICROBUBBLE EA ADDL LES	No pre-authorization is required for all providers.	N/A
76981	ULTRASOUND ELASTOGRAPHY PARENCHYMA	No pre-authorization is required for all providers.	N/A
76982	ULTRASOUND ELASTOGRAPHY FIRST TARGET LESION	No pre-authorization is required for all providers.	N/A
76983	ULTRASOUND ELASTOGRAPHY EA ADDL TARGET LESION	No pre-authorization is required for all providers.	N/A
76998	ULTRASONIC GUIDANCE, INTRAOPERATIVE	No pre-authorization is required for all providers.	N/A
76999	UNLISTED ULTRASOUND PROCEDURE	No pre-authorization is required for all providers.	N/A

77001	FLUOROSCOPIC GUIDANCE FOR CENTRAL VENOUS ACCESS DEVICE PLACEMENT	No pre-authorization is required for all providers.	N/A
77002	NEEDLE LOCALIZATION BY XRAY	No pre-authorization is required for all providers.	N/A
77003	FLUOROGUIDE FOR SPINE INJECT	No pre-authorization is required for all providers.	N/A
77011	COMPUTED TOMOGRAPHY GUIDANCE FOR STEROTACTIC LOCALIZATION	No pre-authorization is required for all providers.	N/A
77012	COMPUTED TOMOGRAPHY GUIDANCE FOR NEEDLE PLACEMENT	No pre-authorization is required for all providers.	N/A
77013	COMPUTERIZED TOMOGRAPHY GUIDANCE FOR, AND MONITORING	No pre-authorization is required for all providers.	N/A
77014	COMPUTED TOMOGRAPHY GUIDANCE	No pre-authorization is required for all providers.	N/A
77021	MRI GUIDANCE NEEDLE PLACEMENT R S AND I	No pre-authorization is required for all providers.	N/A
77022	MRI GUIDANCE FOR PARENCHYMAL TISSUE ABLATION	No pre-authorization is required for all providers.	N/A
77031	STEREOTACTIC LOCALIZATION GUIDANCE	This is no longer a valid code.	N/A
77032	MAMMOGRAPHIC GUIDANCE FOR NEEDLE PLACEMENT, BREAST	This is no longer a valid code.	N/A
77046	MRI BREAST WITHOUT CONTRAST MATERIAL UNILATERAL	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
77047	MRI BREAST WITHOUT CONTRAST MATERIAL BILATERAL	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
77048	MRI BREAST W/OUT AND WITH CONTRAST W/CAD UNILATERAL	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
77049	MRI BREAST WITHOUT AND WITH CONTRAST W/CAD BILATERAL	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
77051	COMPUTER DX MAMMOGRAM ADD-ON	This is no longer a valid code.	N/A
77052	COMP SCREEN MAMMOGRAM ADD-ON	This is no longer a valid code.	N/A
77053	MAMMARY DUCTOGRAM OR GALACTOGRAM	No pre-authorization is required for all providers.	N/A
77054	MAMMARY DUCTOGRAM OR GALACTOGRAM, MULTIPLE DUCTS,	No pre-authorization is required for all providers.	N/A
77055	MAMMOGRAPHY, UNILATERAL	This is no longer a valid code.	N/A
77056	MAMMOGRAPHY, BILATERAL	This is no longer a valid code.	N/A
77057	SCREENING MAMMOGRAPHY, BILATERAL	This is no longer a valid code.	N/A
77058	MRI, BREAST, WO AND/OR W CONTRAST MATERIAL(S)	This is no longer a valid code.	N/A
77059	MRI, BREAST, WO AND/OR W CONTRAST MATERIAL(S)	This is no longer a valid code.	N/A
77061	BREAST TOMOSYNTHESIS UNI	This service is not covered by Superior HealthPlan.	N/A
77062	BREAST TOMOSYNTHESIS BI	This service is not covered by Superior HealthPlan.	N/A
77063	BREAST TOMOSYNTHESIS BI	This service is not covered by Superior HealthPlan.	N/A
77065	DIAGNOSTIC MAMMOGRAPHY COMPUTER-AIDED DETCJ UNI	No pre-authorization is required for all providers.	N/A
77066	DIAGNOSTIC MAMMOGRAPHY COMPUTER-AIDED DETCJ BI	No pre-authorization is required for all providers.	N/A
77067	SCREENING MAMMOGRAPHY BI 2-VIEW BREAST INC CAD	No pre-authorization is required for all providers.	N/A
77071	X-RAY STRESS VIEW	No pre-authorization is required for all providers.	N/A
77072	BONE AGE STUDIES	No pre-authorization is required for all providers.	N/A
77073	BONE LENGTH STUDIES	No pre-authorization is required for all providers.	N/A
77074	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY	No pre-authorization is required for all providers.	N/A
77075	COMPLETE (AXIAL AND APPENDICULAR SKELETON)	No pre-authorization is required for all providers.	N/A
77076	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY, INFANT	No pre-authorization is required for all providers.	N/A
77077	JOINT SURVERY, SINGLE VIEW, 2 OR MORE JOINTS (SPECIFY)	No pre-authorization is required for all providers.	N/A
77078	COMPUTED TOMOGRAPHY, BONE MINERAL DENSITY	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
77080	DUAL-ENERGY X-RAY ABSORPTIOMETRY	No pre-authorization is required for all providers.	N/A
77081	APPENDICULAR SKELETON	No pre-authorization is required for all providers.	N/A
77082	VERTEBRAL FRACTURE ASSESMENT	This is no longer a valid code.	N/A
77084	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BONE MARROW BLOOD SUPPLY	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
77085	DXA BONE DENSITY STUDY	No pre-authorization is required for all providers.	N/A
77086	FRACTURE ASSESMENT VIA DXA	No pre-authorization is required for all providers.	N/A
77261	THERAP RAD TX PLANNING; SIMPL	No pre-authorization is required for all providers.	N/A
77262	THERAP RAD TX PLANNING; INTERMED	No pre-authorization is required for all providers.	N/A
77263	THERAP RAD TX PLANNING; COMPLX	No pre-authorization is required for all providers.	N/A
77280	THERAP RAD SIMULATION-AIDED FIELD SETTING; SIMPL	No pre-authorization is required for all providers.	N/A
77285	THERAP RAD SIMULAT-AIDED FIELD SETTING; INTERMED	No pre-authorization is required for all providers.	N/A
77290	THERAP RAD SIMULAT-AIDED FIELD SETTING; COMPLX	No pre-authorization is required for all providers.	N/A
77293	RESPIRATOR MOTION MGMT SIMUL	No pre-authorization is required for all providers.	N/A
77295	3-D RADIOTHERAPY PLAN	No pre-authorization is required for all providers.	N/A
77299	UNLISTED PROC THERAP RAD CLINICAL TX PLANNING	No pre-authorization is required for all providers.	N/A
77300	BASIC RAD DOSIMETRY CALCULAT-WHEN PRESCRIB BY MD	No pre-authorization is required for all providers.	N/A
77301	INTENSITY MODULATED RADIOTHERAPY PLAN	No pre-authorization is required for all providers.	N/A
77305	TELETHERAPY ISODOSE PLAN; SIMPL	This is no longer a valid code.	N/A
77306	TELETX ISODOSE PLAN SIMPLE	No pre-authorization is required for all providers.	N/A
77307	TELETX ISODOSE PLAN CPLX	No pre-authorization is required for all providers.	N/A
77310	TELETHERAPY ISODOSE PLAN; INTERMED	This is no longer a valid code.	N/A
77315	TELETHERAPY ISODOSE PLAN; COMPLX	This is no longer a valid code.	N/A
77316	BRACHYTX ISODOSE PLAN SIMPLE	No pre-authorization is required for all providers.	N/A
77317	BRACHYTX ISODOSE INTERMED	No pre-authorization is required for all providers.	N/A
77318	BRACHYTX ISODOSE COMPLEX	No pre-authorization is required for all providers.	N/A
77321	SPEC TELETHERAP PORT PLAN PARTICLES HEMI-TOT BOD	No pre-authorization is required for all providers.	N/A
77326	BRACHYTHERAPY ISODOSE PLAN; SIMPLE	This is no longer a valid code.	N/A
77327	BRACHYTX ISODOSE PLAN; INTERMEDIATE	This is no longer a valid code.	N/A
77328	BRACHYTHERAPY ISODOSE PLAN; COMPLEX	This is no longer a valid code.	N/A
77331	SPECIAL DOSIMETRY-WHEN PRESCRIB BY TX PHYS	This service is not covered by Superior HealthPlan.	N/A
77332	TX DEVICES DESIGN & CONSTRUCTION; SIMPL	No pre-authorization is required for all providers.	N/A
77333	TX DEVICES DESIGN & CONSTRUCTION; INTERMED	No pre-authorization is required for all providers.	N/A
77334	TX DEVICES DESIGN & CONSTRUCTION; COMPLX	No pre-authorization is required for all providers.	N/A
77336	CONT MED PHYSICS CONS REPORTED PER WK THER	This service is not covered by Superior HealthPlan.	N/A
77338	DESIGN MLC DEVICE FOR IMRT	No pre-authorization is required for all providers.	N/A
77370	SPECIAL MED RADIATION PHYSICS CONS	This service is not covered by Superior HealthPlan.	N/A
77371	RADIATION DELIVERY STEREOTACTIC CRANIAL COBALT	No pre-authorization is required for all providers.	N/A
77372	RADIATION DELIVERY STEREOTACTIC CRANIAL LINEAR	No pre-authorization is required for all providers.	N/A
77373	STEREOTACTIC BODY RADIATION THERAPY	No pre-authorization is required for all providers.	N/A
77385	NTSTY MODUL RAD TX DLVR SMPL	No pre-authorization is required for all providers.	N/A
77386	NTSTY MODUL RAD TX DLVR CPLX	No pre-authorization is required for all providers.	N/A
77387	GUIDANCE FOR LOCLZJ TARGET VOL FOR RADJ TX DLVR	No pre-authorization is required for all providers.	N/A
77399	UNLIST PROC MED RAD PHYSICS/DOSIMETRY & TX DEVIC	No pre-authorization is required for all providers.	N/A
77401	RADIATION TREATMENT DELIVERY	No pre-authorization is required for all providers.	N/A
77402	RADIATION TREATMENT DELIVERY	No pre-authorization is required for all providers.	N/A
77403	RAD TX DELIV-1 TX AREA-1 PORT-SMPL BLOC; 6-10MEV	This is no longer a valid code.	N/A
77404	RADIATION TX DELIV-1 TX AREA-1 PORT; 11-19 MEV	This is no longer a valid code.	N/A
77406	RADIAT TX DELIV-1 TX AREA-1 PORT; 20 MEV/GREATER	This is no longer a valid code.	N/A
77407	RADIATION TREATMENT DELIVERY	No pre-authorization is required for all providers.	N/A
77408	RAD TX DELIV-2 TX AREAS-3/MORE PORTS; 6-10 MEV	This is no longer a valid code.	N/A
77409	RAD TX DELIV-2 TX AREAS-3/MORE PORTS; 11-19 MEV	This is no longer a valid code.	N/A
77411	RAD TX DELIV-2 TX AREAS-3/MORE PORTS; 20 MEV/GRT	This is no longer a valid code.	N/A
77412	RADIATION TREATMENT DELIVERY	No pre-authorization is required for all providers.	N/A
77413	RADIATION TX DELIV-3/MORE TX AREAS; 6-10 MEV	This is no longer a valid code.	N/A
77414	RADIATION TX DELIV-3/MORE TX AREAS; 11-19 MEV	This is no longer a valid code.	N/A
77416	RADIAT TX DELIV-3/MORE TX AREAS; 20 MEV/GREATER	This is no longer a valid code.	N/A
77417	RADIOLOGY PORT IMAGES(S)	No pre-authorization is required for all providers.	N/A
77418	INTENSITY MODULATED TREATMENT DELIVERY	This is no longer a valid code.	N/A
77421	STRSC X-RAY GDN LOCLZJ TARGET VOL DLVR RADJ THER	This is no longer a valid code.	N/A
77422	HI NRG NEUTRON RADJ TX DLVR 1 TX AREA	This is no longer a valid code.	N/A
77423	NEUTRON BEAM TX COMPLEX	No pre-authorization is required for all providers.	N/A
77424	IO RAD TX DELIVERY BY X-RAY	No pre-authorization is required for all providers.	N/A
77425	IO RAD TX DELIVER BY ELCTRNS	No pre-authorization is required for all providers.	N/A
77427	RADIATION TX MANAGEMENT, X5	No pre-authorization is required for all providers.	N/A
77431	RADIATION THERAP MGMT W/COMPLT COURSE THERAP	No pre-authorization is required for all providers.	N/A
77432	STEREOTCTC RADIATION TX MANAGEMENT CRANIAL LESION	No pre-authorization is required for all providers.	N/A
77435	STEREOTACTIC BODY RADIATION THERAPY	No pre-authorization is required for all providers.	N/A
77469	IO RADIATION TX MANAGEMENT	No pre-authorization is required for all providers.	N/A
77470	SPECIAL RADIATION TREATMENT	No pre-authorization is required for all providers.	N/A
77499	UNLISTED PROC THERAP RAD CLINICAL TX MGMT	No pre-authorization is required for all providers.	N/A
77520	PROTON BEAM DELIVERY	No pre-authorization is required for all providers.	N/A
77522	PROTON TX DELIV; SIMPL W/COMPENSATN 0	No pre-authorization is required for all providers.	N/A
77523	PROTON BEAM DELIVERY	No pre-authorization is required for all providers.	N/A

77525	PROTON TX DELIV; COMPLX 0	No pre-authorization is required for all providers.	N/A
77600	HYPERThERMIa EXT GEN; SUPERF	This service is not covered by Superior HealthPlan.	N/A
77605	HYPERThERMIa EXT GEN; DEEP	This service is not covered by Superior HealthPlan.	N/A
77610	HYPERThERMIa GEN-INTERSTITIAL PROBE; 5/LESS APPL	This service is not covered by Superior HealthPlan.	N/A
77615	HYPERThERMIa GEN-INTERSTITIAL PROBE; > 5 APPLIC	This service is not covered by Superior HealthPlan.	N/A
77620	HYPERThERMIa GEN BY INTRACAVITARY PROBE	This service is not covered by Superior HealthPlan.	N/A
77750	INFUSION/INSTLL RADIOELEMENT SOLUTION	No pre-authorization is required for all providers.	N/A
77761	INTRACAVITARY RADIOELEMENT APPLIC; SIMPL	No pre-authorization is required for all providers.	N/A
77762	INTRACAVITARY RADIOELEMENT APPLIC; INTERMED	No pre-authorization is required for all providers.	N/A
77763	INTRACAVITARY RADIOELEMENT APPLIC; COMPLX	No pre-authorization is required for all providers.	N/A
77767	HDR RDNCL SKN SURF BRACHYTX	No pre-authorization is required for all providers.	N/A
77768	HDR RDNCL SKN SURF BRACHYTX	No pre-authorization is required for all providers.	N/A
77770	HDR RDNCL NTRSTL/ICAV BRCHTX	No pre-authorization is required for all providers.	N/A
77771	HDR RDNCL NTRSTL/ICAV BRCHTX	No pre-authorization is required for all providers.	N/A
77772	HDR RDNCL NTRSTL/ICAV BRCHTX	No pre-authorization is required for all providers.	N/A
77776	INTERSTITIAL RADIOELEMENT APPLIC; SIMPL	This is no longer a valid code.	N/A
77777	INTERSTITIAL RADIOELEMENT APPLIC; INTERMED	This is no longer a valid code.	N/A
77778	INTERSTITIAL RADIOELEMENT APPLIC; COMPLX	No pre-authorization is required for all providers.	N/A
77785	HDR BRACHYTX 1 CHANNEL	This is no longer a valid code.	N/A
77786	HDR BRACHYTX 2-12 CHANNEL	This is no longer a valid code.	N/A
77787	HDR BRACHYTX OVER 12 CHAN	This is no longer a valid code.	N/A
77789	APPLY SURF LDR RADIONUCLIDE	No pre-authorization is required for all providers.	N/A
77790	SUPERVS HANDLING LOADING-RADIOELEMENT	This service is not covered by Superior HealthPlan.	N/A
77799	UNLISTED PROC CLINICAL BRACHYTHERAP	No pre-authorization is required for all providers.	N/A
78012	THYROID UPTAKE MEASUREMENT	No pre-authorization is required for all providers.	N/A
78013	THYROID IMAGING W/BLOOD FLOW	No pre-authorization is required for all providers.	N/A
78014	THYROID IMAGING W/BLOOD FLOW	No pre-authorization is required for all providers.	N/A
78015	THYROID CARCINOMA METASTASES IMAGING; LTD AREA	No pre-authorization is required for all providers.	N/A
78016	THYROID CA METASTASES IMAG; W/ADD STUDIES	No pre-authorization is required for all providers.	N/A
78018	THYROID CARCINOMA METASTASES IMAGING; WHOLE BODY	No pre-authorization is required for all providers.	N/A
78020	THYROID CA METS UPTAKE	No pre-authorization is required for all providers.	N/A
78070	PARATHYROID PLANAR IMAGING	No pre-authorization is required for all providers.	N/A
78071	PARATHYRD PLANAR W/WO SUBTRJ	No pre-authorization is required for all providers.	N/A
78072	PARATHYRD PLANAR W/SPECT&CT	No pre-authorization is required for all providers.	N/A
78075	ADRENAL IMAGING CORTEX &/OR MEDULLA	No pre-authorization is required for all providers.	N/A
78099	UNLISTED ENDOCRINE PROC DX NUCLEAR MEDS	No pre-authorization is required for all providers.	N/A
78102	BONE MARROW IMAGING; LTD AREA	No pre-authorization is required for all providers.	N/A
78103	BONE MARROW IMAGING; MX AREAS	No pre-authorization is required for all providers.	N/A
78104	BONE MARROW IMAGING; WHOLE BODY	No pre-authorization is required for all providers.	N/A
78110	PLASMA VOLUM RADIOPHARM (SEPART PROC); 1 SAMPL	No pre-authorization is required for all providers.	N/A
78111	PLASMA VOLUM RADIOPHARM (SEPART PROC); MX SAMPL	No pre-authorization is required for all providers.	N/A
78120	RED CELL VOLUM DETERM (SEPART PROC); SNGL SAMPL	No pre-authorization is required for all providers.	N/A
78121	RED CELL VOLUM DETERM (SEPART PROC); MX SAMPL	No pre-authorization is required for all providers.	N/A
78122	WHOLE BLD VOLUM DETERM W/SEPART PLASMA/RBC VOLUM	No pre-authorization is required for all providers.	N/A
78130	RED CELL SURVIVAL STUDY	No pre-authorization is required for all providers.	N/A
78135	RED CELL SURVIVAL STUDY; DIFF ORGAN/TISS KINETIC	No pre-authorization is required for all providers.	N/A
78140	LABELED RED CELL SEQUESTRATION DIFF ORGAN/TISS	No pre-authorization is required for all providers.	N/A
78160	PLASMA RADIOIRON DISAP RATE	No pre-authorization is required for all providers.	N/A
78172	CHELATABLE IRON ESTIMATION TOT BODY IRON	No pre-authorization is required for all providers.	N/A
78185	SPLEEN IMAGING ONLY W/WO VASCULAR FLOW	No pre-authorization is required for all providers.	N/A
78190	KINETICS STUDY PLATELET SURVIVAL W/WO DIFF ORGAN	This is no longer a valid code.	N/A
78191	PLATELET SURVIVAL STUDY	No pre-authorization is required for all providers.	N/A
78195	LYMPHATICS & LYMPH GLANDS IMAGING	No pre-authorization is required for all providers.	N/A
78199	UNLIST HEMATOPOIETIC & LYMPHATIC PROC-DX NUCLEAR	No pre-authorization is required for all providers.	N/A
78201	LIVER IMAGING; STATIC ONLY	No pre-authorization is required for all providers.	N/A
78202	LIVER IMAGING; W/VASCULAR FLOW	No pre-authorization is required for all providers.	N/A
78205	LIVER IMAGING (SPECT);	No pre-authorization is required for all providers.	N/A
78206	LIVER IMAG (SPECT); W/VASC FLOW	No pre-authorization is required for all providers.	N/A
78215	LIVER & SPLEEN IMAGING; STATIC ONLY	No pre-authorization is required for all providers.	N/A
78216	LIVER & SPLEEN IMAGING; W/VASCULAR FLOW	No pre-authorization is required for all providers.	N/A
78226	HEPATOBILIARY SYSTEM IMAGING	No pre-authorization is required for all providers.	N/A
78227	HEPATOBIL SYST IMAGE W/DRUG	No pre-authorization is required for all providers.	N/A
78230	SALIVARY GLAND IMAGING	No pre-authorization is required for all providers.	N/A
78231	SALIVARY GLAND IMAGING; W/SERIAL IMAGES	No pre-authorization is required for all providers.	N/A
78232	SALIVARY GLAND FUNCT STUDY	No pre-authorization is required for all providers.	N/A
78258	ESOPH MOTILITY	No pre-authorization is required for all providers.	N/A
78261	GASTRIC MUCOS IMAGING	No pre-authorization is required for all providers.	N/A
78262	GASTROESOPHAGEAL REFLUX STUDY	No pre-authorization is required for all providers.	N/A
78264	GASTRIC EMPTYING IMAG STUDY	No pre-authorization is required for all providers.	N/A
78265	GASTRIC EMPTYING IMAG STUDY	No pre-authorization is required for all providers.	N/A
78266	GASTRIC EMPTYING IMAG STUDY	No pre-authorization is required for all providers.	N/A
78267	BREATH TST ATTAIN/ANAL C-14	No pre-authorization is required for all providers.	N/A
78268	BREATH TEST ANALYSIS, C-14	No pre-authorization is required for all providers.	N/A
78270	VIT B-12 ABSORPTION STUDY; WO INTRINSIC FACTOR	This is no longer a valid code.	N/A
78271	VIT B-12 ABSORPTION STUDY; W/INTRINSIC FACTOR	This is no longer a valid code.	N/A
78272	VIT B-12 ABSORPTION STUDIES COMBO W/WO INTRINSIC	This is no longer a valid code.	N/A
78278	ACUTE GI BLD LOSS IMAGING	No pre-authorization is required for all providers.	N/A
78282	GI PROT LOSS	No pre-authorization is required for all providers.	N/A
78290	BOWEL IMAGING	No pre-authorization is required for all providers.	N/A
78291	PERITONEAL-VEINUS SHUNT PATENCY TEST	No pre-authorization is required for all providers.	N/A
78299	UNLISTED GI PROC DX NUCLEAR MEDS	No pre-authorization is required for all providers.	N/A
78300	BONE &/OR JT IMAGING; LTD AREA	No pre-authorization is required for all providers.	N/A
78305	BONE &/OR JT IMAGING; MX AREAS	No pre-authorization is required for all providers.	N/A
78306	BONE &/OR JT IMAGING; WHOLE BODY	No pre-authorization is required for all providers.	N/A
78315	BONE &/OR JT IMAGING; 3 PHASE STUDY	No pre-authorization is required for all providers.	N/A
78320	BONE &/OR JT IMAGING; TOMOGRAPHIC (SPECT)	No pre-authorization is required for all providers.	N/A
78350	BONE DENSITY-1/MORE SITES; SNGL PHOTON ABSORP	No pre-authorization is required for all providers.	N/A
78351	BONE DENSITY-1/MORE SITES; DUAL PHOTON ABSORP	No pre-authorization is required for all providers.	N/A
78399	UNLISTED MS PROC DX NUCLEAR MEDS	No pre-authorization is required for all providers.	N/A
78414	DETERM CENTRAL C-V HEMODYNAMICS SNGL/MX DETERM	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78428	CARDIAC SHUNT DETECTION	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78429	MYOCDR IMG PET METAB EVAL SINGLE STUDY CNCRNT CT	This service is not covered by Superior HealthPlan.	N/A
78430	MYOCDR IMG PET PRFUJ 1STD REST/STRESS CNCRNT CT	This service is not covered by Superior HealthPlan.	N/A
78431	MYOCDR IMG PET PRFUJ MLT STD RST AND STRS CNCRNT CT	This service is not covered by Superior HealthPlan.	N/A
78432	MYOCDR IMG PET PRFUJ W/METAB DUAL RADIOTRACER	This service is not covered by Superior HealthPlan.	N/A
78433	MYOCDR IMG PET PRFUJ W/METAB 2RTRACER CNCRNT CT	This service is not covered by Superior HealthPlan.	N/A
78434	AQMBF PET REST AND PHARMACOLOGIC STRESS	This service is not covered by Superior HealthPlan.	N/A
78445	NON-CARDIAC VASCULAR FLOW IMAGING	No pre-authorization is required for all providers.	N/A
78451	HT MUSCLE IMAGE SPECT, SING	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78452	HT MUSCLE IMAGE SPECT, MULT	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78453	HT MUSCLE IMAGE, PLANAR, SING	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78454	HT MUSC IMAGE, PLANAR, MULT	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78455	VENOUS THROMBOSIS STUDY	No pre-authorization is required for all providers.	N/A
78456	ACUTE VENOUS THROMBUS IMAGE	No pre-authorization is required for all providers.	N/A
78457	VENOUS THROMBOSIS IMAGING; UNILAT	No pre-authorization is required for all providers.	N/A
78458	VENOUS THROMBOSIS IMAGING; BILAT	No pre-authorization is required for all providers.	N/A
78459	MYOCDR IMG PET METAB EVAL SINGLE STUDY	This service is not covered by Superior HealthPlan.	N/A
78466	MYOCARDIAL IMAG INFARCT AVID PLANAR; QUAL/QUAN	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78468	MYOCARDIAL IMAG PLANAR; W/EJECT FRACT-1ST PASS	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78469	MYOCARDIAL IMAG PLANAR; TOMOGRPH SPECT W/WO QUAN	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78472	CARDIAC BLD POOL IMAG GATED EQUILIB; SNGL STUDY	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019

78473	CARDIAC BLD POOL IMAG GATED EQUILIB; MX STUDIES	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78481	CARDIAC BLD POOL IMAG 1ST PASS; SNGL STUDY	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78483	CARDIAC BLD POOL IMAG 1ST PASS; MX STUDIES	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78491	MYOCDR IMG PET PRFUJ SINGLE STUDY REST/STRESS	This service is not covered by Superior HealthPlan.	N/A
78492	MYOCDR IMG PET PRFUJ MULTIPLE STUDY REST AND STRESS	This service is not covered by Superior HealthPlan.	N/A
78494	CARD BLD POOL IMAG-GATED SPECT-REST-MOTION STUDY	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78496	CARD BLD POOL IMAG-GATED-1 STUDY-REST-1ST PASS	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78499	UNLISTED CARDIOVASCULAR PROC DX NUCLEAR MEDS	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78579	LUNG VENTILATION IMAGING	No pre-authorization is required for all providers.	N/A
78580	LUNG PERFUSION IMAGING	No pre-authorization is required for all providers.	N/A
78582	LUNG VENTILAT&PERFUS IMAGING	No pre-authorization is required for all providers.	N/A
78597	LUNG PERFUSION DIFFERENTIAL	No pre-authorization is required for all providers.	N/A
78598	LUNG PERF&VENTILAT DIFERENTL	No pre-authorization is required for all providers.	N/A
78599	UNLISTED RESPIRATORY PROC DX NUCLEAR MEDS	No pre-authorization is required for all providers.	N/A
78600	BRAIN IMAGING < 4 STATIC VIEWS	No pre-authorization is required for all providers.	N/A
78601	BRAIN IMAGING < 4 STATIC VIEWS W VASCULAR FLOW	No pre-authorization is required for all providers.	N/A
78605	BRAIN IMAGING MIN 4 STATIC VIEWS	No pre-authorization is required for all providers.	N/A
78606	BRAIN IMAGING MIN 4 STATIC VIEWS W VASCULAR FLOW	No pre-authorization is required for all providers.	N/A
78607	BRAIN IMAGING TOMOGRAPHIC SPECT	No pre-authorization is required for all providers.	N/A
78608	BRAIN IMAG POSITRON EMISSION TOMOGRPY; METABOLIC	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78609	BRAIN IMAG POSITRON EMISSION TOMOGRPY; PERFUSION	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78610	BRAIN IMAGING VASCULAR FLOW ONLY	No pre-authorization is required for all providers.	N/A
78630	CEREBROSPINAL FLUID FLOW IMAGING; CISTERNOGRAPHY	No pre-authorization is required for all providers.	N/A
78635	CEREBROSPINAL FLUID FLOW IMAG; VENTRICULOGRAPHY	No pre-authorization is required for all providers.	N/A
78645	CEREBROSPINAL FLUID FLOW IMAGING; SHUNT EVAL	No pre-authorization is required for all providers.	N/A
78647	CEREBROSPINAL FLUID FLOW IMAG; TOMO (SPECT)	No pre-authorization is required for all providers.	N/A
78650	CSF LEAKAGE DETECTION & LOCALIZ	No pre-authorization is required for all providers.	N/A
78660	RADIOPHARM DACRYOCYSTOGRAPHY	No pre-authorization is required for all providers.	N/A
78699	UNLISTED NERV SYST PROC DX NUCLEAR MEDS	No pre-authorization is required for all providers.	N/A
78700	KIDNEY IMAGING MORPHOLOGY,	No pre-authorization is required for all providers.	N/A
78701	KIDNEY IMAGING; W/VASCULAR FLOW	No pre-authorization is required for all providers.	N/A
78707	KIDNEY IMAG MORPH, W VASCULAR FLOW & FUNCT, SINGLE STUDY W/OUT PHARMAC	No pre-authorization is required for all providers.	N/A
78708	KIDNEY IMAG MORPH, W VASCULAR FLOW & FUNCT, SINGLE STUDY W PHARM INTERV	No pre-authorization is required for all providers.	N/A
78709	KIDNEY IMAG MORPH, W VASCULAR FLOW & FUNCT, MULT STUDY W & W/OUT PHARM	No pre-authorization is required for all providers.	N/A
78710	KIDNEY IMAING MORPHOLOGY, TOMOGRAPHIC (SPECT)	No pre-authorization is required for all providers.	N/A
78725	KIDNEY FUNT STUDY NON-IMAGING RADIOISOTOPIC	No pre-authorization is required for all providers.	N/A
78730	URIN BLADDER RESIDUAL STUDY	No pre-authorization is required for all providers.	N/A
78740	URETERAL REFLUX STUDY	No pre-authorization is required for all providers.	N/A
78761	TESTICULAR IMAGING W/ITH VASCULAR FLOW	No pre-authorization is required for all providers.	N/A
78799	UNLISTED GENITOURINARY PROC DX NUCLEAR MEDS	No pre-authorization is required for all providers.	N/A
78800	RP LOCLZJ TUM PLNR 1 AREA SINGLE DAY IMAGING	No pre-authorization is required for all providers.	N/A
78801	RP LOCLZJ TUM PLNR 2+AREA 1+D IMG/1 AREA IMG>2+D	No pre-authorization is required for all providers.	N/A
78802	RP LOCLZJ TUM PLNR WHOLE BODY SINGLE DAY IMAGING	No pre-authorization is required for all providers.	N/A
78803	RP LOCLZJ TUM SPECT 1 AREA SINGLE DAY IMAGING	No pre-authorization is required for all providers.	N/A
78804	RP LOCLZJ TUM PLNR WHOLE BODY 2+ DAYS IMAGING	No pre-authorization is required for all providers.	N/A
78805	RADIOPHARM LOCALIZ ABSCESS; LTD AREA	No pre-authorization is required for all providers.	N/A
78806	RADIOPHARM LOCALIZ ABSCESS; WHOLE BODY	No pre-authorization is required for all providers.	N/A
78807	RADIOPHARM LOCALIZ ABSCESS; TOMOGRAPHIC (SPECT)	No pre-authorization is required for all providers.	N/A
78808	IV INJ RA DRUG DX STUDY	This service is not covered by Superior HealthPlan.	N/A
78811	PET IMAGING LIMITED AREA CHEST HEAD/NECK	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78812	PET IMAGING SKULL BASE TO MID-THIGH	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78813	PET IMAGING WHOLE BODY	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78814	PET IMAGING CT FOR ATTENUATION LIMITED AREA	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78815	PET IMAGING CT ATTENUATION SKULL BASE MID-THIGH	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78816	PET IMAGING FOR CT ATTENUATION WHOLE BODY	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
78830	RP LOCLZJ TUM SPECT W/CT 1 AREA 1 DAY IMAGING	No pre-authorization is required for all providers.	N/A
78831	RP LOCLZJ TUM SPECT 2 AREA 1D IMG/1 AREA IMG>2+D	No pre-authorization is required for all providers.	N/A
78832	RP LOCLZJ TUM SPECT CT 2AREA 1D IMG/1 AR IMG>2+D	No pre-authorization is required for all providers.	N/A
78835	RADIOPHARMACEUTICAL QUANTIFICATION MEAS 1 AREA	No pre-authorization is required for all providers.	N/A
78999	UNLISTED MISC PROC DX NUCLEAR MEDS	No pre-authorization is required for all providers.	N/A
79005	RADIOPHARMACEUTICAL THERAPY ORAL ADMINISTRATION	No pre-authorization is required for all providers.	N/A
79101	RADIOPHARMACEUTICAL THERAPY IV ADMINISTRATION	No pre-authorization is required for all providers.	N/A
79200	INTRACAVITARY RADIOACTIVE COLLOID THERAP	No pre-authorization is required for all providers.	N/A
79300	INTERSTITIAL RADIOACTIVE COLLOID THERAP	No pre-authorization is required for all providers.	N/A
79403	RADOPHARM TX MA IV INFUSION	No pre-authorization is required for all providers.	N/A
79440	INTRA-ARTICULAR RADIOPHARM THERAP	No pre-authorization is required for all providers.	N/A
79445	RADIOPHARM TX INTRA-ARTERIAL PARTICULATE ADMIN	No pre-authorization is required for all providers.	N/A
79900	PROVISION THERAP RADIOPHARM	No pre-authorization is required for all providers.	N/A
79999	UNLISTED RADIOPHARM THERAP PROC	No pre-authorization is required for all providers.	N/A
80047	METABOLIC PANEL IONIZED CA	No pre-authorization is required for all providers.	N/A
80048	METABOLIC PANEL TOTAL CA	No pre-authorization is required for all providers.	N/A
80049	BASIC METABOLIC PANEL	No pre-authorization is required for all providers.	N/A
80050	GENERAL HEALTH PANEL	No pre-authorization is required for all providers.	N/A
80051	ELECTROLYTE PANEL	No pre-authorization is required for all providers.	N/A
80053	COMPREHEN METABOLIC PANEL	No pre-authorization is required for all providers.	N/A
80054	COMP METABOLIC PANEL	No pre-authorization is required for all providers.	N/A
80055	OBSTETRIC PANEL	No pre-authorization is required for all providers.	N/A
80058	HEPATIC FUNCT PANEL	No pre-authorization is required for all providers.	N/A
80059	HEPATITIS PANEL	No pre-authorization is required for all providers.	N/A
80061	LIPID PANEL	No pre-authorization is required for all providers.	N/A
80069	RENAL FUNCTION PANEL	No pre-authorization is required for all providers.	N/A
80074	ACUTE HEPATITIS PANEL	No pre-authorization is required for all providers.	N/A
80076	HEPATIC FUNCTION PANEL	No pre-authorization is required for all providers.	N/A
80081	OBSTETRIC PANEL	No pre-authorization is required for all providers.	N/A
80091	THYROID PANEL	No pre-authorization is required for all providers.	N/A
80092	THYROID PANEL W/TSH	No pre-authorization is required for all providers.	N/A
80099	5-HIAA & CREATININE	No pre-authorization is required for all providers.	N/A
80100	DRUG SCREEN; MX DRUG CLASSES EA PROC	This is no longer a valid code.	N/A
80101	DRUG SCREEN; SNGL DRUG CLASS EA DRUG CLASS	This is no longer a valid code.	N/A
80102	DRUG CONFIRM EA PROC	This is no longer a valid code.	N/A
80103	TISS PREP DRUG ANALY	This is no longer a valid code.	N/A
80104	DRUG SCRIN 1+ CLASS NONCHROM	This is no longer a valid code.	N/A
80145	DRUG ASSAY ADALIMUMAB	No pre-authorization is required for all providers.	N/A
80150	AMIKACIN	No pre-authorization is required for all providers.	N/A
80152	AMITRIPTYLINE	This is no longer a valid code.	N/A
80154	BENZODIAZEPINES	This is no longer a valid code.	N/A
80155	DRUG SCREEN QUANT CAFFEINE	No pre-authorization is required for all providers.	N/A
80156	CARBAMAZEPINE	No pre-authorization is required for all providers.	N/A
80157	CARBAMAZEPINE; FREE 0	No pre-authorization is required for all providers.	N/A
80158	CYCLOSPORINE	No pre-authorization is required for all providers.	N/A
80159	DRUG SCREEN QUANT CLOZAPINE	No pre-authorization is required for all providers.	N/A
80160	DESIPRAMINE	This is no longer a valid code.	N/A
80162	ASSAY OF DIGOXIN TOTAL	No pre-authorization is required for all providers.	N/A
80163	ASSAY OF DIGOXIN FREE	No pre-authorization is required for all providers.	N/A
80164	ASSAY DIPROPYLACETIC ACID TOT	No pre-authorization is required for all providers.	N/A
80165	DIPROPYLACETIC ACID FREE	No pre-authorization is required for all providers.	N/A
80166	DOXEPIN	This is no longer a valid code.	N/A
80168	ETHOSUXIMIDE	No pre-authorization is required for all providers.	N/A
80169	DRUG SCREEN QUANT EVEROLIMUS	No pre-authorization is required for all providers.	N/A
80170	GENTAMICIN	No pre-authorization is required for all providers.	N/A
80171	DRUG SCREEN QUANT GABAPENTIN	No pre-authorization is required for all providers.	N/A

80172	GOLD	This is no longer a valid code.	N/A
80173	HALOPERIDOL 0	No pre-authorization is required for all providers.	N/A
80174	IMIPRAMINE	This is no longer a valid code.	N/A
80175	DRUG SCREEN QUAN LAMOTRIGINE	No pre-authorization is required for all providers.	N/A
80176	LIDOCAINE	No pre-authorization is required for all providers.	N/A
80177	DRUG SCR N QUAN LEVETIRACETAM	No pre-authorization is required for all providers.	N/A
80178	LITHIUM	No pre-authorization is required for all providers.	N/A
80180	DRUG SCR N QUAN MYCOPHENOLATE	No pre-authorization is required for all providers.	N/A
80182	NORTRIPTYLINE	This is no longer a valid code.	N/A
80183	DRUG SCR N QUAN OXCARBAZEPIN	No pre-authorization is required for all providers.	N/A
80184	PHENOBARBITAL	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
80185	PHENYTOIN; TOT	No pre-authorization is required for all providers.	N/A
80186	PHENYTOIN; FREE	No pre-authorization is required for all providers.	N/A
80187	DRUG ASSAY POSACONAZOLE	No pre-authorization is required for all providers.	N/A
80188	PRIMIDONE	No pre-authorization is required for all providers.	N/A
80190	PROCAINAMIDE	No pre-authorization is required for all providers.	N/A
80192	PROCAINAMIDE; W/METABOLITES	No pre-authorization is required for all providers.	N/A
80194	QUINIDINE	No pre-authorization is required for all providers.	N/A
80195	SIROLIMUS	No pre-authorization is required for all providers.	N/A
80196	SALICYLATE	This is no longer a valid code.	N/A
80197	TACROLIMUS	No pre-authorization is required for all providers.	N/A
80198	THEOPHYLLINE	No pre-authorization is required for all providers.	N/A
80199	DRUG SCREEN QUANT TIAGABINE	No pre-authorization is required for all providers.	N/A
80200	TOBRAMYCIN	No pre-authorization is required for all providers.	N/A
80201	TOPIRAMATE	No pre-authorization is required for all providers.	N/A
80202	VANCOMYCIN	No pre-authorization is required for all providers.	N/A
80203	DRUG SCREEN QUANT ZONISAMIDE	No pre-authorization is required for all providers.	N/A
80230	DRUG ASSAY INFLIXIMAB	No pre-authorization is required for all providers.	N/A
80235	DRUG ASSAY LACOSAMIDE	No pre-authorization is required for all providers.	N/A
80280	DRUG ASSAY VEDOLIZUMAB	No pre-authorization is required for all providers.	N/A
80285	DRUG ASSAY VORICONAZOLE	No pre-authorization is required for all providers.	N/A
80299	QUANTITATIVE ASSAY DRUG	No pre-authorization is required for all providers.	N/A
80300	DRUG SCREEN NON TLC DEVICES	This is no longer a valid code.	N/A
80301	DRUG SCREEN CLASS LIST A	This is no longer a valid code.	N/A
80302	DRUG SCREEN PRSMPTV 1 CLASS	This is no longer a valid code.	N/A
80303	DRUG SCREEN ONE/MULT CLASS	This is no longer a valid code.	N/A
80304	DRUG SCREEN ONE/MULT CLASS	This is no longer a valid code.	N/A
80305	DRUG TEST PRSMV DIR OPT OBS	No pre-authorization is required for all providers.	N/A
80306	DRUG TEST PRSMV INSTRMNT	No pre-authorization is required for all providers.	N/A
80307	DRUG TEST PRSMV CHEM ANALYZR	No pre-authorization is required for all providers.	N/A
80320	DRUG SCREEN QUANTALCOHOLS	No pre-authorization is required for all providers.	N/A
80321	ALCOHOLS BIOMARKERS 1OR 2	No pre-authorization is required for all providers.	N/A
80322	ALCOHOLS BIOMARKERS 3/MORE	No pre-authorization is required for all providers.	N/A
80323	ALKALOIDS NOS	No pre-authorization is required for all providers.	N/A
80324	DRUG SCREEN AMPHETAMINES 1/2	Pre-authorization is required for all providers.	Prior to 09/01/2019
80325	AMPHETAMINES 3OR 4	Pre-authorization is required for all providers.	Prior to 09/01/2019
80326	AMPHETAMINES 5 OR MORE	Pre-authorization is required for all providers.	Prior to 09/01/2019
80327	ANABOLIC STEROID 1 OR 2	No pre-authorization is required for all providers.	N/A
80328	ANABOLIC STEROID 3 OR MORE	No pre-authorization is required for all providers.	N/A
80329	ANALGESICS NON-OPIOID 1 OR 2	No pre-authorization is required for all providers.	N/A
80330	ANALGESICS NON-OPIOID 3-5	No pre-authorization is required for all providers.	N/A
80331	ANALGESICS NON-OPIOID 6/MORE	No pre-authorization is required for all providers.	N/A
80332	ANTIDEPRESSANTS CLASS 1 OR 2	No pre-authorization is required for all providers.	N/A
80333	ANTIDEPRESSANTS CLASS 3-5	No pre-authorization is required for all providers.	N/A
80334	ANTIDEPRESSANTS CLASS 6/MORE	No pre-authorization is required for all providers.	N/A
80335	ANTIDEPRESSANT TRICYCLIC 1/2	No pre-authorization is required for all providers.	N/A
80336	ANTIDEPRESSANT TRICYCLIC 3-5	No pre-authorization is required for all providers.	N/A
80337	TRICYCLIC & CYCLICALS 6/MORE	No pre-authorization is required for all providers.	N/A
80338	ANTIDEPRESSANT NOT SPECIFIED	No pre-authorization is required for all providers.	N/A
80339	ANTIPILEPTICS NOS 1-3	No pre-authorization is required for all providers.	N/A
80340	ANTIPILEPTICS NOS 4-6	No pre-authorization is required for all providers.	N/A
80341	ANTIPILEPTICS NOS 7/MORE	No pre-authorization is required for all providers.	N/A
80342	ANTIPSYCHOTICS NOS 1-3	No pre-authorization is required for all providers.	N/A
80343	ANTIPSYCHOTICS NOS 4-6	No pre-authorization is required for all providers.	N/A
80344	ANTIPSYCHOTICS NOS 7/MORE	No pre-authorization is required for all providers.	N/A
80345	DRUG SCREENING BARBITURATES	Pre-authorization is required for all providers.	Prior to 09/01/2019
80346	BENZODIAZEPINES 1-12	Pre-authorization is required for all providers.	Prior to 09/01/2019
80347	BENZODIAZEPINES 13 OR MORE	Pre-authorization is required for all providers.	Prior to 09/01/2019
80348	DRUG SCREENING BUPRENORPHINE	Pre-authorization is required for all providers.	Prior to 09/01/2019
80349	CANNABINOIDS NATURAL	Pre-authorization is required for all providers.	Prior to 09/01/2019
80350	CANNABINOIDS SYNTHETIC 1-3	Pre-authorization is required for all providers.	Prior to 09/01/2019
80351	CANNABINOIDS SYNTHETIC 4-6	Pre-authorization is required for all providers.	Prior to 09/01/2019
80352	CANNABINOID SYNTHETIC 7/MORE	Pre-authorization is required for all providers.	Prior to 09/01/2019
80353	DRUG SCREENING COCAINE	Pre-authorization is required for all providers.	Prior to 09/01/2019
80354	DRUG SCREENING FENTANYL	Pre-authorization is required for all providers.	Prior to 09/01/2019
80355	GABAPENTIN NON-BLOOD	No pre-authorization is required for all providers.	N/A
80356	HEROIN METABOLITE	Pre-authorization is required for all providers.	Prior to 09/01/2019
80357	KETAMINE AND NORKETAMINE	Pre-authorization required for all providers.	Prior to 09/01/2019
80358	DRUG SCREENING METHADONE	Pre-authorization is required for all providers.	Prior to 09/01/2019
80359	METHYLENEDIOXYAMPHETAMINES	Pre-authorization is required for all providers.	Prior to 09/01/2019
80360	METHYLPHENIDATE	Pre-authorization is required for all providers.	Prior to 09/01/2019
80361	OPIATES 1 OR MORE	Pre-authorization is required for all providers.	Prior to 09/01/2019
80362	OPIOIDS & OPIATE ANALOGS 1/2	Pre-authorization is required for all providers.	Prior to 09/01/2019
80363	OPIOIDS & OPIATE ANALOGS 3/4	Pre-authorization is required for all providers.	Prior to 09/01/2019
80364	OPIOID & OPIATE ANALOG 5/MORE	Pre-authorization is required for all providers.	Prior to 09/01/2019
80365	DRUG SCREENING OXYCODONE	Pre-authorization is required for all providers.	Prior to 09/01/2019
80366	DRUG SCREENING PREGABALIN	No pre-authorization is required for all providers.	N/A
80367	DRUG SCREENING PROPOXYPHENE	Pre-authorization required for all providers.	Prior to 09/01/2019
80368	SEDATIVE HYPNOTICS	Pre-authorization required for all providers.	Prior to 09/01/2019
80369	SKELETAL MUSCLE RELAXANT 1/2	Pre-authorization required for all providers.	Prior to 09/01/2019
80370	SKEL MUSC RELAXANT 3 OR MORE	Pre-authorization required for all providers.	Prior to 09/01/2019
80371	STIMULANTS SYNTHETIC	Pre-authorization is required for all providers.	Prior to 09/01/2019
80372	DRUG SCREENING TAPENTADOL	Pre-authorization required for all providers.	Prior to 09/01/2019
80373	DRUG SCREENING TRAMADOL	Pre-authorization required for all providers.	Prior to 09/01/2019
80374	STEREISOIMER ANALYSIS	No pre-authorization is required for all providers.	N/A
80375	DRUG/SUBSTANCE NOS 1-3	No pre-authorization is required for all providers.	N/A
80376	DRUG/SUBSTANCE NOS 4-6	No pre-authorization is required for all providers.	N/A
80377	DRUG/SUBSTANCE NOS 7/MORE	No pre-authorization is required for all providers.	N/A
80400	ACTH STIM PANEL; ADRENAL INSUFF	No pre-authorization is required for all providers.	N/A
80402	ACTH STIM PANEL; 21 HYDROXYLASE DEFICIENCY	No pre-authorization is required for all providers.	N/A
80406	ACTH STIM PANEL; 3 BETA-HYDROXYDEHYDROGENASE DEF	No pre-authorization is required for all providers.	N/A
80408	ALDOSTERONE SUPPRESSION EVAL PANEL	No pre-authorization is required for all providers.	N/A
80410	CALCITONIN STIM PANEL	No pre-authorization is required for all providers.	N/A
80412	CORTICOTROPIC RELEASING HORMONE STIM PANEL	No pre-authorization is required for all providers.	N/A
80414	CHORIONIC GONADOTROPHIN STIM PANEL; TESTOSTERONE	No pre-authorization is required for all providers.	N/A
80415	CHORIONIC GONADOTROP STIM PANEL; ESTRADIOL RESPO	No pre-authorization is required for all providers.	N/A
80416	RENAL VEIN RENIN STIM PANEL	No pre-authorization is required for all providers.	N/A
80417	PERIPHERAL VEIN RENIN STIM PANEL	No pre-authorization is required for all providers.	N/A
80418	COMBO RAPID PITUITARY EVAL PANEL	No pre-authorization is required for all providers.	N/A
80420	DEXAMETHASONE SUPPRESSION PANEL 48 HR	No pre-authorization is required for all providers.	N/A
80422	GLUCAGON TOLERANCE PANEL; INSULINOMA	No pre-authorization is required for all providers.	N/A

80424	GLUCAGON TOLERANCE PANEL; PHEOCHROMOCYTOMA	No pre-authorization is required for all providers.	N/A
80426	GONADOTROPIN RELEASING HORMONE STIM PANEL	No pre-authorization is required for all providers.	N/A
80428	GROWTH HORMONE STIM PANEL	No pre-authorization is required for all providers.	N/A
80430	GROWTH HORMONE SUPPRESSION PANEL	No pre-authorization is required for all providers.	N/A
80432	INSULIN-INDUCED C-PEPTIDE SUPPRESSION PANEL	No pre-authorization is required for all providers.	N/A
80434	INSULIN TOLERANCE PANEL; ACTH INSUFF	No pre-authorization is required for all providers.	N/A
80435	INSULIN TOLERANCE PANEL; GROWTH HORMONE DEFICIEN	No pre-authorization is required for all providers.	N/A
80436	METYRAPONE PANEL	No pre-authorization is required for all providers.	N/A
80438	THYROTROPIN RELEASE HORMONE STIM PANEL; 1 HR	No pre-authorization is required for all providers.	N/A
80439	THYROTROPIN RELEASE HORMONE STIM PANEL; 2 HR	No pre-authorization is required for all providers.	N/A
80440	THYROTROP RELEASE HORMONE STIM; HYPERPROLACTINEM	This is no longer a valid code.	N/A
80500	CLINIC PATH CONS; LTD WO REVIEW HX & MED RECORDS	No pre-authorization is required for all providers.	N/A
80502	CLINIC PATH CONS; COMP COMPLEX DX W/REVIEW	No pre-authorization is required for all providers.	N/A
81000	UA DIP STICK/TABLET REAGENT; NON-AUTO W/MICRO	No pre-authorization is required for all providers.	N/A
81001	UA DIP STICK/TABLET REAGENT; AUTO W/MICRO	No pre-authorization is required for all providers.	N/A
81002	UA DIP STICK/TABLET REAGENT; WO MICRO NON-AUTO	No pre-authorization is required for all providers.	N/A
81003	UA DIP STICK/TABLET REAGENT; WO MICRO AUTO	No pre-authorization is required for all providers.	N/A
81005	UA; QUAL/SEMIQUAN EX IMMUNOASSAYS	No pre-authorization is required for all providers.	N/A
81007	UA; BACTERURIA SCRIN NON-CULT TECH COMMERCIAL KIT	No pre-authorization is required for all providers.	N/A
81015	UA; MICRO ONLY	No pre-authorization is required for all providers.	N/A
81020	UA; 2 OR 3 GLASS TEST	No pre-authorization is required for all providers.	N/A
81025	URIN PG TEST BY VISUAL COLOR COMPAR METHD	No pre-authorization is required for all providers.	N/A
81050	VOLUM MEASUR TIMED COLLEC EA	No pre-authorization is required for all providers.	N/A
81099	UNLISTED UA PROC	No pre-authorization is required for all providers.	N/A
81105	HPA-1 GENOTYPING	Pre-authorization is required for all providers.	Prior to 09/01/2019
81106	HPA-2 GENOTYPING	Pre-authorization is required for all providers.	Prior to 09/01/2019
81107	HPA-3 GENOTYPING	Pre-authorization is required for all providers.	Prior to 09/01/2019
81108	HPA-4 GENOTYPING	Pre-authorization is required for all providers.	Prior to 09/01/2019
81109	HPA-5 GENOTYPING	Pre-authorization is required for all providers.	Prior to 09/01/2019
81110	HPA-6 GENOTYPING	Pre-authorization is required for all providers.	Prior to 09/01/2019
81111	HPA-9 GENOTYPING	Pre-authorization is required for all providers.	Prior to 09/01/2019
81112	HPA-15 GENOTYPING	Pre-authorization is required for all providers.	Prior to 09/01/2019
81120	IDH1 COMMON VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81121	IDH2 COMMON VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81161	DMD DUP/DELET ANALYSIS	Pre-authorization required for all providers.	Prior to 09/01/2019
81162	BRCA1 BRCA2 GENE ALYS FULL SEQ FULL DUP/DEL ALYS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81163	BRCA1 BRCA2 GENE ANALYSIS FULL SEQUENCE ANALYSIS	Pre-authorization required for all providers.	Prior to 09/01/2019
81164	BRCA1 BRCA2 GENE ANALYSIS FULL DUP/DEL ANALYSIS	Pre-authorization required for all providers.	Prior to 09/01/2019
81165	BRCA1 GENE ANALYSIS FULL SEQUENCE ANALYSIS	Pre-authorization required for all providers.	Prior to 09/01/2019
81166	BRCA1 GENE ANALYSIS FULL DUP/DEL ANALYSIS	Pre-authorization required for all providers.	Prior to 09/01/2019
81167	BRCA2 GENE ANALYSIS FULL DUP/DEL ANALYSIS	Pre-authorization required for all providers.	Prior to 09/01/2019
81170	ABL1 GENE	Pre-authorization required for all providers.	Prior to 09/01/2019
81171	AFF2 GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	This service is not covered by Superior HealthPlan.	N/A
81172	AFF2 GENE ANALYSIS CHARACTERIZATION OF ALLELES	This service is not covered by Superior HealthPlan.	N/A
81173	AR GENE ANALYSIS FULL GENE SEQUENCE	This service is not covered by Superior HealthPlan.	N/A
81174	AR GENE ANALYSIS KNOWN FAMILIAL VARIANT	This service is not covered by Superior HealthPlan.	N/A
81175	ASXL1 FULL GENE SEQUENCE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81176	ASXL1 GENE TARGET SEQ ALYS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81177	ATN1 GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	Pre-authorization required for all providers.	Prior to 09/01/2019
81178	ATXN1 GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	Pre-authorization required for all providers.	Prior to 09/01/2019
81179	ATXN2 GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	Pre-authorization required for all providers.	Prior to 09/01/2019
81180	ATXN3 GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	Pre-authorization required for all providers.	Prior to 09/01/2019
81181	ATXN7 GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	Pre-authorization required for all providers.	Prior to 09/01/2019
81182	ATXN8OS GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	This service is not covered by Superior HealthPlan.	N/A
81183	ATXN10 GENE ANALYSIS EVAL DETC ABNORMAL ALLELES	This service is not covered by Superior HealthPlan.	N/A
81184	CACNA1A GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	Pre-authorization required for all providers.	Prior to 09/01/2019
81185	CACNA1A GENE ANALYSIS FULL GENE SEQUENCE	Pre-authorization required for all providers.	Prior to 09/01/2019
81186	CACNA1A GENE ANALYSIS KNOWN FAMILIAL VARIANT	Pre-authorization required for all providers.	Prior to 09/01/2019
81187	CNBP GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	This service is not covered by Superior HealthPlan.	N/A
81188	CSTB GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	This service is not covered by Superior HealthPlan.	N/A
81189	CSTB GENE ANALYSIS FULL GENE SEQUENCE	This service is not covered by Superior HealthPlan.	N/A
81190	CSTB GENE ANALYSIS KNOWN FAMILIAL VARIANTS	This service is not covered by Superior HealthPlan.	N/A
81200	ASPA GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81201	APC GENE FULL SEQUENCE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81202	APC GENE KNOWN FAM VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81203	APC GENE DUP/DELET VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81204	AR GENE ANALYSIS CHARACTERIZATION OF ALLELES	This service is not covered by Superior HealthPlan.	N/A
81205	BCKDHB GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81206	BCR/ABL1 GENE MAJOR BP	Pre-authorization is required for all providers.	Prior to 09/01/2019
81207	BCR/ABL1 GENE MINOR BP	Pre-authorization is required for all providers.	Prior to 09/01/2019
81208	BCR/ABL1 GENE OTHER BP	Pre-authorization is required for all providers.	Prior to 09/01/2019
81209	BLM GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81210	BRAF GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81211	BRCA1&2 SEQ & COM DUP/DEL	This is no longer a valid code.	N/A
81212	BRCA1 BRCA 2 GEN ALYS 185DELAG 5385INSC 6174DELT	Pre-authorization is required for all providers.	Prior to 09/01/2019
81213	BRCA1&2 UNCOM DUP/DEL VAR	This is no longer a valid code.	N/A
81214	BRCA1 FULL SEQ & COM DUP/DEL	This is no longer a valid code.	N/A
81215	BRCA1 GENE ANALYSIS KNOWN FAMILIAL VARIANT	Pre-authorization is required for all providers.	Prior to 09/01/2019
81216	BRCA2 GENE ANALYSIS FULL SEQUENCE ANALYSIS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81217	BRCA2 GENE ANALYSIS KNOWN FAMILIAL VARIANT	Pre-authorization is required for all providers.	Prior to 09/01/2019
81218	CEBPA GENE FULL SEQUENCE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81219	CALR GENE COM VARIANTS	Pre-authorization required for all providers.	Prior to 09/01/2019
81220	CFTR GENE COM VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81221	CFTR GENE KNOWN FAM VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81222	CFTR GENE DUP/DELET VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81223	CFTR GENE FULL SEQUENCE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81224	CFTR GENE INTRON POLY T	Pre-authorization is required for all providers.	Prior to 09/01/2019
81225	CYP2C19 GENE COM VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81226	CYP2D6 GENE COM VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81227	CYP2C9 GENE COM VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81228	CYTOGEN MICRARRAY COPY NMBR	This service is not covered by Superior HealthPlan.	N/A
81229	CYTOGEN M ARRAY COPY NO&SNP	This service is not covered by Superior HealthPlan.	N/A
81230	CYP3A4 GENE COMMON VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81231	CYP3A5 GENE COMMON VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81232	DPYD GENE COMMON VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81233	BTK GENE ANALYSIS COMMON VARIANTS	Pre-authorization required for all providers.	Prior to 09/01/2019
81234	DMPK GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	This service is not covered by Superior HealthPlan.	N/A
81235	EGFR GENE COM VARIANTS	This service is not covered by Superior HealthPlan.	N/A
81236	EZH2 GENE ANALYSIS FULL GENE SEQUENCE	This service is not covered by Superior HealthPlan.	N/A
81237	EZH2 GENE ANALYSIS COMMON VARIANTS	Pre-authorization required for all providers.	Prior to 09/01/2019
81238	F9 FULL GENE SEQUENCE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81239	DMPK GENE ANALYSIS CHARACTERIZATION OF ALLELES	This service is not covered by Superior HealthPlan.	N/A
81240	F2 GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81241	F5 GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81242	FANCC GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81243	FMR1 GENE DETECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
81244	FMR1 GENE ANALYSIS CHARACTERIZATION OF ALLELES	Pre-authorization is required for all providers.	Prior to 09/01/2019
81245	FLT3 GENE	No pre-authorization is required for all providers.	N/A
81246	FLT3 GENE ANALYSIS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81247	G6PD GENE ALYS CMN VARIANT	Pre-authorization is required for all providers.	Prior to 09/01/2019
81248	G6PD KNOWN FAMILIAL VARIANT	Pre-authorization is required for all providers.	Prior to 09/01/2019

81249	G6PD FULL GENE SEQUENCE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81250	G6PC GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81251	GBA GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81252	GJB2 GENE FULL SEQUENCE	This service is not covered by Superior HealthPlan.	N/A
81253	GJB2 GENE KNOWN FAM VARIANTS	This service is not covered by Superior HealthPlan.	N/A
81254	GJB6 GENE COM VARIANTS	This service is not covered by Superior HealthPlan.	N/A
81255	HEXA GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81256	HFE GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81257	HBA1/HBA2 GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81258	HBA1/HBA2 GENE FAM VRNT	Pre-authorization is required for all providers.	Prior to 09/01/2019
81259	HBA1/HBA2 FULL GENE SEQUENCE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81260	IKBKAP GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81261	IGH GENE REARRANGE AMP METH	Pre-authorization is required for all providers.	Prior to 09/01/2019
81262	IGH GENE REARRANG DIR PROBE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81263	IGH VARI REGIONAL MUTATION	Pre-authorization is required for all providers.	Prior to 09/01/2019
81264	IGK REARRANGEABN CLONAL POP	Pre-authorization is required for all providers.	Prior to 09/01/2019
81265	STR MARKERS SPECIMEN ANAL	No pre-authorization is required for all providers.	N/A
81266	STR MARKERS SPEC ANAL ADDL	No pre-authorization is required for all providers.	N/A
81267	CHIMERISM ANAL NO CELL SELEC	No pre-authorization is required for all providers.	N/A
81268	CHIMERISM ANAL W/CELL SELECT	Pre-authorization is required for all providers.	Prior to 09/01/2019
81269	HBA1/HBA2 GENE DUP/DEL VRNTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81270	JAK2 GENE	No pre-authorization is required for all providers.	N/A
81271	HTT GENE ANALYSIS DETECT ABNORMAL ALLELES	This service is not covered by Superior HealthPlan.	N/A
81272	KIT GENE TARGETED SEQ ANALYS	Pre-authorization required for all providers.	Prior to 09/01/2019
81273	KIT GENE ANALYS D816 VARIANT	Pre-authorization required for all providers.	Prior to 09/01/2019
81274	HTT GENE ANALYSIS CHARACTERIZATION ALLELES	This service is not covered by Superior HealthPlan.	N/A
81275	KRAS GENE VARIANTS EXON 2	Pre-authorization is required for all providers.	Prior to 09/01/2019
81276	KRAS GENE ADDL VARIANTS	Pre-authorization required for all providers.	Prior to 09/01/2019
81277	CYTOGENOMIC NEOPLASIA MICROARRAY ANALYSIS	This service is not covered by Superior HealthPlan.	N/A
81280	LONG QT SYND GENE FULL SEQ	This is no longer a valid code.	N/A
81281	LONG QT SYND KNOWN FAM VAR	This is no longer a valid code.	N/A
81282	LONG QT SYN GENE DUP/DLT VAR	This is no longer a valid code.	N/A
81283	IFNL3 GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81284	FXN GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	This service is not covered by Superior HealthPlan.	N/A
81285	FXN GENE ANALYSIS CHARACTERIZATION ALLELES	This service is not covered by Superior HealthPlan.	N/A
81286	FXN GENE ANALYSIS FULL GENE SEQUENCE	This service is not covered by Superior HealthPlan.	N/A
81287	MGMT GENE PROMOTER METHYLATION ANALYSIS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81288	MLH1 GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81289	FXN GENE ANALYSIS KNOWN FAMILIAL VARIANTS	This service is not covered by Superior HealthPlan.	N/A
81290	MCOLN1 GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81291	MTHFR GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81292	MLH1 GENE FULL SEQ	Pre-authorization is required for all providers.	Prior to 09/01/2019
81293	MLH1 GENE KNOWN VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81294	MLH1 GENE DUP/DELETE VARIANT	Pre-authorization is required for all providers.	Prior to 09/01/2019
81295	MSH2 GENE FULL SEQ	Pre-authorization is required for all providers.	Prior to 09/01/2019
81296	MSH2 GENE KNOWN VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81297	MSH2 GENE DUP/DELETE VARIANT	Pre-authorization is required for all providers.	Prior to 09/01/2019
81298	MSH6 GENE FULL SEQ	Pre-authorization is required for all providers.	Prior to 09/01/2019
81299	MSH6 GENE KNOWN VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81300	MSH6 GENE DUP/DELETE VARIANT	Pre-authorization is required for all providers.	Prior to 09/01/2019
81301	MICROSATELLITE INSTABILITY	Pre-authorization is required for all providers.	Prior to 09/01/2019
81302	MECP2 GENE FULL SEQ	Pre-authorization is required for all providers.	Prior to 09/01/2019
81303	MECP2 GENE KNOWN VARIANT	Pre-authorization is required for all providers.	Prior to 09/01/2019
81304	MECP2 GENE DUP/DELET VARIANT	Pre-authorization is required for all providers.	Prior to 09/01/2019
81305	MYD88 GENE ANALYSIS P.LEU265 (L265P) VARIANT	This service is not covered by Superior HealthPlan.	N/A
81306	NUDT15 GENE ANALYSIS COMMON VARIANTS	This service is not covered by Superior HealthPlan.	N/A
81307	PALB2 GENE ANALYSIS FULL GENE SEQUENCE	This service is not covered by Superior HealthPlan.	N/A
81308	PALB2 GENE ANALYSIS KNOWN FAMILIAL VARIANT	This service is not covered by Superior HealthPlan.	N/A
81309	PIK3CA GENE ANALYSIS TARGETED SEQUENCE ANALYSIS	This service is not covered by Superior HealthPlan.	N/A
81310	NPM1 GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81311	NRAS GENE VARIANTS EXON 2&3	This service is not covered by Superior HealthPlan.	N/A
81312	PABPN1 GENE ANALYSIS EVAL DETC ABNORMAL ALLELES	This service is not covered by Superior HealthPlan.	N/A
81313	PCA3/KLK3 ANTIGEN	Pre-authorization is required for all providers.	Prior to 09/01/2019
81314	PDGFRA GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81315	PML/RARALPHA COM BREAKPOINTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81316	PML/RARALPHA 1 BREAKPOINT	Pre-authorization is required for all providers.	Prior to 09/01/2019
81317	PMS2 GENE FULL SEQ ANALYSIS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81318	PMS2 KNOWN FAMILIAL VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81319	PMS2 GENE DUP/DELET VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81320	PLCG2 GENE ANALYSIS COMMON VARIANTS	This service is not covered by Superior HealthPlan.	N/A
81321	PTEN GENE FULL SEQUENCE	Pre-authorization required for all providers.	Prior to 09/01/2019
81322	PTEN GENE KNOWN FAM VARIANT	Pre-authorization is required for all providers.	Prior to 09/01/2019
81323	PTEN GENE DUP/DELET VARIANT	Pre-authorization is required for all providers.	Prior to 09/01/2019
81324	PMP22 GENE DUP/DELET	Pre-authorization is required for all providers.	Prior to 09/01/2019
81325	PMP22 GENE FULL SEQUENCE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81326	PMP22 GENE KNOWN FAM VARIANT	Pre-authorization is required for all providers.	Prior to 09/01/2019
81327	SEPT9 GENE PROMOTER METHYLATION ANALYSIS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81328	SLCO1B1 GENE COM VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81329	SMN1 GENE ANALYSIS DOSAGE/DELET ALYS W/SMN2 ALYS	Pre-authorization required for all providers.	Prior to 09/01/2019
81330	SMPD1 GENE COMMON VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81331	SNRPN/UBE3A GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81332	SERPINA1 GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81333	TGFB1 GENE ANALYSIS COMMON VARIANTS	This service is not covered by Superior HealthPlan.	N/A
81334	RUNX1 GENE TARGETED SEQ ALYS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81335	TPMT GENE COM VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81336	SMN1 GENE ANALYSIS FULL GENE SEQUENCE	Pre-authorization required for all providers.	Prior to 09/01/2019
81337	SMN1 GENE ANALYSIS KNOWN FAMILIAL SEQ VARIANTS	Pre-authorization required for all providers.	Prior to 09/01/2019
81340	TRB@ GENE REARRANGE AMPLIFY	Pre-authorization is required for all providers.	Prior to 09/01/2019
81341	TRB@ GENE REARRANGE DIRPROBE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81342	TRG GENE REARRANGEMENT ANAL	Pre-authorization is required for all providers.	Prior to 09/01/2019
81343	PPP2R2B GENE ANALYSIS EVAL DETC ABNORMAL ALLELES	This service is not covered by Superior HealthPlan.	N/A
81344	TBP GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	This service is not covered by Superior HealthPlan.	N/A
81345	TERT GENE ANALYSIS TARGETED SEQUENCE ANALYSIS	This service is not covered by Superior HealthPlan.	N/A
81346	TYMS GENE COM VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81350	UGT1A1 GENE ANALYSIS COMMON VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81355	VKORC1 GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81361	HBB GENE COM VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81362	HBB GENE KNOWN FAM VARIANT	Pre-authorization is required for all providers.	Prior to 09/01/2019
81363	HBB GENE DUP/DEL VARIANTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
81364	HBB FULL GENE SEQUENCE	Pre-authorization is required for all providers.	Prior to 09/01/2019
81370	HLA I & II TYPING LR	Pre-authorization is required for all providers.	Prior to 09/01/2019
81371	HLA I & II TYPE VERIFY LR	Pre-authorization is required for all providers.	Prior to 09/01/2019
81372	HLA I TYPING COMPLETE LR	Pre-authorization is required for all providers.	Prior to 09/01/2019
81373	HLA I TYPING 1 LOCUS LR	Pre-authorization is required for all providers.	Prior to 09/01/2019
81374	HLA I TYPING 1 ANTIGEN LR	Pre-authorization is required for all providers.	Prior to 09/01/2019
81375	HLA II TYPING AG EQUIV LR	Pre-authorization is required for all providers.	Prior to 09/01/2019
81376	HLA II TYPING 1 LOCUS LR	Pre-authorization is required for all providers.	Prior to 09/01/2019
81377	HLA II TYPE 1 AG EQUIV LR	Pre-authorization is required for all providers.	Prior to 09/01/2019
81378	HLA I & II TYPING HR	Pre-authorization is required for all providers.	Prior to 09/01/2019
81379	HLA I TYPING COMPLETE HR	Pre-authorization is required for all providers.	Prior to 09/01/2019
81380	HLA I TYPING 1 LOCUS HR	Pre-authorization is required for all providers.	Prior to 09/01/2019

81381	HLA I TYPING 1 ALLELE HR	Pre-authorization is required for all providers.	Prior to 09/01/2019
81382	HLA II TYPING 1 LOC HR	Pre-authorization is required for all providers.	Prior to 09/01/2019
81383	HLA II TYPING 1 ALLELE HR	Pre-authorization is required for all providers.	Prior to 09/01/2019
81400	MOLECULAR PATHOLOGY PROCEDURE LEVEL 1	Pre-authorization is required for all providers.	Prior to 09/01/2019
81401	MOLECULAR PATHOLOGY PROCEDURE LEVEL 2	Pre-authorization is required for all providers.	Prior to 09/01/2019
81402	MOPATH PROCEDURE LEVEL 3	Pre-authorization is required for all providers.	Prior to 09/01/2019
81403	MOLECULAR PATHOLOGY PROCEDURE LEVEL 4	Pre-authorization is required for all providers.	Prior to 09/01/2019
81404	MOLECULAR PATHOLOGY PROCEDURE LEVEL 5	Pre-authorization is required for all providers.	Prior to 09/01/2019
81405	MOLECULAR PATHOLOGY PROCEDURE LEVEL 6	Pre-authorization is required for all providers.	Prior to 09/01/2019
81406	MOLECULAR PATHOLOGY PROCEDURE LEVEL 7	Pre-authorization is required for all providers.	Prior to 09/01/2019
81407	MOLECULAR PATHOLOGY PROCEDURE LEVEL 8	Pre-authorization is required for all providers.	Prior to 09/01/2019
81408	MOPATH PROCEDURE LEVEL 9	Pre-authorization is required for all providers.	Prior to 09/01/2019
81410	AORTIC DYSFUNCTION/DILATION	Pre-authorization is required for all providers.	Prior to 09/01/2019
81411	AORTIC DYSFUNCTION/DILATION	Pre-authorization is required for all providers.	Prior to 09/01/2019
81412	ASHKENAZI JEWISH ASSOC DIS	This service is not covered by Superior HealthPlan.	N/A
81413	CAR ION CHNNLPATH GENOMIC SEQ ALYS INC 10 GNS	This service is not covered by Superior HealthPlan.	N/A
81414	CAR ION CHNNLPATH DUP/DEL GN ALYS PANEL 2 GENES	This service is not covered by Superior HealthPlan.	N/A
81415	EXOME SEQUENCE ANALYSIS	This service is not covered by Superior HealthPlan.	N/A
81416	EXOME SEQUENCE ANALYSIS	This service is not covered by Superior HealthPlan.	N/A
81417	EXOME RE-EVALUATION	This service is not covered by Superior HealthPlan.	N/A
81420	FETAL CHRMOML ANEUPLOIDY	Pre-authorization is required for all providers.	Prior to 09/01/2019
81422	FETAL CHROMOSOMAL MICRODELTAJ GENOMIC SEQ ANALYS	This service is not covered by Superior HealthPlan.	N/A
81425	GENOME SEQUENCE ANALYSIS	This service is not covered by Superior HealthPlan.	N/A
81426	GENOME SEQUENCE ANALYSIS	This service is not covered by Superior HealthPlan.	N/A
81427	GENOME RE-EVALUATION	This service is not covered by Superior HealthPlan.	N/A
81430	HEARING LOSS SEQUENCE ANALYS	This service is not covered by Superior HealthPlan.	N/A
81431	HEARING LOSS DUP/DEL ANALYS	This service is not covered by Superior HealthPlan.	N/A
81432	HRDTRY BRST CA-RLATD DSORDRS	This service is not covered by Superior HealthPlan.	N/A
81433	HRDTRY BRST CA-RLATD DSORDRS	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
81434	HEREDITARY RETINAL DISORDERS	This service is not covered by Superior HealthPlan.	N/A
81435	HEREDITARY COLON CA DSORDRS	This service is not covered by Superior HealthPlan.	N/A
81436	HEREDITARY COLON CA DSORDRS	This service is not covered by Superior HealthPlan.	N/A
81437	HEREDTRY NURONDCRN TUM DSRDR	This service is not covered by Superior HealthPlan.	N/A
81438	HEREDTRY NURONDCRN TUM DSRDR	This service is not covered by Superior HealthPlan.	N/A
81439	HRDTRY CARDMPY GENE PANEL	This service is not covered by Superior HealthPlan.	N/A
81440	MITOCHONDRIAL GENE	This service is not covered by Superior HealthPlan.	N/A
81442	NOONAN SPECTRUM DISORDERS	This service is not covered by Superior HealthPlan.	N/A
81443	GENETIC TESTING FOR SEVERE INHERITED CONDITIONS	This service is not covered by Superior HealthPlan.	N/A
81445	TARGETED GENOMIC SEQ ANALYS	This service is not covered by Superior HealthPlan.	N/A
81448	HRDTRY PERPH NEURPHY PANEL	Pre-authorization is required for all providers.	Prior to 09/01/2019
81450	TARGETED GENOMIC SEQ ANALYS	Pre-authorization required for all providers.	Prior to 09/01/2019
81455	TARGETED GENOMIC SEQ ANALYS	This service is not covered by Superior HealthPlan.	N/A
81460	WHOLE MITOCHONDRIAL GENOME	This service is not covered by Superior HealthPlan.	N/A
81465	WHOLE MITOCHONDRIAL GENOME	This service is not covered by Superior HealthPlan.	N/A
81470	X-LINKED INTELLECTUAL DBLT	This service is not covered by Superior HealthPlan.	N/A
81471	X-LINKED INTELLECTUAL DBLT	This service is not covered by Superior HealthPlan.	N/A
81479	UNLISTED MOLECULAR PATHOLOGY	This service is not covered by Superior HealthPlan.	N/A
81490	AUTOIMMUNE RHEUMATOID ARTHR	This service is not covered by Superior HealthPlan.	N/A
81493	COR ARTERY DISEASE MRNA	This service is not covered by Superior HealthPlan.	N/A
81500	ONCO (OVAR) TWO PROTEINS	This service is not covered by Superior HealthPlan.	N/A
81503	ONCO (OVAR) FIVE PROTEINS	This service is not covered by Superior HealthPlan.	N/A
81504	ONCOLOGY TISSUE OF ORIGIN	This service is not covered by Superior HealthPlan.	N/A
81506	ENDO ASSAY SEVEN ANAL	This service is not covered by Superior HealthPlan.	N/A
81507	FETAL ANEUPLOIDY TRISOM RISK	Pre-authorization is required for all providers.	Prior to 09/01/2019
81508	FTL CGEN ABNOR TWO PROTEINS	This service is not covered by Superior HealthPlan.	N/A
81509	FTL CGEN ABNOR 3 PROTEINS	This service is not covered by Superior HealthPlan.	N/A
81510	FTL CGEN ABNOR THREE ANAL	This service is not covered by Superior HealthPlan.	N/A
81511	FTL CGEN ABNOR FOUR ANAL	This service is not covered by Superior HealthPlan.	N/A
81512	FTL CGEN ABNOR FIVE ANAL	This service is not covered by Superior HealthPlan.	N/A
81518	ONCOLOGY BREAST MRNA GENE EXPRESSION 11 GENES	This service is not covered by Superior HealthPlan.	N/A
81519	ONCOLOGY BREAST MRNA	No pre-authorization is required for all providers.	N/A
81520	ONC BREAST MRNA 58 GENES	Pre-authorization is required for all providers.	Prior to 09/01/2019
81521	ONC BREAST MRNA 70 GENES	Pre-authorization is required for all providers.	Prior to 09/01/2019
81522	ONCOLOGY BREAST MRNA GENE XPRSN PRFL 12 GENES	This service is not covered by Superior HealthPlan.	N/A
81525	ONCOLOGY COLON MRNA	This service is not covered by Superior HealthPlan.	N/A
81528	ONCOLOGY COLORECTAL SCR	This service is not covered by Superior HealthPlan.	N/A
81535	ONCOLOGY GYNECOLOGIC	This service is not covered by Superior HealthPlan.	N/A
81536	ONCOLOGY GYNECOLOGIC	This service is not covered by Superior HealthPlan.	N/A
81538	ONCOLOGY LUNG	This service is not covered by Superior HealthPlan.	N/A
81539	ONCOLOGY PROSTATE BIOCHEMICAL ASSAY 4 PROTEINS	This service is not covered by Superior HealthPlan.	N/A
81540	ONCOLOGY TUM UNKNOWN ORIGIN	This service is not covered by Superior HealthPlan.	N/A
81541	ONC PROSTATE MRNA 46 GENES	Pre-authorization is required for all providers.	Prior to 09/01/2019
81542	ONC PRST8 MRNA MICRORA GENE XPRSN PRFL 22 GENES	This service is not covered by Superior HealthPlan.	N/A
81545	ONCOLOGY THYROID	This service is not covered by Superior HealthPlan.	N/A
81551	ONC PROSTATE 3 GENES	Pre-authorization is required for all providers.	Prior to 09/01/2019
81552	ONC UVEAL MLNMA MRNA GENE XPRSN PRFL 15 GENES	This service is not covered by Superior HealthPlan.	N/A
81595	CARDIOLOGY HRT TRNSPL MRNA	This service is not covered by Superior HealthPlan.	N/A
81596	NFCT DS CHRNC HCV 6 BIOCHEM ASSAY SRM ALG LVR	This service is not covered by Superior HealthPlan.	N/A
81599	UNLISTED MAAA	This service is not covered by Superior HealthPlan.	N/A
82000	ACETALDEHYDE BLD	This is no longer a valid code.	N/A
82003	ACETAMINOPHEN	This is no longer a valid code.	N/A
82009	TEST FOR ACETONE/KETONES	No pre-authorization is required for all providers.	N/A
82010	ACETONE ASSAY	No pre-authorization is required for all providers.	N/A
82013	ACETYLCHOLINESTERASE	No pre-authorization is required for all providers.	N/A
82016	ACYLCARNITINES; QUAL EA SPEC	No pre-authorization is required for all providers.	N/A
82017	ACYLCARNITINES; QUAN EA SPEC	No pre-authorization is required for all providers.	N/A
82024	ADRENOCORTICOTROPIC HORMONE	No pre-authorization is required for all providers.	N/A
82030	ADENOSINE 5'-MONOPHOSPHATE CYCLIC	No pre-authorization is required for all providers.	N/A
82040	ASSAY OF SERUM ALBUMIN	No pre-authorization is required for all providers.	N/A
82042	OTHER SOURCE ALBUMIN QUAN EA	No pre-authorization is required for all providers.	N/A
82043	UR ALBUMIN QUANTITATIVE	No pre-authorization is required for all providers.	N/A
82044	UR ALBUMIN SEMIQUANTITATIVE	No pre-authorization is required for all providers.	N/A
82045	ALBUMIN; ISCHEMIA MODIFIED	No pre-authorization is required for all providers.	N/A
82055	ALCOHOL; ANY SPECMN EX BREATH	This is no longer a valid code.	N/A
82075	ALCOHOL; BREATH	No pre-authorization is required for all providers.	N/A
82085	ALDOLASE	No pre-authorization is required for all providers.	N/A
82088	ALDOSTERONE	No pre-authorization is required for all providers.	N/A
82101	ALKALOIDS URIN QUAN	This is no longer a valid code.	N/A
82103	ALPHA-1-ANTITRYPSIN; TOT	No pre-authorization is required for all providers.	N/A
82104	ALPHA-1-ANTITRYPSIN; PHENOTYPE	No pre-authorization is required for all providers.	N/A
82105	ALPHA-FETOPROTEIN; SERUM	No pre-authorization is required for all providers.	N/A
82106	ALPHA-FETOPROTEIN; AMNIOTIC FLUID	No pre-authorization is required for all providers.	N/A
82107	AFP-L3 FRACTION ISOFORM AND TOTAL AFP (INCLUDING RATIO)	No pre-authorization is required for all providers.	N/A
82108	ALUMINUM	No pre-authorization is required for all providers.	N/A
82120	AMINES, VAGINAL FLUID QUAL'	No pre-authorization is required for all providers.	N/A
82127	AMINO ACIDS; 1-QUAL EA SPEC	No pre-authorization is required for all providers.	N/A
82128	AMINO ACIDS; MX QUAL EA SPEC	No pre-authorization is required for all providers.	N/A
82131	AMINO ACIDS; SINGL QUAN EA SPEC	No pre-authorization is required for all providers.	N/A
82135	AMINOLEVULINIC ACID DELTA	No pre-authorization is required for all providers.	N/A
82136	AMINO ACIDS 2 TO 5-QUAN-EA SPEC	No pre-authorization is required for all providers.	N/A
82139	AMINO ACIDS 6/>-QUAN-EA SPEC	No pre-authorization is required for all providers.	N/A

82140	AMMONIA	No pre-authorization is required for all providers.	N/A
82143	AMNIOTIC FLUID SCAN	No pre-authorization is required for all providers.	N/A
82145	AMPHETAMINE/METHAMPHETAMINE	This is no longer a valid code.	N/A
82150	AMYLASE	No pre-authorization is required for all providers.	N/A
82154	ANDROSTANEDIOL GLUCURONIDE	No pre-authorization is required for all providers.	N/A
82157	ANDROSTENEDIONE	No pre-authorization is required for all providers.	N/A
82160	ANDROSTERONE	No pre-authorization is required for all providers.	N/A
82163	ANGIOTENSIN II	No pre-authorization is required for all providers.	N/A
82164	ANGIOTENSIN I- CONVERTING ENZYME	No pre-authorization is required for all providers.	N/A
82172	APOLIPOPROTEIN EA	No pre-authorization is required for all providers.	N/A
82175	ARSENIC	No pre-authorization is required for all providers.	N/A
82180	ASCORBIC ACID BLD	No pre-authorization is required for all providers.	N/A
82190	ATOMIC ABSORPTION SPECTROSCOPY EA ANALYTE	No pre-authorization is required for all providers.	N/A
82205	BARBITURATES NES	This is no longer a valid code.	N/A
82232	BETA-2 MICROGLOBULIN	No pre-authorization is required for all providers.	N/A
82239	BILE ACIDS; TOT	No pre-authorization is required for all providers.	N/A
82240	BILE ACIDS; CHOLYLGLYCINE	No pre-authorization is required for all providers.	N/A
82247	BILIRUBIN; TOT	No pre-authorization is required for all providers.	N/A
82248	BILIRUBIN; DIRECT	No pre-authorization is required for all providers.	N/A
82252	BILI; FECES QUAL	No pre-authorization is required for all providers.	N/A
82261	BIOTINIDASE EA SPEC	No pre-authorization is required for all providers.	N/A
82270	BLD OCCULT; FECES 1-3 SIMULTANEOUS DETERM	No pre-authorization is required for all providers.	N/A
82271	BLD OCLT PROXIDASE ACTV QUAL OTH SRCS	No pre-authorization is required for all providers.	N/A
82272	BLOOD OCCULT PEROXIDASE ACTV QUAL FECES 1-3 SPEC	No pre-authorization is required for all providers.	N/A
82274	FECAL HEMOGLOBIN IMMUNOASSAY TEST	No pre-authorization is required for all providers.	N/A
82286	BRADYKININ	No pre-authorization is required for all providers.	N/A
82300	CADMIUM	No pre-authorization is required for all providers.	N/A
82306	CALCIFEDIOL	No pre-authorization is required for all providers.	N/A
82308	CALCITONIN	No pre-authorization is required for all providers.	N/A
82310	CALCIUM; TOT	No pre-authorization is required for all providers.	N/A
82330	CALCIUM; IONIZED	No pre-authorization is required for all providers.	N/A
82331	CALCIUM; AFTER CALCIUM INFUSION TEST	No pre-authorization is required for all providers.	N/A
82340	CALCIUM; URIN QUAN TIMED SPECMN	No pre-authorization is required for all providers.	N/A
82355	CALCU; QUAL ANALY	No pre-authorization is required for all providers.	N/A
82360	CALCU; QUAN ANALY CHEM	No pre-authorization is required for all providers.	N/A
82365	CALCU; INFRARED SPECTROSCOPY	No pre-authorization is required for all providers.	N/A
82370	CALCU; X-RAY DIFFRACTION	No pre-authorization is required for all providers.	N/A
82373	CARBOHYDRATE DEFICIENT TRANSFERRIN 0	No pre-authorization is required for all providers.	N/A
82374	CARBON DIOXIDE	No pre-authorization is required for all providers.	N/A
82375	ASSAY CARBOXYHB QUANT	No pre-authorization is required for all providers.	N/A
82376	ASSAY CARBOXYHB QJAL	No pre-authorization is required for all providers.	N/A
82378	CARCINOEMBRYONIC ANTIG	No pre-authorization is required for all providers.	N/A
82379	CARNITINE (TOT & FREE) QUAN EA SPEC	No pre-authorization is required for all providers.	N/A
82380	CAROTENE	No pre-authorization is required for all providers.	N/A
82382	CATECHOLAMINES; TOT URIN	No pre-authorization is required for all providers.	N/A
82383	CATECHOLAMINES; BLD	No pre-authorization is required for all providers.	N/A
82384	CATECHOLAMINES; FRACTIONATED	No pre-authorization is required for all providers.	N/A
82387	CATHEPSIN-D	No pre-authorization is required for all providers.	N/A
82390	CERULOPLASMIN	No pre-authorization is required for all providers.	N/A
82397	CHEMILUMINESCENT ASSAY	No pre-authorization is required for all providers.	N/A
82415	CHLORAMPHENICOL	No pre-authorization is required for all providers.	N/A
82435	CHLORIDE; BLD	No pre-authorization is required for all providers.	N/A
82436	CHLORIDE; URIN	No pre-authorization is required for all providers.	N/A
82438	CHLORIDE; OTHER SOURCE	No pre-authorization is required for all providers.	N/A
82441	CHLORINATED HYDROCARBONS SCREEN	No pre-authorization is required for all providers.	N/A
82465	CHOL SERUM TOT	No pre-authorization is required for all providers.	N/A
82480	CHOLINESTERASE; SERUM	No pre-authorization is required for all providers.	N/A
82482	CHOLINESTERASE; RBC	No pre-authorization is required for all providers.	N/A
82485	CHONDROITIN B SULFATE QUAN	No pre-authorization is required for all providers.	N/A
82486	CHROMATOGRAPHY QUAL; COLUMN ANALYTE NES	This is no longer a valid code.	N/A
82487	CHROMATOGRAPHY QUAL; PAPER 1-DIMEN ANALYTE NES	This is no longer a valid code.	N/A
82488	CHROMATOGRAPHY QUAL; PAPER 2-DIMEN ANALYTE NES	This is no longer a valid code.	N/A
82489	CHROMATOGRAPHY QUAL; THIN LAYER ANALYTE NES	This is no longer a valid code.	N/A
82491	CHROMATOGRAPHY QUAN COLUMN; 1 ANALYTE NES	This is no longer a valid code.	N/A
82492	CHROMATOGRAPHY QUAN COLUMN; MULT ANALYTES	This is no longer a valid code.	N/A
82495	CHROMIUM	No pre-authorization is required for all providers.	N/A
82507	CITRATE	No pre-authorization is required for all providers.	N/A
82520	COCAINE/METABOLITE	This is no longer a valid code.	N/A
82523	COLLAGEN CROSS LINKS-ANY METHD	No pre-authorization is required for all providers.	N/A
82525	COPPER	No pre-authorization is required for all providers.	N/A
82528	CORTICOSTERONE	No pre-authorization is required for all providers.	N/A
82530	CORTISOL; FREE	No pre-authorization is required for all providers.	N/A
82533	CORTISOL; TOT	No pre-authorization is required for all providers.	N/A
82540	CREATINE	No pre-authorization is required for all providers.	N/A
82541	COLUMN CHROMATOGRAPHY QUAL	This is no longer a valid code.	N/A
82542	COL CHROMOTOGRAPHY QUAL/QUAN	No pre-authorization is required for all providers.	N/A
82543	COLUMN CHROMOTOGRAPH/ISOTOPE	This is no longer a valid code.	N/A
82544	COLUMN CHROMOTOGRAPH/ISOTOPE	This is no longer a valid code.	N/A
82550	CREATINE KINASE; TOT	No pre-authorization is required for all providers.	N/A
82552	CREATINE KINASE; ISOENZYMES	No pre-authorization is required for all providers.	N/A
82553	CREATINE KINASE; MB FRACTION ONLY	No pre-authorization is required for all providers.	N/A
82554	CREATINE KINASE; ISOFORMS	No pre-authorization is required for all providers.	N/A
82565	CREATININE; BLD	No pre-authorization is required for all providers.	N/A
82570	CREATININE; OTHER SOURCE	No pre-authorization is required for all providers.	N/A
82575	CREATININE; CLEARANCE	No pre-authorization is required for all providers.	N/A
82585	CRYOFIBRINOGEN	No pre-authorization is required for all providers.	N/A
82595	CRYOGLOBULIN	No pre-authorization is required for all providers.	N/A
82600	CYANIDE	No pre-authorization is required for all providers.	N/A
82607	CYANOCOBALAMIN	No pre-authorization is required for all providers.	N/A
82608	CYANOCOBALAMIN; UNSATURATED BINDING CAPACITY	No pre-authorization is required for all providers.	N/A
82610	CYSTATIN C	No pre-authorization is required for all providers.	N/A
82615	CYSTINE & HOMOCYSTEINE URIN QUAL	No pre-authorization is required for all providers.	N/A
82626	DEHYDROEPIANDROSTERONE	No pre-authorization is required for all providers.	N/A
82627	DEHYDROEPIANDROSTERONE-SULFATE	No pre-authorization is required for all providers.	N/A
82633	DESOXYCORTICOSTERONE 11-	No pre-authorization is required for all providers.	N/A
82634	DEOXYCORTISOL 11-	No pre-authorization is required for all providers.	N/A
82638	DIBUCAINE NUMBER	No pre-authorization is required for all providers.	N/A
82642	DIHYDROTTESTOSTERONE (DHT)	No pre-authorization is required for all providers.	N/A
82646	DIHYDROCODEINONE	This is no longer a valid code.	N/A
82649	DIHYDROMORPHINONE	This is no longer a valid code.	N/A
82651	DIHYDROTTESTOSTERONE	This is no longer a valid code.	N/A
82652	DIHYDROXYVITAMIN D 1 25-	No pre-authorization is required for all providers.	N/A
82654	DIMETHADIONE	This is no longer a valid code.	N/A
82656	ELASTASE PANCREATIC FECAL QUALITATIVE/SEMQUAN	No pre-authorization is required for all providers.	N/A
82657	ENZYM ACTIV-BLD CELL/CULT CELL/TISS NES; NONRAD	No pre-authorization is required for all providers.	N/A
82658	ENZYM ACTIV-BLD CELL/CULT CELL/TISS NES; RAD-EA	No pre-authorization is required for all providers.	N/A
82664	ELEC-PHORE TECH NES	No pre-authorization is required for all providers.	N/A
82666	EPIANDROSTERONE	This is no longer a valid code.	N/A
82668	ERYTHROPOIETIN	No pre-authorization is required for all providers.	N/A
82670	ESTRADIOL	No pre-authorization is required for all providers.	N/A
82671	ESTROGENS; FRACTIONATED	No pre-authorization is required for all providers.	N/A

82672	ESTROGENS; TOT	No pre-authorization is required for all providers.	N/A
82677	ESTRIOL	No pre-authorization is required for all providers.	N/A
82679	ESTRONE	No pre-authorization is required for all providers.	N/A
82690	ETHCHLORVYNOL	This is no longer a valid code.	N/A
82693	ETHYLENE GLYCOL	No pre-authorization is required for all providers.	N/A
82696	ETIOCHOLANOLONE	No pre-authorization is required for all providers.	N/A
82705	FAT/LIPIDS FECES; QUAL	No pre-authorization is required for all providers.	N/A
82710	FAT/LIPIDS FECES; QUAN	No pre-authorization is required for all providers.	N/A
82715	FAT DIFF FECES QUAN	No pre-authorization is required for all providers.	N/A
82725	FATTY ACIDS NONESTERIFIED	No pre-authorization is required for all providers.	N/A
82726	VERY LONG CHAIN FATTY ACIDS	No pre-authorization is required for all providers.	N/A
82728	FERRITIN	No pre-authorization is required for all providers.	N/A
82731	FETAL FIBRONECTIN-CERV/VAG SECRETIONS-SEMIQUAN	No pre-authorization is required for all providers.	N/A
82735	FLUORIDE	No pre-authorization is required for all providers.	N/A
82742	FLURAZEPAM	This is no longer a valid code.	N/A
82746	FOLIC ACID; SERUM	No pre-authorization is required for all providers.	N/A
82747	FOLIC ACID; RBC	No pre-authorization is required for all providers.	N/A
82757	FRUCTOSE SEMEN	No pre-authorization is required for all providers.	N/A
82759	GALACTOKINASE RBC	No pre-authorization is required for all providers.	N/A
82760	GALACTOSE	No pre-authorization is required for all providers.	N/A
82775	GALACTOSE-1-PHOSPHATE URIDYL TRANSFERASE; QUAN	No pre-authorization is required for all providers.	N/A
82776	GALACTOSE-1-PHOSPHATE URIDYL TRANSFERASE; SCREEN	No pre-authorization is required for all providers.	N/A
82777	GALECTIN 3	This service is not covered by Superior HealthPlan.	N/A
82784	GG; IGA, IGD, IGG, IGM, EA	No pre-authorization is required for all providers.	N/A
82785	GG; IGE	No pre-authorization is required for all providers.	N/A
82787	GG; IMMUNOGLOBULIN SUBCLASSES	No pre-authorization is required for all providers.	N/A
82800	GASES BLD PH ONLY	No pre-authorization is required for all providers.	N/A
82803	GASES BLD ANY COMBO-PH/PCO2/PO2/CO2/HCO3	No pre-authorization is required for all providers.	N/A
82805	GASES BLD ANY COMBO; W/O2 SAT EX OXIMETRY	No pre-authorization is required for all providers.	N/A
82810	GASES BLD O2 SAT ONLY DIREC MEASUR EX OXIMETRY	No pre-authorization is required for all providers.	N/A
82820	HGB-O2 AFFINITY	No pre-authorization is required for all providers.	N/A
82930	GASTRIC ANALY W/PH EA SPEC	No pre-authorization is required for all providers.	N/A
82938	GASTRIN AFTER SECRETIN STIM	No pre-authorization is required for all providers.	N/A
82941	GASTRIN	No pre-authorization is required for all providers.	N/A
82943	GLUCAGON	No pre-authorization is required for all providers.	N/A
82945	GLUCOSE-BODY FLUID OTH THAN BLD 0	No pre-authorization is required for all providers.	N/A
82946	GLUCAGON TOLERANCE TEST	No pre-authorization is required for all providers.	N/A
82947	GLU; QUAN	No pre-authorization is required for all providers.	N/A
82948	GLU; BLD REAGENT STRIP	No pre-authorization is required for all providers.	N/A
82950	GLU; POST GLU DOSE	No pre-authorization is required for all providers.	N/A
82951	GLU; TOLERANCE TEST 3 SPECMN	No pre-authorization is required for all providers.	N/A
82952	GTT-ADDED SAMPLES	No pre-authorization is required for all providers.	N/A
82953	GLU; TOLBUTAMIDE TOLERANCE TEST	This is no longer a valid code.	N/A
82955	GLU-6-PHOSPHATE DEHYDROGENASE; QUAN	No pre-authorization is required for all providers.	N/A
82960	GLU-6-PHOSPHATE DEHYDROGENASE; SCREEN	No pre-authorization is required for all providers.	N/A
82962	GLU BLD MONITOR CLEARED-FDA-HOME USE	This service is not covered by Superior HealthPlan.	N/A
82963	GLUCOSIDASE BETA	No pre-authorization is required for all providers.	N/A
82965	GLUTAMATE DEHYDROGENASE	No pre-authorization is required for all providers.	N/A
82975	GLUTAMINE	This is no longer a valid code.	N/A
82977	GLUTAMYLTRANSFERASE GAMMA	No pre-authorization is required for all providers.	N/A
82978	GLUTATHIONE	No pre-authorization is required for all providers.	N/A
82979	GLUTATHIONE REDUCTASE RBC	No pre-authorization is required for all providers.	N/A
82980	GLUTETHIMIDE	This is no longer a valid code.	N/A
82985	GLYCATED PROT	No pre-authorization is required for all providers.	N/A
83001	GONADOTROPIN; FOLLICLE STIM HORMONE	No pre-authorization is required for all providers.	N/A
83002	GONADOTROPIN; LUTEINIZING HORMONE	No pre-authorization is required for all providers.	N/A
83003	GROWTH HORMONE HUMAN	No pre-authorization is required for all providers.	N/A
83006	GROWTH STIMULATION GENE 2	No pre-authorization is required for all providers.	N/A
83008	GUANOSINE MONOPHOSPHATE CYCLIC	This is no longer a valid code.	N/A
83009	H PYLORI BLOOD TEST UREASE NON-RADIOACTV ISOTOPE	No pre-authorization is required for all providers.	N/A
83010	HAPTOGLOBIN; QUAN	No pre-authorization is required for all providers.	N/A
83012	HAPTOGLOBIN; PHENOTYPES	No pre-authorization is required for all providers.	N/A
83013	HELICOBACTER PYLORI BREATH TEST ANALY;	No pre-authorization is required for all providers.	N/A
83014	HELICOBACTER PYLORI BREATH ANALY; DRUG ADMIN	No pre-authorization is required for all providers.	N/A
83015	HEAVY METAL QUAL ANY ANAL	No pre-authorization is required for all providers.	N/A
83018	HEAVY METAL QUANT EACH NES	No pre-authorization is required for all providers.	N/A
83020	HGB FRACTIONAT & QUANTITAT: ELEC-PHORE	No pre-authorization is required for all providers.	N/A
83021	HEMOGLOB FRACTIONATION & QUAN; CHROMOTOGRAPHY	No pre-authorization is required for all providers.	N/A
83026	HGB; BY COPPER SULFATE METHD NON-AUTOMATED	No pre-authorization is required for all providers.	N/A
83030	HGB; F CHEM	No pre-authorization is required for all providers.	N/A
83033	HGB; F QUAL TEST FECAL	No pre-authorization is required for all providers.	N/A
83036	HGB; GLYCATED	No pre-authorization is required for all providers.	N/A
83037	HGB GLYCOSYLATED DEV CLEARED FDA HOME USE	No pre-authorization is required for all providers.	N/A
83045	HGB; METHHEMOGLOBIN QUAL	No pre-authorization is required for all providers.	N/A
83050	HGB; METHHEMOGLOBIN QUAN	No pre-authorization is required for all providers.	N/A
83051	HGB; PLASMA	No pre-authorization is required for all providers.	N/A
83055	HGB; SULFHEMOGLOBIN QUAL	This is no longer a valid code.	N/A
83060	HGB; SULFHEMOGLOBIN QUAN	No pre-authorization is required for all providers.	N/A
83065	HGB; THERMOLABILE	No pre-authorization is required for all providers.	N/A
83068	HGB; UNSTABLE SCREEN	No pre-authorization is required for all providers.	N/A
83069	HGB; URIN	No pre-authorization is required for all providers.	N/A
83070	HEMOSIDERIN; QUAL	No pre-authorization is required for all providers.	N/A
83071	HEMOSIDERIN; QUAN	This is no longer a valid code.	N/A
83080	B-HEXOSAMINIDASE EA ASSAY	No pre-authorization is required for all providers.	N/A
83088	HISTAMINE	No pre-authorization is required for all providers.	N/A
83090	HOMOCYSTINE 0	No pre-authorization is required for all providers.	N/A
83150	HOMOVANILLIC ACID	No pre-authorization is required for all providers.	N/A
83491	HYDROXYCORTICOSTEROIDS 17-	No pre-authorization is required for all providers.	N/A
83497	HYDROXYINDOLACETIC ACID 5-	No pre-authorization is required for all providers.	N/A
83498	HYDROXYPROGESTERONE 17-D	No pre-authorization is required for all providers.	N/A
83499	HYDROXYPROGESTERONE 20-	This is no longer a valid code.	N/A
83500	HYDROXYPROLINE; FREE	No pre-authorization is required for all providers.	N/A
83505	HYDROXYPROLINE; TOT	No pre-authorization is required for all providers.	N/A
83516	IMMUNOASSAY ANALYTE NOT AB/INFECT AG; MX STEP	No pre-authorization is required for all providers.	N/A
83518	IMMUNOASSAY ANALYTE NOT AB/INFECT AG; SINGL STEP	No pre-authorization is required for all providers.	N/A
83519	IMMUNOASSAY ANALYTE QUAN; BY RADIOPHARM TECH	No pre-authorization is required for all providers.	N/A
83520	IMMUNOASSAY ANALYTE QUAN; NOS	No pre-authorization is required for all providers.	N/A
83525	INSULIN; TOT	No pre-authorization is required for all providers.	N/A
83527	INSULIN; FREE	No pre-authorization is required for all providers.	N/A
83528	INTRINSIC FACTOR	No pre-authorization is required for all providers.	N/A
83540	IRON	No pre-authorization is required for all providers.	N/A
83550	IRON BINDING CAPACITY	No pre-authorization is required for all providers.	N/A
83570	ISOCITRIC DEHYDROGENASE	No pre-authorization is required for all providers.	N/A
83582	KETOGENIC STEROIDS FRACTIONATION	No pre-authorization is required for all providers.	N/A
83586	KETOSTEROIDS 17-; TOT	No pre-authorization is required for all providers.	N/A
83593	KETOSTEROIDS 17-; FRACTIONATION	No pre-authorization is required for all providers.	N/A
83605	LACTATE	No pre-authorization is required for all providers.	N/A
83615	LACTATE DEHYDROGENASE	No pre-authorization is required for all providers.	N/A
83625	LACTATE DEHYDROGENASE; ISOENZYMES SEPART & QUAN	No pre-authorization is required for all providers.	N/A
83630	LACTOFERRIN FECAL QUALITATIVE	No pre-authorization is required for all providers.	N/A
83631	LACTOFERRIN FECAL QUAN	No pre-authorization is required for all providers.	N/A

83632	LACTOGEN HUMN PLACENT HUMN CHORIONIC SOMATOMAMMO	No pre-authorization is required for all providers.	N/A
83633	LACTOSE URIN; QUAL	No pre-authorization is required for all providers.	N/A
83634	LACTOSE URIN; QUAN	This is no longer a valid code.	N/A
83655	LEAD	No pre-authorization is required for all providers.	N/A
83661	LECITHIN-SPHINGOMYELIN RATIO; QUAN	No pre-authorization is required for all providers.	N/A
83662	LECITHIN-SPHINGOMYELIN RATIO;FOAM STABILITY TEST	No pre-authorization is required for all providers.	N/A
83663	FETAL LUNG MATUR; FLUORESC POLARIZA 0	No pre-authorization is required for all providers.	N/A
83664	FETAL LUNG MATUR; LAMELLAR BODY DEN 0	No pre-authorization is required for all providers.	N/A
83670	LEUCINE AMINOPEPTIDASE	No pre-authorization is required for all providers.	N/A
83690	LIPASE	No pre-authorization is required for all providers.	N/A
83695	LIPOPROTEIN A	No pre-authorization is required for all providers.	N/A
83698	LIPOPROTEIN-ASSOCIATED PHOSPHOLIPASE A2, (LP-PLA2)	This service is not covered by Superior HealthPlan.	N/A
83700	LIPOPROTEIN BLD ELECTROP SEP&QUAN	No pre-authorization is required for all providers.	N/A
83701	LIPOPROTEIN BLD HR SUBCLASSES	No pre-authorization is required for all providers.	N/A
83704	LIPOPROTEIN BLD QUAN PART	No pre-authorization is required for all providers.	N/A
83716	LIPOPROTEIN BLD HI RES FRAC & QUAN	No pre-authorization is required for all providers.	N/A
83718	LIPOPROTEIN DIRECT MEASUR; HIGH DENSITY CHOL	No pre-authorization is required for all providers.	N/A
83719	LIPOPROTEIN DIRECT MEASUR; VLDL CHOL	No pre-authorization is required for all providers.	N/A
83721	LIPOPROTEIN DIRECT MEASUR; LDL CHOL	No pre-authorization is required for all providers.	N/A
83722	DIR MEAS LIPOPROTEIN SMALL DENSE LDL CHOLESTEROL	No pre-authorization is required for all providers.	N/A
83727	LUTEINIZING RELEASING FACTOR	No pre-authorization is required for all providers.	N/A
83735	MAGNESIUM	No pre-authorization is required for all providers.	N/A
83775	MALATE DEHYDROGENASE	No pre-authorization is required for all providers.	N/A
83785	MANGANESE	No pre-authorization is required for all providers.	N/A
83788	MASS SPECTROM & TANDEM SPECTR ANALYTE NES; QUAL	This is no longer a valid code.	N/A
83789	MASS SPECTROMETRY QUAL/QUAN	No pre-authorization is required for all providers.	N/A
83805	MEPROBAMATE	This is no longer a valid code.	N/A
83825	MERCURY QUAN	No pre-authorization is required for all providers.	N/A
83835	METANEPHRINES	No pre-authorization is required for all providers.	N/A
83840	METHADONE	This is no longer a valid code.	N/A
83857	METHMALBUMIN	No pre-authorization is required for all providers.	N/A
83858	METHSUXIMIDE	This is no longer a valid code.	N/A
83861	MICROFLUID ANALY TEARS	No pre-authorization is required for all providers.	N/A
83864	MUCOPOLYSACCHARIDES ACID; QUAN	No pre-authorization is required for all providers.	N/A
83866	MUCOPOLYSACCHARIDES ACID; SCREEN	This is no longer a valid code.	N/A
83872	MUCIN SYNOVIAL FLUID	No pre-authorization is required for all providers.	N/A
83873	MYELIN BASIC PROT CSF	No pre-authorization is required for all providers.	N/A
83874	MYOGLOBIN	No pre-authorization is required for all providers.	N/A
83876	ASSAY MYELOPEROXIDASE	This service is not covered by Superior HealthPlan.	N/A
83880	NATRIURETIC PEPTIDE	No pre-authorization is required for all providers.	N/A
83883	NEPHELOMETRY EA ANALYTE NES	No pre-authorization is required for all providers.	N/A
83885	NICKEL	No pre-authorization is required for all providers.	N/A
83887	NICOTINE	This is no longer a valid code.	N/A
83890	MOLECULE ISOLATE	This is no longer a valid code.	N/A
83891	MOLECULE ISOLATE NUCLEIC	This is no longer a valid code.	N/A
83915	NUCLEOTIDASE 5'-	Pre-authorization is required for all providers.	Prior to 09/01/2019
83916	OLIGOCLONAL IMMUNOGLOBULIN	No pre-authorization is required for all providers.	N/A
83918	ORGANIC ACIDS QUAN EA SPEC	No pre-authorization is required for all providers.	N/A
83919	ORGANIC ACIDS; QUAL EA SPEC	No pre-authorization is required for all providers.	N/A
83921	ORGANIC ACID-SNGL-QUAN 0	No pre-authorization is required for all providers.	N/A
83925	ASSAY OF OPIATES	This is no longer a valid code.	N/A
83930	OSMOLALITY; BLD	No pre-authorization is required for all providers.	N/A
83935	OSMOLALITY; URIN	No pre-authorization is required for all providers.	N/A
83937	OSTEOCALCIN	No pre-authorization is required for all providers.	N/A
83945	OXALATE	No pre-authorization is required for all providers.	N/A
83950	ONCOPROTEIN HER-2/NEU	No pre-authorization is required for all providers.	N/A
83951	ONCOPROTEIN DCP	No pre-authorization is required for all providers.	N/A
83970	PARATHORMONE	No pre-authorization is required for all providers.	N/A
83986	PH BODY FLUID EX BLD	No pre-authorization is required for all providers.	N/A
83987	EXHALED BREATH CONDENSATE	This service is not covered by Superior HealthPlan.	N/A
83992	PHENCYCLIDINE	Pre-authorization is required in all locations except Inpatient and Emergency Room.	Prior to 09/01/2019
83993	ASSAY FOR CALPROTECTIN FECAL	No pre-authorization is required for all providers.	N/A
84022	PHENOTHIAZINE	This is no longer a valid code.	N/A
84030	PHENYLALANINE BLD	No pre-authorization is required for all providers.	N/A
84035	PHENYLKETONES QUAL	No pre-authorization is required for all providers.	N/A
84060	PHOSPHATASE ACID; TOT	No pre-authorization is required for all providers.	N/A
84061	PHOSPHATASE ACID; FORENSIC EXAM	This is no longer a valid code.	N/A
84066	PHOSPHATASE ACID; PROSTATIC	No pre-authorization is required for all providers.	N/A
84075	PHOSPHATASE ALKALINE	No pre-authorization is required for all providers.	N/A
84078	PHOSPHATASE ALKALINE; HEAT STABLE	No pre-authorization is required for all providers.	N/A
84080	PHOSPHATASE ALKALINE; ISOENZYMES	No pre-authorization is required for all providers.	N/A
84081	PHOSPHATIDYLGlycerol	No pre-authorization is required for all providers.	N/A
84085	PHOSPHOGLUCONATE 6- DEHYDROGENASE RBC	No pre-authorization is required for all providers.	N/A
84087	PHOSPHOHEXOSE ISOMERASE	No pre-authorization is required for all providers.	N/A
84100	PHOSPHORUS INORGANIC	No pre-authorization is required for all providers.	N/A
84105	PHOSPHORUS INORGANIC; URIN	No pre-authorization is required for all providers.	N/A
84106	PORPHOBILINOGEN URIN; QUAL	No pre-authorization is required for all providers.	N/A
84110	PORPHOBILINOGEN URIN; QUAN	No pre-authorization is required for all providers.	N/A
84112	EVAL AMNIOTIC FLUID PROTEIN	No pre-authorization is required for all providers.	N/A
84119	PORPHYRINS URIN; QUAL	No pre-authorization is required for all providers.	N/A
84120	PORPHYRINS URIN; QUAN & FRACTIONATION	No pre-authorization is required for all providers.	N/A
84126	PORPHYRINS FECES; QUAN	No pre-authorization is required for all providers.	N/A
84127	PORPHYRINS FECES; QUAL	This is no longer a valid code.	N/A
84132	ASSAY OF SERUM POTASSIUM	No pre-authorization is required for all providers.	N/A
84133	POTASSIUM; URIN	This service is not covered by Superior HealthPlan.	N/A
84134	PREALBUMIN	No pre-authorization is required for all providers.	N/A
84135	PREGNANEDIOL	No pre-authorization is required for all providers.	N/A
84138	PREGNANETRIOL	No pre-authorization is required for all providers.	N/A
84140	PREGNENOLONE	No pre-authorization is required for all providers.	N/A
84143	17-HYDROXYPREGNENOLONE	No pre-authorization is required for all providers.	N/A
84144	PROGESTERONE	No pre-authorization is required for all providers.	N/A
84145	PROCALCITONIN (PCT)	No pre-authorization is required for all providers.	N/A
84146	PROLACTIN	No pre-authorization is required for all providers.	N/A
84150	PROSTAGLANDIN EA	No pre-authorization is required for all providers.	N/A
84152	PSA; COMPLEXED (DIRECT MEASUR) 0	No pre-authorization is required for all providers.	N/A
84153	PROSTATE SPEC ANTIG; TOT	No pre-authorization is required for all providers.	N/A
84154	PROSTATE SPEC ANTIG; FREE	No pre-authorization is required for all providers.	N/A
84155	ASSAY OF PROTEIN SERUM	No pre-authorization is required for all providers.	N/A
84156	PROT TOTAL NO REFRACTOMETRY URINE	No pre-authorization is required for all providers.	N/A
84157	PROT TOT NO REFRACTOMETRY OTH SRC	No pre-authorization is required for all providers.	N/A
84160	PROTEIN TOT REFRACTOMETRY ANY SRC	No pre-authorization is required for all providers.	N/A
84163	PREGNANCY-ASSOCIATED PLASMA PROTEIN-A PAPP-A	No pre-authorization is required for all providers.	N/A
84165	PROT ELEC-PHORE FRACTIONATION&QUAN	No pre-authorization is required for all providers.	N/A
84166	PROTEIN; ELECTROPHORETIC FRACTIONATN&QUAN OTH FL	No pre-authorization is required for all providers.	N/A
84181	PROT; WESTERN BLOT BLD/OTHER FLUID	No pre-authorization is required for all providers.	N/A
84182	PROT; WESTERN BLOT IMMUNOL PROBE-BAND ID EA	No pre-authorization is required for all providers.	N/A
84202	PROTOPORPHYRIN RBC; QUAN	No pre-authorization is required for all providers.	N/A
84203	PROTOPORPHYRIN RBC; SCREEN	No pre-authorization is required for all providers.	N/A
84206	PROINSULIN	No pre-authorization is required for all providers.	N/A
84207	PYRIDOXAL PHOSPHATE	No pre-authorization is required for all providers.	N/A
84210	PYRUVATE	No pre-authorization is required for all providers.	N/A

84220	PYRUVATE KINASE	No pre-authorization is required for all providers.	N/A
84228	QUININE	No pre-authorization is required for all providers.	N/A
84233	RECEPTOR ASSAY; ESTROGEN	No pre-authorization is required for all providers.	N/A
84234	RECEPTOR ASSAY; PROGESTERONE	No pre-authorization is required for all providers.	N/A
84235	RECEPTOR ASSAY; ENDOCRINE NOT ESTROGN/PROGESTERON	No pre-authorization is required for all providers.	N/A
84238	RECEPTOR ASSAY; NON-ENDOCRINE	No pre-authorization is required for all providers.	N/A
84244	RENIN	No pre-authorization is required for all providers.	N/A
84252	RIBOFLAVIN	No pre-authorization is required for all providers.	N/A
84255	SELENIUM	No pre-authorization is required for all providers.	N/A
84260	SEROTONIN	No pre-authorization is required for all providers.	N/A
84270	SEX HORMONE BINDING GLOB	No pre-authorization is required for all providers.	N/A
84275	SIALIC ACID	No pre-authorization is required for all providers.	N/A
84285	SILICA	No pre-authorization is required for all providers.	N/A
84295	ASSAY OF SERUM SODIUM	No pre-authorization is required for all providers.	N/A
84300	SODIUM; URIN	No pre-authorization is required for all providers.	N/A
84302	SODIUM; OTHER SOURCE	No pre-authorization is required for all providers.	N/A
84305	SOMATOMEDIN	No pre-authorization is required for all providers.	N/A
84307	SOMATOSTATIN	No pre-authorization is required for all providers.	N/A
84311	SPECTROPHOTOMETRY ANALYTE NES	No pre-authorization is required for all providers.	N/A
84315	SPEC GRAVITY	No pre-authorization is required for all providers.	N/A
84375	SUGARS CHROMATOGRAPHIC TLC/PAPER CHROMATOGRAPHY	No pre-authorization is required for all providers.	N/A
84376	SUGARS; 1 QUAL EA SPECMN	No pre-authorization is required for all providers.	N/A
84377	SUGARS; MX QUAL EA SPECMN	No pre-authorization is required for all providers.	N/A
84378	SUGARS; 1 QUAN EA SPECMN	No pre-authorization is required for all providers.	N/A
84379	SUGARS; MX QUAN EA SPECMN	No pre-authorization is required for all providers.	N/A
84392	SULFATE URIN	No pre-authorization is required for all providers.	N/A
84402	TESTOSTERONE; FREE	No pre-authorization is required for all providers.	N/A
84403	TESTOSTERONE; TOT	No pre-authorization is required for all providers.	N/A
84410	ASSAY BIOVLBL TESTOSTERONE DIRECT MEASUREMENT	This service is not covered by Superior HealthPlan.	N/A
84425	THIAMINE	No pre-authorization is required for all providers.	N/A
84430	THIOCYANATE	No pre-authorization is required for all providers.	N/A
84431	THROMBOXANE, URINE	No pre-authorization is required for all providers.	N/A
84432	THYROGLOBULIN	No pre-authorization is required for all providers.	N/A
84436	THYROXINE; TOT	No pre-authorization is required for all providers.	N/A
84437	THYROXINE; REQUIRING ELUTION	No pre-authorization is required for all providers.	N/A
84439	THYROXINE; FREE	No pre-authorization is required for all providers.	N/A
84442	THYROXINE BINDING GLOB	No pre-authorization is required for all providers.	N/A
84443	THYROID STIM HORMONE	No pre-authorization is required for all providers.	N/A
84445	THYROID STIM IMMUNOGLOBULINS	No pre-authorization is required for all providers.	N/A
84446	TOCOPHEROL ALPHA	No pre-authorization is required for all providers.	N/A
84449	TRASCORTIN	No pre-authorization is required for all providers.	N/A
84450	TRANSFERASE; ASPARTATE AMINO	No pre-authorization is required for all providers.	N/A
84460	TRANSFERASE; ALANINE AMINO	No pre-authorization is required for all providers.	N/A
84466	TRANSFERRIN	No pre-authorization is required for all providers.	N/A
84478	TRIGLYCERIDES	No pre-authorization is required for all providers.	N/A
84479	THYROID HORMONE UPTAKE/HORMONE BINDING RATIO	No pre-authorization is required for all providers.	N/A
84480	TRIIODOTHYRONINE T3; TOT (TT3)	No pre-authorization is required for all providers.	N/A
84481	TRIIODOTHYRONINE T3; FREE	No pre-authorization is required for all providers.	N/A
84482	TRIIODOTHYRONINE T3; REVERSE	No pre-authorization is required for all providers.	N/A
84484	TROPONIN, QUAN	No pre-authorization is required for all providers.	N/A
84485	TRYPSIN; DUODENAL FLUID	No pre-authorization is required for all providers.	N/A
84488	TRYPSIN; FECES QUAL	No pre-authorization is required for all providers.	N/A
84490	TRYPSIN; FECES QUAN 24-HR COLLEC	No pre-authorization is required for all providers.	N/A
84510	TYROSINE	No pre-authorization is required for all providers.	N/A
84512	TROPONIN, QUAL	No pre-authorization is required for all providers.	N/A
84520	UREA NITRO; QUAN	No pre-authorization is required for all providers.	N/A
84525	UREA NITRO; SEMIQUANTITATIVE	No pre-authorization is required for all providers.	N/A
84540	UREA NITRO URIN	No pre-authorization is required for all providers.	N/A
84545	UREA NITRO CLEARANCE	No pre-authorization is required for all providers.	N/A
84550	URIC ACID; BLD	No pre-authorization is required for all providers.	N/A
84560	URIC ACID; OTHER SOURCE	No pre-authorization is required for all providers.	N/A
84577	UROBILINOGEN FECES QUAN	No pre-authorization is required for all providers.	N/A
84578	UROBILINOGEN URIN; QUAL	No pre-authorization is required for all providers.	N/A
84580	UROBILINOGEN URIN; QUAN TIMED SPECMN	No pre-authorization is required for all providers.	N/A
84583	UROBILINOGEN URIN; SEMIQUAN	No pre-authorization is required for all providers.	N/A
84585	VANILLYLMADELIC ACID URIN	No pre-authorization is required for all providers.	N/A
84586	VASOACTIVE INTESTINAL PEPTIDE	No pre-authorization is required for all providers.	N/A
84588	VASOPRESSIN	No pre-authorization is required for all providers.	N/A
84590	VITAMIN A	No pre-authorization is required for all providers.	N/A
84591	VITAMIN NOS 0	No pre-authorization is required for all providers.	N/A
84597	VITAMIN K	No pre-authorization is required for all providers.	N/A
84600	ASSAY OF VOLATILES	No pre-authorization is required for all providers.	N/A
84620	XYLOSE ABSORPTION TEST BLD &/OR URIN	No pre-authorization is required for all providers.	N/A
84630	ZINC	No pre-authorization is required for all providers.	N/A
84681	C-PEPTIDE	No pre-authorization is required for all providers.	N/A
84702	GONADOTROPIN CHORIONIC; QUAN	No pre-authorization is required for all providers.	N/A
84703	GONADOTROPIN CHORIONIC; QUAL	No pre-authorization is required for all providers.	N/A
84704	HCG FREE BETACHAIN TEST	No pre-authorization is required for all providers.	N/A
84830	OVULATION TESTS VISUAL COLOR COMPAR METHD	This service is not covered by Superior HealthPlan.	N/A
84999	UNLISTED CHEM PROC	No pre-authorization is required for all providers.	N/A
85002	BLEEDING TIME	No pre-authorization is required for all providers.	N/A
85004	BLOOD COUNT; AUTO DIFF WBC COUNT	No pre-authorization is required for all providers.	N/A
85007	BLD CNT; SMER MIC EX MNL DIFF WBC	No pre-authorization is required for all providers.	N/A
85008	BLD CNT;SMER MIC EX NO MNL DIFF WBC	No pre-authorization is required for all providers.	N/A
85009	BLD CNT;MNL DIFF WBC CNT BUFFY COAT	No pre-authorization is required for all providers.	N/A
85013	BLD CT; SPUN MICROHEMATOCRIT	No pre-authorization is required for all providers.	N/A
85014	BLOOD COUNT; HEMATOCRIT	No pre-authorization is required for all providers.	N/A
85018	BLOOD COUNT; HEMOGLOBIN	No pre-authorization is required for all providers.	N/A
85021	BLD CT; HG AUTOMATED	No pre-authorization is required for all providers.	N/A
85025	BLD CNT;Cmpl AUTO&AUTO DIFF WBC CNT	No pre-authorization is required for all providers.	N/A
85027	BLOOD COUNT; COMPLETE AUTOMATIC	No pre-authorization is required for all providers.	N/A
85029	ADD AUTO HG INDICES; 1-3 INDICES	No pre-authorization is required for all providers.	N/A
85030	ADD AUTO HG INDICES; 4/MORE INDICES	No pre-authorization is required for all providers.	N/A
85031	BLD CT; HG MANUAL COMPLT CBC	No pre-authorization is required for all providers.	N/A
85032	BLOOD COUNT; MANUAL CELL COUNT EA	No pre-authorization is required for all providers.	N/A
85041	BLOOD COUNT; RBC AUTOMATED	No pre-authorization is required for all providers.	N/A
85044	BLOOD COUNT; RETICULOCYTE MANUAL	No pre-authorization is required for all providers.	N/A
85045	BLOOD COUNT; RETICULOCYTE AUTOMATED	No pre-authorization is required for all providers.	N/A
85046	BLD CNT; RETICULOCYTES-HGB CONCENTRATION	No pre-authorization is required for all providers.	N/A
85048	BLOOD COUNT; LEUKOCYTE AUTO	No pre-authorization is required for all providers.	N/A
85049	BLOOD COUNT; PLATELET AUTOMATED	No pre-authorization is required for all providers.	N/A
85055	RETICULATED PLATELET ASSAY	No pre-authorization is required for all providers.	N/A
85060	BLD SMEAR PERIPHERAL INTERPT-PHYS W/WRT REPORT	No pre-authorization is required for all providers.	N/A
85097	BONE MARROW; SMEAR INTERPT ONLY W/WO DIF CELL CT	No pre-authorization is required for all providers.	N/A
85130	CHROMOGENIC SUBSTRATE ASSAY	No pre-authorization is required for all providers.	N/A
85170	CLOT RETRACTION	No pre-authorization is required for all providers.	N/A
85175	CLOT LYSIS TIME WHOLE BLD DILUT	No pre-authorization is required for all providers.	N/A
85210	CLOTTING; FACTOR II PROTHROMBIN SPEC	No pre-authorization is required for all providers.	N/A
85220	CLOTTING; FACTOR V LABILE FACTOR	No pre-authorization is required for all providers.	N/A
85230	CLOTTING; FACTOR VII	No pre-authorization is required for all providers.	N/A
85240	CLOTTING; FACTOR VIII 1 STAGE	No pre-authorization is required for all providers.	N/A

85244	CLOTTING; FACTOR VIII RELATED ANTIG	No pre-authorization is required for all providers.	N/A
85245	CLOT; FACTOR VIII VW FACTOR RISTOCETIN COFACTOR	No pre-authorization is required for all providers.	N/A
85246	CLOTTING; FACTOR VIII VW FACTOR ANTIG	No pre-authorization is required for all providers.	N/A
85247	CLOT; VIII VON WILLEBRAND FACT MX-METRIC ANALY	No pre-authorization is required for all providers.	N/A
85250	CLOTTING; FACTOR IX	No pre-authorization is required for all providers.	N/A
85260	CLOTTING; FACTOR X	No pre-authorization is required for all providers.	N/A
85270	CLOTTING; FACTOR XI	No pre-authorization is required for all providers.	N/A
85280	CLOTTING; FACTOR XII	No pre-authorization is required for all providers.	N/A
85290	CLOTTING; FACTOR XIII	No pre-authorization is required for all providers.	N/A
85291	CLOTTING; FACTOR XIII SCREEN SOLUBILITY	No pre-authorization is required for all providers.	N/A
85292	CLOTTING; PREKALLIKREIN ASSAY	No pre-authorization is required for all providers.	N/A
85293	CLOTTING; HIGH MOLECULAR WT KININOGEN ASSAY	No pre-authorization is required for all providers.	N/A
85300	CLOT INHIBIT/ANTICOAG; ANTITHROMBIN III ACTIVITY	No pre-authorization is required for all providers.	N/A
85301	CLOT INHIB/ANTICOAG;ANTITHROMBIN III ANTIG ASSAY	No pre-authorization is required for all providers.	N/A
85302	CLOT INHIBIT/ANTICOAGULANTS; PROT C ANTIG	No pre-authorization is required for all providers.	N/A
85303	CLOT INHIBIT/ANTICOAGULANTS; PROT C ACTIVITY	No pre-authorization is required for all providers.	N/A
85305	CLOTTING INHIBIT OR ANTICOAGULANTS; PROT S TOT	No pre-authorization is required for all providers.	N/A
85306	CLOTTING INHIBIT/ANTICOAGULANTS; PROT S FREE	No pre-authorization is required for all providers.	N/A
85307	ACTIVATED PROTEIN C RESISTANC ASSAY 0	No pre-authorization is required for all providers.	N/A
85335	FACTOR INHIBIT TEST	No pre-authorization is required for all providers.	N/A
85337	THROMBOMODULIN	No pre-authorization is required for all providers.	N/A
85345	COAGULATION TIME; LEE & WHITE	No pre-authorization is required for all providers.	N/A
85347	COAGULATION TIME; ACTIVATED	No pre-authorization is required for all providers.	N/A
85348	COAGULATION TIME; OTHER METHD	No pre-authorization is required for all providers.	N/A
85360	EUGLOBULIN LYSIS	No pre-authorization is required for all providers.	N/A
85362	FIBRIN DEGRAD PROD; AGGLUTINATION SLIDE-SEMIQUAN	No pre-authorization is required for all providers.	N/A
85366	FIBRIN DEGRADATION PRODUCTS; PARACOAGULATION	No pre-authorization is required for all providers.	N/A
85370	FIBRIN DEGRADATION PRODUCTS; QUAN	No pre-authorization is required for all providers.	N/A
85378	FDP D-DIMER; QUALITATIVE/SEMIQUAN	No pre-authorization is required for all providers.	N/A
85379	FIBRIN DEGRADATION PRODUCTS D-DIMER; QUAN	No pre-authorization is required for all providers.	N/A
85380	FDP D-DIMER;ULTRSNSTV QUAL/SEMIQUAN	No pre-authorization is required for all providers.	N/A
85384	FIBRINOGEN; ACTIVITY	No pre-authorization is required for all providers.	N/A
85385	FIBRINOGEN; ANTIG	No pre-authorization is required for all providers.	N/A
85390	FIBRINOLYSINS/COAGULOPATHY SCREEN INTERPT/REPORT	No pre-authorization is required for all providers.	N/A
85396	COAGULAT/FIBRNLYSIS ASSAY WB I&R-DA	No pre-authorization is required for all providers.	N/A
85397	CLOTTING FUNCT ACTIVITY	No pre-authorization is required for all providers.	N/A
85400	FIBRINOLYTIC FACTORS & INHIBIT; PLASMIN	No pre-authorization is required for all providers.	N/A
85410	FIBRINOLYTIC FACT & INHIBIT; ALPHA-2 ANTIPLASMIN	No pre-authorization is required for all providers.	N/A
85415	FIBRINOLYTIC FACT & INHIBIT; PLASMINOGEN ACTIVAT	No pre-authorization is required for all providers.	N/A
85420	FIBRINOLYTIC FACT/INHIB; PLASMINOGEN NOT ANTIGENIC	No pre-authorization is required for all providers.	N/A
85421	FIBRINOLYTIC FACT/INHIB; PLASMINOGEN ANTIG ASSAY	No pre-authorization is required for all providers.	N/A
85441	HEINZ BODIES; DIRECT	No pre-authorization is required for all providers.	N/A
85445	HEINZ BODIES; INDUCED ACETYL PHENYLHYDRAZINE	No pre-authorization is required for all providers.	N/A
85460	HGB/RBC FETAL-FETOMATERNAL HEMORR; DIFF LYSIS	No pre-authorization is required for all providers.	N/A
85461	HGB/RBC FETAL-FETOMATERNAL HEMORR; ROSETTE	No pre-authorization is required for all providers.	N/A
85475	HEMOLYSIN; ACID	No pre-authorization is required for all providers.	N/A
85520	HEPARIN ASSAY	No pre-authorization is required for all providers.	N/A
85525	HEPARIN NEUTRALIZATION	No pre-authorization is required for all providers.	N/A
85530	HEPARIN-PROTAMINE TOLERANCE TEST	No pre-authorization is required for all providers.	N/A
85536	IRON STAIN PERIPH BLD 0	No pre-authorization is required for all providers.	N/A
85540	LEUKOCYTE ALKALINE PHOSPHATASE W/CT	No pre-authorization is required for all providers.	N/A
85547	MECH FRAGILITY RBC	No pre-authorization is required for all providers.	N/A
85549	MURAMIDASE	No pre-authorization is required for all providers.	N/A
85555	OSMOTIC FRAGILITY RBC; UNINCUBATED	No pre-authorization is required for all providers.	N/A
85557	OSMOTIC FRAGILITY RBC; INCUBATED	No pre-authorization is required for all providers.	N/A
85576	PLATELET AGGREGATION EACH AGENT	No pre-authorization is required for all providers.	N/A
85585	PLATELET; ESTIMATION SMEAR ONLY	No pre-authorization is required for all providers.	N/A
85595	PLATELET; AUTOMATED CT	No pre-authorization is required for all providers.	N/A
85597	PHOSPHOLIPID PLTLT NEUTRALI	No pre-authorization is required for all providers.	N/A
85598	HEXAGNAL PHOSPH PLTLT NEUTR	No pre-authorization is required for all providers.	N/A
85610	PROTHROMBIN TIME	No pre-authorization is required for all providers.	N/A
85611	PROTHROMBIN TIME; SUBSTITUT PLASMA FRACTIONS EA	No pre-authorization is required for all providers.	N/A
85612	RUSSELL VIPER VENOM TIME; UNDILUTED	No pre-authorization is required for all providers.	N/A
85613	RUSSELL VIPER VENOM TIME; DILUTED	No pre-authorization is required for all providers.	N/A
85635	REPTILASE TEST	No pre-authorization is required for all providers.	N/A
85651	SED RATE ERYTHROCYTE NON-AUTOMATED	No pre-authorization is required for all providers.	N/A
85652	SED RATE, ERYTHROCYTE; AUTO	No pre-authorization is required for all providers.	N/A
85660	SICKLING RBC REDUCTION	No pre-authorization is required for all providers.	N/A
85670	THROMBIN TIME; PLASMA	No pre-authorization is required for all providers.	N/A
85675	THROMBIN TIME; TITER	No pre-authorization is required for all providers.	N/A
85705	THROMBOPLASTIN INHIBIT; TISS	No pre-authorization is required for all providers.	N/A
85730	THROMBOPLASTIN TIME PART; PLASMA/WHOLE BLD	No pre-authorization is required for all providers.	N/A
85732	THROMBOPLASTIN TIME PART; SUBSTIT PLASMA FRACT EA	No pre-authorization is required for all providers.	N/A
85810	VISCOSITY	No pre-authorization is required for all providers.	N/A
85999	UNLISTED HEMATOLOGY & COAGULATION PROC	No pre-authorization is required for all providers.	N/A
86000	AGGLUTININS FEBRILE EA ANTIG	No pre-authorization is required for all providers.	N/A
86001	ALLERG SPEC IgG QUAN/SEMIQUAN-EA 0	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
86003	ALLG SPEC IGE CRUDE XTRC EA	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
86005	ALLG SPEC IGE MULTIALLG SCR	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
86008	ALLG SPEC IGE RECOMB EA	No pre-authorization is required for all providers.	N/A
86021	ANTIB IDENT; LEUKOCYTE ANTIB	No pre-authorization is required for all providers.	N/A
86022	ANTIB IDENT; PLATELET ANTIB	No pre-authorization is required for all providers.	N/A
86023	ANTIB IDENT; PLATELET ASSOC IMMUNOGLOBULIN ASSAY	No pre-authorization is required for all providers.	N/A
86038	ANTINUCLEAR ANTIB	No pre-authorization is required for all providers.	N/A
86039	ANTINUCLEAR ANTIB; TITER	No pre-authorization is required for all providers.	N/A
86060	ANTISTREPTOLYSIN 0; TITER	No pre-authorization is required for all providers.	N/A
86063	ANTISTREPTOLYSIN 0; SCREEN	No pre-authorization is required for all providers.	N/A
86077	BLD BNK PHYS SERV; DIFF X-MATCH/EVAL IRREG ANTIB	No pre-authorization is required for all providers.	N/A
86078	BLD BNK PHYS SERV; INVESTIGAT TRANSFUSION REACT	No pre-authorization is required for all providers.	N/A
86079	BLD BNK PHYS SERV; AUTHORIZAT DEVIAT STAND PROC	No pre-authorization is required for all providers.	N/A
86140	C-REACTIVE PROT	No pre-authorization is required for all providers.	N/A
86141	HIGH SENSITIVITY C-REACTIVE PROTEIN	No pre-authorization is required for all providers.	N/A
86146	BETA 2 GLYCOPROTEIN I ANTIBODY-EA 0	No pre-authorization is required for all providers.	N/A
86147	CARDIOLIPIN ANTIB	No pre-authorization is required for all providers.	N/A
86148	ANTI-PHOSPHATIDYLSERINE ANTIBODY	No pre-authorization is required for all providers.	N/A
86152	CELL ENUMERATION & ID	This service is not covered by Superior HealthPlan.	N/A
86153	CELL ENUMERATION PHYS INTERP	This service is not covered by Superior HealthPlan.	N/A
86155	CHEMOTAXIS ASSAY SPEC METHD	No pre-authorization is required for all providers.	N/A
86156	COLD AGGLUTININ; SCREEN	No pre-authorization is required for all providers.	N/A
86157	COLD AGGLUTININ; TITER	No pre-authorization is required for all providers.	N/A
86160	COMPLEMENT; ANTIG EA COMPONENT	No pre-authorization is required for all providers.	N/A
86161	COMPLEMENT; FUNCT ACTIVITY EA COMPONENT	No pre-authorization is required for all providers.	N/A
86162	COMPLEMENT; TOT HEMOLYTIC	No pre-authorization is required for all providers.	N/A
86171	COMPLEMENT FIXA TESTS EA ANTIG	No pre-authorization is required for all providers.	N/A
86185	COUNTERIMMUNOELECTROPHORESIS EA ANTIG	This is no longer a valid code.	N/A
86200	CYCLIC CITRULLINATED PEPTIDE ANTB	No pre-authorization is required for all providers.	N/A
86215	DEOXYRIBONUCLEASE ANTIB	No pre-authorization is required for all providers.	N/A
86225	DNA ANTIB; NATIVE/DOUBLE STRANDED	No pre-authorization is required for all providers.	N/A
86226	DNA ANTIB; SNGL STRANDED	No pre-authorization is required for all providers.	N/A

86235	EXTRACTABLE NUCLEAR ANTIG ANTIB ANY METHD	No pre-authorization is required for all providers.	N/A
86243	FC RECEPTOR	This is no longer a valid code.	N/A
86255	FLUORESCENT NONINFECT AGENT ANTIB; SCREEN EA	No pre-authorization is required for all providers.	N/A
86256	FLUORESCENT ANTIB; TITER EA ANTIB	No pre-authorization is required for all providers.	N/A
86277	GROWTH HORMONE HUMAN ANTIB	No pre-authorization is required for all providers.	N/A
86280	HEMAGGLUTINATION INHIBIT TEST	No pre-authorization is required for all providers.	N/A
86287	HEPATITIS B (HBsAG)	No pre-authorization is required for all providers.	N/A
86289	HEPATITIS BC ANTIBODY TEST	No pre-authorization is required for all providers.	N/A
86290	HEPATITIS BC ANTIBODY TEST	No pre-authorization is required for all providers.	N/A
86291	HEPATITIS BS ANTIBODY TEST	No pre-authorization is required for all providers.	N/A
86293	HEPATITIS BE ANTIBODY TEST	No pre-authorization is required for all providers.	N/A
86294	IMMUNOAS TUMOR ANTIG-QUAL/SEMIQUAN 0	No pre-authorization is required for all providers.	N/A
86295	HEPATITIS BE ANTIBODY TEST	No pre-authorization is required for all providers.	N/A
86296	HEPATITIS A ANTIBODY TEST	No pre-authorization is required for all providers.	N/A
86299	HEPATITIS A ANTIBODY TEST	No pre-authorization is required for all providers.	N/A
86300	IMMUNOAS TUMOR ANTIG-QUAN; CA 15-3 0	No pre-authorization is required for all providers.	N/A
86301	IMMUNOAS TUMOR ANTIG-QUAN; CA 19-9 0	No pre-authorization is required for all providers.	N/A
86302	HEPATITIS C ANTIBODY	No pre-authorization is required for all providers.	N/A
86303	HEPATITIS C CONFIRMATORY TEST	No pre-authorization is required for all providers.	N/A
86304	IMMUNOAS TUMOR ANTIG-QUAN; CA 125 0	No pre-authorization is required for all providers.	N/A
86305	HUMAN EPIDIDYMSIS PROTEIN 4	No pre-authorization is required for all providers.	N/A
86306	HEPATITIS, DELTA AGENT	No pre-authorization is required for all providers.	N/A
86308	HETEROPHILE ANTIB; SCREENING	No pre-authorization is required for all providers.	N/A
86309	HETEROPHILE ANTIB; TITER	No pre-authorization is required for all providers.	N/A
86310	HETEROPHILE ANTIB; TITER AFTER ABSORPT	No pre-authorization is required for all providers.	N/A
86311	HIV ANTIGEN TEST	No pre-authorization is required for all providers.	N/A
86313	IMMUNOASSAY FOR INFECTIOUS AGENT ANTIGEN	No pre-authorization is required for all providers.	N/A
86315	IMMUNOASSAY FOR INFECTIOUS AGENT ANTIGEN	No pre-authorization is required for all providers.	N/A
86316	IMMUNOASSAY TUMOR ANTIG EA	No pre-authorization is required for all providers.	N/A
86317	IMMUNOASSAY INFEC AGENT ANTIB QUAN NOS	No pre-authorization is required for all providers.	N/A
86318	IA INFECTIOUS AGT ANTIBODY QUAL/SEMIQ 1STEP METH	No pre-authorization is required for all providers.	N/A
86320	IMMUNOELECTROPHORESIS; SERUM	No pre-authorization is required for all providers.	N/A
86325	IMMUNOELECTROPHORESIS; OTHER FLUIDS W/CONCNRAT	No pre-authorization is required for all providers.	N/A
86327	IMMUNOELECTROPHORESIS; CROSSED	No pre-authorization is required for all providers.	N/A
86329	IMMUNODIFFUSION; NES	No pre-authorization is required for all providers.	N/A
86331	IMMUNODIFFUSION; GEL DIFFUS QUAL EA ANTIG/ANTIB	No pre-authorization is required for all providers.	N/A
86332	IMMUNE COMPLX ASSAY	No pre-authorization is required for all providers.	N/A
86334	IMMUNOFIXATION ELEC-PHORE	No pre-authorization is required for all providers.	N/A
86335	IMMUNOFIXATION ELECTROPHORESIS; OTH FL W/CONC	No pre-authorization is required for all providers.	N/A
86336	INHIBIN A	No pre-authorization is required for all providers.	N/A
86337	INSULIN ANTIB	No pre-authorization is required for all providers.	N/A
86340	INTRINSIC FACTOR ANTIB	No pre-authorization is required for all providers.	N/A
86341	ISLET CELL ANTIBODY	No pre-authorization is required for all providers.	N/A
86343	LEUKOCYTE HISTAMINE RELEASE TEST	No pre-authorization is required for all providers.	N/A
86344	LEUKOCYTE PHAGOCYTOSIS	No pre-authorization is required for all providers.	N/A
86352	CELL FUNCTION ASSAY W/STIM	No pre-authorization is required for all providers.	N/A
86353	LYMPHOCYTE TRANSFORM MITOGEN/ANTIG INDUCED BLAST	No pre-authorization is required for all providers.	N/A
86355	B CELLS TOT CNT	No pre-authorization is required for all providers.	N/A
86356	MONONUCLEAR CELL ANTIGEN	No pre-authorization is required for all providers.	N/A
86357	NATURAL KILLER CELLS TOT CNT	No pre-authorization is required for all providers.	N/A
86359	T CELLS; TOT CT	No pre-authorization is required for all providers.	N/A
86360	T CELLS; ABSOLUTE CD4 & CD8 COUNT, INCLU RATIO	No pre-authorization is required for all providers.	N/A
86361	T CELLS; ABSOLUTE CD4 COUNT	No pre-authorization is required for all providers.	N/A
86367	STEM CELLS TOT CNT	No pre-authorization is required for all providers.	N/A
86376	MICROSOMAL ANTIB EA	No pre-authorization is required for all providers.	N/A
86378	MIGRATION INHIBIT FACTOR TEST	This is no longer a valid code.	N/A
86379	NATURAL KILLER CELLS TOTAL COUNT	No pre-authorization is required for all providers.	N/A
86382	NEUTRALIZATION TEST VIRAL	No pre-authorization is required for all providers.	N/A
86384	NITROBLUE TETRAZOLIUM DYE TEST	No pre-authorization is required for all providers.	N/A
86386	NUCLEAR MATRIX PROTEIN 22	No pre-authorization is required for all providers.	N/A
86403	PARTICLE AGGLUTINATION; SCREEN-EA ANTIB	No pre-authorization is required for all providers.	N/A
86406	PARTICLE AGGLUTINATION; TITER EA ANTIB	No pre-authorization is required for all providers.	N/A
86430	RHEUMATOID FACTOR; QUAL	No pre-authorization is required for all providers.	N/A
86431	RHEUMATOID FACTOR; QUAN	No pre-authorization is required for all providers.	N/A
86480	TB TEST CELL IMMUN MEASURE	No pre-authorization is required for all providers.	N/A
86481	TB AG RESPONSE T-CELL SUSP	No pre-authorization is required for all providers.	N/A
86485	SKIN TEST; CANDIDA	No pre-authorization is required for all providers.	N/A
86486	SKIN TEST NOS ANTIGEN	No pre-authorization is required for all providers.	N/A
86490	SKIN TEST; COCCIDIOIDOMYCOSIS	No pre-authorization is required for all providers.	N/A
86510	SKIN TEST; HISTOPLASMOSIS	No pre-authorization is required for all providers.	N/A
86580	SKIN TEST; TUBERCULOSIS INTRADERMAL	No pre-authorization is required for all providers.	N/A
86588	STREPTOCOCCUS SCREEN DIRECT	No pre-authorization is required for all providers.	N/A
86590	STREPTOKINASE ANTIB	No pre-authorization is required for all providers.	N/A
86592	SYPHILIS TEST; QUAL	No pre-authorization is required for all providers.	N/A
86593	SYPHILIS TEST; QUAN	No pre-authorization is required for all providers.	N/A
86602	ANTIB; ACTINOMYCES	No pre-authorization is required for all providers.	N/A
86603	ANTIB; ADENOVIRUS	No pre-authorization is required for all providers.	N/A
86606	ANTIB; ASPERGILLUS	No pre-authorization is required for all providers.	N/A
86609	ANTIB; BACTERIUM NES	No pre-authorization is required for all providers.	N/A
86611	ANTIBODY; BARTONELLA 0	No pre-authorization is required for all providers.	N/A
86612	ANTIB; BLASTOMYCES	No pre-authorization is required for all providers.	N/A
86615	ANTIB; BORDETELLA	No pre-authorization is required for all providers.	N/A
86617	BORRELIA BURGDORFERI CONFIRM TEST	No pre-authorization is required for all providers.	N/A
86618	ANTIB; BORRELIA BURGDORFERI	No pre-authorization is required for all providers.	N/A
86619	ANTIB; BORRELIA	No pre-authorization is required for all providers.	N/A
86622	ANTIB; BRUCELLA	No pre-authorization is required for all providers.	N/A
86625	ANTIB; CAMPYLOBACTER	No pre-authorization is required for all providers.	N/A
86628	ANTIB; CANDIDA	No pre-authorization is required for all providers.	N/A
86631	ANTIB; CHLAMYDIA	No pre-authorization is required for all providers.	N/A
86632	ANTIB; CHLAMYDIA IGM	No pre-authorization is required for all providers.	N/A
86635	ANTIB; COCCIDIOIDES	No pre-authorization is required for all providers.	N/A
86638	ANTIB; COXIELLA BRUNETII	No pre-authorization is required for all providers.	N/A
86641	ANTIB; CRYPTOCOCCUS	No pre-authorization is required for all providers.	N/A
86644	ANTIB; CYTOMEGALOVIRUS	No pre-authorization is required for all providers.	N/A
86645	ANTIB; CYTOMEGALOVIRUS IGM	No pre-authorization is required for all providers.	N/A
86648	ANTIB; DIPHTHERIA	No pre-authorization is required for all providers.	N/A
86651	ANTIB; ENCEPHALITIS CALIFORNIA	No pre-authorization is required for all providers.	N/A
86652	ANTIB; ENCEPHALITIS EASTERN EQUINE	No pre-authorization is required for all providers.	N/A
86653	ANTIB; ENCEPHALITIS ST. LOUIS	No pre-authorization is required for all providers.	N/A
86654	ANTIB; ENCEPHALITIS WESTERN EQUINE	No pre-authorization is required for all providers.	N/A
86658	ANTIB; ENTEROVIRUS	No pre-authorization is required for all providers.	N/A
86663	ANTIB; EPSTEIN-BARR VIRUS EARLY ANTIG	No pre-authorization is required for all providers.	N/A
86664	ANTIB; EPSTEIN-BARR VIRUS NUCLEAR ANTIG	No pre-authorization is required for all providers.	N/A
86665	ANTIB; EPSTEIN-BARR VIRUS VIRAL CAPSID	No pre-authorization is required for all providers.	N/A
86666	ANTIBODY; EHRlichia 0	No pre-authorization is required for all providers.	N/A
86668	ANTIB; FRANCISELLA TULARENSIS	No pre-authorization is required for all providers.	N/A
86671	ANTIB; FUNGUS NES	No pre-authorization is required for all providers.	N/A
86674	ANTIB; GIARDIA LAMBLIA	No pre-authorization is required for all providers.	N/A
86677	ANTIB; HELICOBACTER PYLORI	No pre-authorization is required for all providers.	N/A
86682	ANTIB; HELMINTH NES	No pre-authorization is required for all providers.	N/A
86683	ANTIBODY; HEMOGLOBIN-FECAL 0	No pre-authorization is required for all providers.	N/A

86684	ANTIB; HEMOPHILUS INFLUENZA	No pre-authorization is required for all providers.	N/A
86687	ANTIB; HTLV I	No pre-authorization is required for all providers.	N/A
86688	ANTIB; HTLV-II	No pre-authorization is required for all providers.	N/A
86689	ANTIB; HTLV/HIV ANTIB CONFIRM TEST	No pre-authorization is required for all providers.	N/A
86692	ANTIB; HEPATITIS DELTA AGENT	No pre-authorization is required for all providers.	N/A
86694	ANTIB; HERPES SIMPLEX NON-SPEC TYPE TEST	No pre-authorization is required for all providers.	N/A
86695	ANTIB; HERPES SIMPLEX TYPE I	No pre-authorization is required for all providers.	N/A
86696	ANTIBODY; HERPES SIMPLEX TYPE 2 0	No pre-authorization is required for all providers.	N/A
86698	ANTIB; HISTOPLASMA	No pre-authorization is required for all providers.	N/A
86701	ANTIB; HIV-1	No pre-authorization is required for all providers.	N/A
86702	ANTIB; HIV-2	No pre-authorization is required for all providers.	N/A
86703	HIV-1/HIV-2 SINGLE RESULT	No pre-authorization is required for all providers.	N/A
86704	HEPATITIS B CORE ANTIBODY; IGG & IGM	No pre-authorization is required for all providers.	N/A
86705	HEPATITIS B CORE ANTIBODY; IGM ANTIBODY	No pre-authorization is required for all providers.	N/A
86706	HEPATITIS B SURFACE ANTIBODY	No pre-authorization is required for all providers.	N/A
86707	HEPATITIS BE ANTIBODY	No pre-authorization is required for all providers.	N/A
86708	HEPATITIS A ANTIBODY	No pre-authorization is required for all providers.	N/A
86709	HEPATITIS A ANTIBODY; IGM ANTIBODY	No pre-authorization is required for all providers.	N/A
86710	ANTIB; INFLUENZA VIRUS	No pre-authorization is required for all providers.	N/A
86711	JOHN CUNNINGHAM ANTIBODY	No pre-authorization is required for all providers.	N/A
86713	ANTIB; LEGIONELLA	No pre-authorization is required for all providers.	N/A
86717	ANTIB; LEISHMANIA	No pre-authorization is required for all providers.	N/A
86720	ANTIB; LEPTOSPIRA	No pre-authorization is required for all providers.	N/A
86723	ANTIB; LISTERIA MONOCYTOGENES	No pre-authorization is required for all providers.	N/A
86727	ANTIB; LYMPHOCYTIC CHORIOMENINGITIS	No pre-authorization is required for all providers.	N/A
86729	ANTIB; LYMPHOGRANULOMA VENEREUM	This is no longer a valid code.	N/A
86732	ANTIB; MUCORMYCOSIS	No pre-authorization is required for all providers.	N/A
86735	ANTIB; MUMPS	No pre-authorization is required for all providers.	N/A
86738	ANTIB; MYCOPLASMA	No pre-authorization is required for all providers.	N/A
86741	ANTIB; NEISSERIA MENINGITIDIS	No pre-authorization is required for all providers.	N/A
86744	ANTIB; NOCARDIA	No pre-authorization is required for all providers.	N/A
86747	ANTIB; PARVOVIRUS	No pre-authorization is required for all providers.	N/A
86750	ANTIB; PLASMODIUM	No pre-authorization is required for all providers.	N/A
86753	ANTIB; PROTOZOA NES	No pre-authorization is required for all providers.	N/A
86756	ANTIB; RESPIRATORY SYNCYTIAL VIRUS	No pre-authorization is required for all providers.	N/A
86757	ANTIBODY; RICKETTSIA 0	No pre-authorization is required for all providers.	N/A
86759	ANTIB; ROTAVIRUS	No pre-authorization is required for all providers.	N/A
86762	ANTIB; RUBELLA	No pre-authorization is required for all providers.	N/A
86765	ANTIB; RUBEOLA	No pre-authorization is required for all providers.	N/A
86768	ANTIB; SALMONELLA	No pre-authorization is required for all providers.	N/A
86771	ANTIB; SHIGELLA	No pre-authorization is required for all providers.	N/A
86774	ANTIB; TETANUS	No pre-authorization is required for all providers.	N/A
86777	ANTIB; TOXOPLASMA	No pre-authorization is required for all providers.	N/A
86778	ANTIB; TOXOPLASMA IGM	No pre-authorization is required for all providers.	N/A
86780	TREPONEMA PALLIDUM	No pre-authorization is required for all providers.	N/A
86784	ANTIB; TRICHINELLA	No pre-authorization is required for all providers.	N/A
86787	ANTIB; VARICELLA-ZOSTER	No pre-authorization is required for all providers.	N/A
86788	WEST NILE VIRUS, IGM	No pre-authorization is required for all providers.	N/A
86789	WEST NILE VIRUS	No pre-authorization is required for all providers.	N/A
86790	ANTIB; VIRUS NES	No pre-authorization is required for all providers.	N/A
86793	ANTIB; YERSINIA	No pre-authorization is required for all providers.	N/A
86794	ZIKA VIRUS IGM ANTIBODY	No pre-authorization is required for all providers.	N/A
86800	THYROGLOBULIN ANTIB	No pre-authorization is required for all providers.	N/A
86803	HEPATITIS C ANTIBODY;	No pre-authorization is required for all providers.	N/A
86804	HEPATITIS C ANTIBODY; CONFIRM TEST	No pre-authorization is required for all providers.	N/A
86805	LYMPHOCYTOTOXICITY ASSAY VISUAL X-MATCH W/TITRAT	No pre-authorization is required for all providers.	N/A
86806	LYMPHOCYTOTOXICITY ASSY VISUAL X-MATCH;WO TITRAT	No pre-authorization is required for all providers.	N/A
86807	SERUM SCREEN CYTOTOXIC % REACTIVE ANTIB; STANDRD	No pre-authorization is required for all providers.	N/A
86808	SERUM SCREEN CYTOTOXIC % REACTIVE ANTIB; QUICK	No pre-authorization is required for all providers.	N/A
86812	HLA TYPING; A B/C SNGL ANTIG	Pre-authorization is required for all providers.	Prior to 09/01/2019
86813	HLA TYPING; A B/C MX ANTIG	Pre-authorization is required for all providers.	Prior to 09/01/2019
86816	HLA TYPING; DR/DQ SNGL ANTIG	Pre-authorization is required for all providers.	Prior to 09/01/2019
86817	HLA TYPING; DR/DQ MX ANTIG	Pre-authorization is required for all providers.	Prior to 09/01/2019
86821	HLA TYPING; LYMPHOCYTE CULTURE MIX	Pre-authorization is required for all providers.	Prior to 09/01/2019
86822	HLA TYPING; LYMPHOCYTE CULTURE PRIMED	This is no longer a valid code.	N/A
86825	HLA X-MATCH, NON-CYTOTOXIC	Pre-authorization is required for all providers.	Prior to 09/01/2019
86826	HLA X-MATCH, NON-CYT ADD-ON	Pre-authorization is required for all providers.	Prior to 09/01/2019
86828	HLA CLASS I&II ANTIBODY QUAL	Pre-authorization is required for all providers.	Prior to 09/01/2019
86829	HLA CLASS I/III ANTIBODY QUAL	Pre-authorization is required for all providers.	Prior to 09/01/2019
86830	HLA CLASS I PHENOTYPE QUAL	Pre-authorization is required for all providers.	Prior to 09/01/2019
86831	HLA CLASS II PHENOTYPE QUAL	Pre-authorization is required for all providers.	Prior to 09/01/2019
86832	HLA CLASS I HIGH DEFIN QUAL	Pre-authorization is required for all providers.	Prior to 09/01/2019
86833	HLA CLASS II HIGH DEFIN QUAL	Pre-authorization is required for all providers.	Prior to 09/01/2019
86834	HLA CLASS I SEMIQUANT PANEL	Pre-authorization is required for all providers.	Prior to 09/01/2019
86835	HLA CLASS II SEMIQUANT PANEL	Pre-authorization is required for all providers.	Prior to 09/01/2019
86849	UNLISTED IMMUNOLOGY PROC	No pre-authorization is required for all providers.	N/A
86850	ANTIB SCREEN RBC EA SERUM TECH	No pre-authorization is required for all providers.	N/A
86860	ANTIB ELUTION EA ELUTION	No pre-authorization is required for all providers.	N/A
86870	ANTIB IDENT RBC ANTIB EA PANEL EA SERUM TECH	No pre-authorization is required for all providers.	N/A
86880	ANTIHUMAN GLOB TEST; DIRECT EA ANTISERUM	No pre-authorization is required for all providers.	N/A
86885	ANTIHUMAN GLOBULIN INDIR QUAL EA REAGENT CELL	No pre-authorization is required for all providers.	N/A
86886	ANTIHUMAN GLOBULIN INDIRECT EA ANTIBODY TITER	No pre-authorization is required for all providers.	N/A
86890	AUTOLGUS BLD/COMP COLLEC PROCES/STOR; PREDEPOSIT	This service is not covered by Superior HealthPlan.	N/A
86891	AUTOLOGOUS BLD/COMP; INTRA/POSTOP SALVAGE	This service is not covered by Superior HealthPlan.	N/A
86900	BLOOD TYPING SEROLOGIC ABO	No pre-authorization is required for all providers.	N/A
86901	BLOOD TYPING SEROLOGIC RH(D)	No pre-authorization is required for all providers.	N/A
86902	BLOOD TYPE ANTIGEN DONOR EA	No pre-authorization is required for all providers.	N/A
86904	BLOOD TYPING PATIENT SERUM	No pre-authorization is required for all providers.	N/A
86905	BLOOD TYPING RBC ANTIGENS	No pre-authorization is required for all providers.	N/A
86906	BLD TYPING SEROLOGIC RH PHNT	No pre-authorization is required for all providers.	N/A
86910	BLD TYP PATERNTY TEST/INDIVID; ABO-RH & MN	This service is not covered by Superior HealthPlan.	N/A
86911	BLD TYPING PATERNTY TST/INDIVI; EA ADD ANTIG SYS	This service is not covered by Superior HealthPlan.	N/A
86920	COMPAT TEST EA UNIT; IMMED SPIN TECH	No pre-authorization is required for all providers.	N/A
86921	COMPAT TEST EA UNIT; INCUBATION TECH	No pre-authorization is required for all providers.	N/A
86922	COMPAT TEST EA UNIT; ANTIGLOBULIN TECH	No pre-authorization is required for all providers.	N/A
86923	COMPATIBILITY EA UNIT ELEC	No pre-authorization is required for all providers.	N/A
86927	FRESH FROZEN PLASMA THAWING EA UNIT	This service is not covered by Superior HealthPlan.	N/A
86930	FROZEN BLOOD EACH UNIT; FREEZING	This service is not covered by Superior HealthPlan.	N/A
86931	FROZEN BLOOD EACH UNIT; THAWING	This service is not covered by Superior HealthPlan.	N/A
86932	FRZN BLD EA UNIT; FREEZING&THAWING	This service is not covered by Superior HealthPlan.	N/A
86940	HEMOLYSINS & AGGLUTININS; AUTO SCREEN EA	No pre-authorization is required for all providers.	N/A
86941	HEMOLYSINS & AGGLUTININS; INCUBATED	No pre-authorization is required for all providers.	N/A
86945	IRRADIATION BLD PRODUCT EA UNIT	This service is not covered by Superior HealthPlan.	N/A
86950	LEUKOCYTE TRANSFUSION	No pre-authorization is required for all providers.	N/A
86960	VOL RDCTJ BLD/BLD PRODUX EA UNIT	No pre-authorization is required for all providers.	N/A
86965	POOLING PLATELETS/OTHER BLD PRODUCTS	This service is not covered by Superior HealthPlan.	N/A
86970	PRETX RBC'S; INCUBATION W/CHEM AGENTS/DRUGS EA	This service is not covered by Superior HealthPlan.	N/A
86971	PRETX RBC'S; INCUBATION W/ENZYMES EA	This service is not covered by Superior HealthPlan.	N/A
86972	PRETX RBC'S; DENSITY GRADIENT SEPARATION	This service is not covered by Superior HealthPlan.	N/A
86975	PRETX SERUM-RBC ANTIB ID; INCUBATION W/DRUGS EA	This service is not covered by Superior HealthPlan.	N/A
86976	PRETX SERUM-RBC ANTIB ID; BY DILUTION	This service is not covered by Superior HealthPlan.	N/A

86977	PRETX SERUM-RBC ANTIB ID; INCUB W/INHIBITORS EA	This service is not covered by Superior HealthPlan.	N/A
86978	PRETX SERUM-ANTIB ID; DIFF RED CELL ABSORPT EA	This service is not covered by Superior HealthPlan.	N/A
86985	SPLITTING BLD/BLD PRODUCTS EA UNIT	This service is not covered by Superior HealthPlan.	N/A
86999	UNLISTED TRANSFUSION MEDS PROC	No pre-authorization is required for all providers.	N/A
87001	ANIMAL INOCULATION SMALL ANIMAL; W/OBSRV	This is no longer a valid code.	N/A
87003	ANIMAL INOCUL SM ANIMAL; W/OBSRV & DISSECTION	No pre-authorization is required for all providers.	N/A
87015	CONCNTRAT PARASITES OVA/TUBERCLE BACILLUS	No pre-authorization is required for all providers.	N/A
87040	CULT BACT BLD AEROBIC ISOLAT & ID	No pre-authorization is required for all providers.	N/A
87045	CULT BACT STOOL AEROBIC SALM&SHIG	No pre-authorization is required for all providers.	N/A
87046	CULT BACT STOOL AEROBIC ADD PATH	No pre-authorization is required for all providers.	N/A
87070	CULT BACT NO URINE/BLD/STOOL AEROBC	No pre-authorization is required for all providers.	N/A
87071	CULT BACT; QUAN-AERO-NO URI/BLD/STL 0	No pre-authorization is required for all providers.	N/A
87073	CULT BACT; QUAN-ANAER-NO UR/BLD/STL 0	No pre-authorization is required for all providers.	N/A
87075	CULT BACT ANY SRC NO BLD ANAEROB	No pre-authorization is required for all providers.	N/A
87076	CULT BACT ANY SOURCE; DEFIN ID EA ANAEROBIC	No pre-authorization is required for all providers.	N/A
87077	CULT BACT; AEROB-ADD-DEFIN ID-EA 0	No pre-authorization is required for all providers.	N/A
87081	CULTURE BACTERIAL SCREENING ONLY SNGL ORGANISMS	No pre-authorization is required for all providers.	N/A
87084	CULT PRESUMPT SCRIN ONLY KIT; W/COLONY ESTIMATES	No pre-authorization is required for all providers.	N/A
87086	CULTURE BACTERIAL URIN; QUAN COLONY CT	No pre-authorization is required for all providers.	N/A
87088	CULTURE BACTERIAL URIN; IDENT ADD QUAN/KIT	No pre-authorization is required for all providers.	N/A
87101	CULTURE FUNGI ISOLATION; SKIN	No pre-authorization is required for all providers.	N/A
87102	CULTURE FUNGI ISOLATION; OTHER SOURCE	No pre-authorization is required for all providers.	N/A
87103	CULTURE FUNGI ISOLATION; BLD	No pre-authorization is required for all providers.	N/A
87106	CULTURE FUNGI DEFINITIVE IDENT EA FUNGUS	No pre-authorization is required for all providers.	N/A
87107	CULT FUNGI ID EA ORGANISM; MOLD 0	No pre-authorization is required for all providers.	N/A
87109	CULTURE MYCOPLASMA ANY SOURCE	No pre-authorization is required for all providers.	N/A
87110	CULTURE CHLAMYDIA	No pre-authorization is required for all providers.	N/A
87116	CULT TB/AFB/MYCOBACTERIA; ANY SOURCE ISOLAT ONLY	No pre-authorization is required for all providers.	N/A
87118	CULT MYCOBACTERIA DEFINITIVE IDENT EA ORGANISM	No pre-authorization is required for all providers.	N/A
87140	CULTURE TYPING; FLUORESCENT METHD EA ANTISERUM	No pre-authorization is required for all providers.	N/A
87143	CULTURE TYPING; GAS LIQUID CHROMATOGRAPHY METHD	No pre-authorization is required for all providers.	N/A
87147	CULTURE TYPE IMMUNOLOGIC	No pre-authorization is required for all providers.	N/A
87149	CULT TYPING; NUCLEIC ACID PROBE ID 0	No pre-authorization is required for all providers.	N/A
87150	DNA/RNA, AMPLIFIED PROBE	No pre-authorization is required for all providers.	N/A
87152	CULT TYPE; PULSE FIELD GEL TYPING I 0	No pre-authorization is required for all providers.	N/A
87153	DNA/RNA SEQUENCING	No pre-authorization is required for all providers.	N/A
87158	CULTURE TYPING; OTHER METHD	No pre-authorization is required for all providers.	N/A
87164	DARK FIELD EXAM ANY SOURCE; INCL SPECM N COLLEC	No pre-authorization is required for all providers.	N/A
87166	DARK FIELD EXAM ANY SOURCE; WO COLLEC	No pre-authorization is required for all providers.	N/A
87168	MACROSCOPIC EXAM; ARTHROPOD 0	No pre-authorization is required for all providers.	N/A
87169	MACROSCOPIC EXAM; PARASITE 0	No pre-authorization is required for all providers.	N/A
87172	PINWORM EXAM 0	No pre-authorization is required for all providers.	N/A
87176	ENDOTOXIN BACTERIAL; HOMOGENIZATION TISS CULT	No pre-authorization is required for all providers.	N/A
87177	OVA & PARASITES DIRECT SMEARS CONCNRAT & IDENT	No pre-authorization is required for all providers.	N/A
87178	MICROBE IDENTIFICATION	No pre-authorization is required for all providers.	N/A
87179	MICROBE IDENTIFICATION	No pre-authorization is required for all providers.	N/A
87181	SENSITIV ANTIBIOT; AGAR DIFF METHD PER ANTIBIOT	No pre-authorization is required for all providers.	N/A
87184	SENSITIVITY ANTIBIOTIC; DISK METHOD/PLATE	No pre-authorization is required for all providers.	N/A
87185	SUSCEPT-ANTIMICROB; ENZYME DETEC-EA 0	No pre-authorization is required for all providers.	N/A
87186	SENSITIV ANTIBIOTIC; MICROTITR MIC ANY # ANTIBIO	No pre-authorization is required for all providers.	N/A
87187	SENSITIV ANTIBIOTIC; MINI BACTERICIDAL CONCNRAT	No pre-authorization is required for all providers.	N/A
87188	SENSITIV ANTIBIOTIC; MACROTUBE DILUT EA ANTIBIOT	No pre-authorization is required for all providers.	N/A
87190	SENSITIV ANTIBIOTIC; TUBERCLE BACILLUS EA DRUG	No pre-authorization is required for all providers.	N/A
87197	BACTERICIDAL LEVEL SERUM	No pre-authorization is required for all providers.	N/A
87205	SMEAR PRIM SOURCE W/INTERPT; ROUTINE STAIN	No pre-authorization is required for all providers.	N/A
87206	SMEAR PRIM SOURCE W/INTERPT; FLUORSC & ACID FAST	No pre-authorization is required for all providers.	N/A
87207	SMEAR PRIM SRC INTEPR;SPCL STAIN	No pre-authorization is required for all providers.	N/A
87209	SMR PRIM SRC CPLX SPEC STAIN OVA&PARASITS	No pre-authorization is required for all providers.	N/A
87210	SMEAR PRIM W/INTERPT; WET MOUNT W/SMPL STAIN	No pre-authorization is required for all providers.	N/A
87220	TISS EXAM FUNGI	No pre-authorization is required for all providers.	N/A
87230	TOXIN/ANTITOXIN ASSAY TISS CULTURE	No pre-authorization is required for all providers.	N/A
87250	VIRUS ID; INOC EGGS/SM ANIMAL W/OBSRV & DISSECT	No pre-authorization is required for all providers.	N/A
87252	VIRUS IDENT; TISS CULTURE INOCULATION & OBSRV	No pre-authorization is required for all providers.	N/A
87253	VIRUS INOCULATE TISSUE ADDL	No pre-authorization is required for all providers.	N/A
87254	VIRUS ISOLAT; CENTRIFUGE EA VIRUS	No pre-authorization is required for all providers.	N/A
87255	VIRUS ISOLAT; W/ID NON-IMMUOLOGIC	No pre-authorization is required for all providers.	N/A
87260	INFEC AG-DIR FLUORES AB; ADENOVIRUS	No pre-authorization is required for all providers.	N/A
87265	INFEC AG-DIR FLUORES AB; BORDATELLA PERTUSSIS	No pre-authorization is required for all providers.	N/A
87267	INF AGT ANTIG IMMUOFLUORS; ENTRVRUS	No pre-authorization is required for all providers.	N/A
87269	INF AGT ANTIG DETCT IF TECH GIARDIA	No pre-authorization is required for all providers.	N/A
87270	INFEC AG-DIR FLUORES AB; CHLAMYDIA TRACHOMATIS	No pre-authorization is required for all providers.	N/A
87271	INF AGT ANTIG IMMUOFLUORS; CYTOMEGA	No pre-authorization is required for all providers.	N/A
87272	INF AGT-IMMUOFLUOR CRYPTOSPORIDIUM	No pre-authorization is required for all providers.	N/A
87273	AG-IMMUOFLUOR; HERPES SIMP TYPE 2 0	No pre-authorization is required for all providers.	N/A
87274	INFEC AG-DIR FLUORES AB; HERPES SIMPLEX VIRUS	No pre-authorization is required for all providers.	N/A
87275	AG-IMMUOFLUOR; INFLUENZA B VIRUS 0	No pre-authorization is required for all providers.	N/A
87276	INFEC AG-DIR FLUORES AB; INFLUENZA A VIRUS	No pre-authorization is required for all providers.	N/A
87277	AG-IMMUOFLUOR; LEGIONELLA MICDADEI 0	This is no longer a valid code.	N/A
87278	INFEC AG-DIR FLUORES AB; LEGIONELLA PNEUMOPHILA	No pre-authorization is required for all providers.	N/A
87279	AG-IMMUOFLUOR; PARAINFLUENZA-EA 0	No pre-authorization is required for all providers.	N/A
87280	INFEC AG-DIR FLUORES AB; RESP SYNCYTIAL VIRUS	No pre-authorization is required for all providers.	N/A
87281	AG-IMMUOFLUOR; PNEUMOCYSTIS CARINI 0	No pre-authorization is required for all providers.	N/A
87283	INFEC AG-IMMUOFLUOR; RUBEOLA 0	No pre-authorization is required for all providers.	N/A
87285	INFEC AG-DIR FLUORES AB; TREPONEMA PALLIDUM	No pre-authorization is required for all providers.	N/A
87290	INFEC AG-DIR FLUORES AB; VARICELLA ZOSTER VIRUS	No pre-authorization is required for all providers.	N/A
87299	INFEC AG-DIR FLUORES AB; NOS	No pre-authorization is required for all providers.	N/A
87300	AG-IMMUOFL POLYVL MX ORG-EA ANTISE 0	No pre-authorization is required for all providers.	N/A
87301	ADENOVIRUS AG IA	No pre-authorization is required for all providers.	N/A
87305	ASPERGILLUS AG IA	No pre-authorization is required for all providers.	N/A
87320	CHYLMD TRACH AG IA	No pre-authorization is required for all providers.	N/A
87324	CLOSTRIDIUM AG IA	No pre-authorization is required for all providers.	N/A
87327	CRYPTOCOCCUS NEOFORM AG IA	No pre-authorization is required for all providers.	N/A
87328	CRYPTOSPORIDIUM AG IA	No pre-authorization is required for all providers.	N/A
87329	GIARDIA AG IA	No pre-authorization is required for all providers.	N/A
87332	CYTOGALOVIRUS AG IA	No pre-authorization is required for all providers.	N/A
87335	E COLI 0157 AG IA	No pre-authorization is required for all providers.	N/A
87336	ENTAMOEB HIST DISPR AG IA	No pre-authorization is required for all providers.	N/A
87337	ENTAMOEB HIST GROUP AG IA	No pre-authorization is required for all providers.	N/A
87338	HPYLORI STOOL IA	No pre-authorization is required for all providers.	N/A
87339	H PYLORI AG IA	This service is not covered by Superior HealthPlan.	N/A
87340	HEPATITIS B SURFACE AG IA	No pre-authorization is required for all providers.	N/A
87341	HEPATITIS B SURFACE AG IA	No pre-authorization is required for all providers.	N/A
87350	HEPATITIS BE AG IA	No pre-authorization is required for all providers.	N/A
87380	HEPATITIS DELTA AG IA	No pre-authorization is required for all providers.	N/A
87385	HISTOPLASMA CAPSUL AG IA	No pre-authorization is required for all providers.	N/A
87389	HIV-1 AG W/HIV-1 & HIV-2 AB	No pre-authorization is required for all providers.	N/A
87390	HIV-1 AG IA	No pre-authorization is required for all providers.	N/A
87391	HIV-2 AG IA	No pre-authorization is required for all providers.	N/A
87400	INFLUENZA A/B AG IA	No pre-authorization is required for all providers.	N/A
87420	RESP SYNCYTIAL AG IA	No pre-authorization is required for all providers.	N/A
87425	ROTAVIRUS AG IA	No pre-authorization is required for all providers.	N/A

87426	IAAD IA SEVERE AQT RESPIR SYND CORONAVIRUS	No pre-authorization is required for all providers.	N/A
87427	SHIGA-LIKE TOXIN AG IA	No pre-authorization is required for all providers.	N/A
87430	STREP A AG IA	No pre-authorization is required for all providers.	N/A
87449	AG DETECT NOS IA MULT	No pre-authorization is required for all providers.	N/A
87450	AG DETECT NOS IA SINGLE	No pre-authorization is required for all providers.	N/A
87451	AG DETECT POLYVAL IA MULT	No pre-authorization is required for all providers.	N/A
87470	INFEC AGT-DNA/RNA; BARTONELLA H & Q-DIR PROBE	This is no longer a valid code.	N/A
87471	BARTONELLA DNA AMP PROBE	No pre-authorization is required for all providers.	N/A
87472	INFEC AGT-DNA/RNA; BARTONELLA H & Q-QUAN	No pre-authorization is required for all providers.	N/A
87475	INFEC AGT-DNA/RNA; BORRELIA BURGDORFERI-DIR PROB	No pre-authorization is required for all providers.	N/A
87476	INFEC AGT-DNA/RNA; BORRELIA BURGDORFERI-AMPLI	No pre-authorization is required for all providers.	N/A
87477	INFEC AGT-DNA/RNA; BORRELIA BURGDORFERI-QUAN	This is no longer a valid code.	N/A
87480	INFEC AGT-DNA/RNA; CANDIDA SPECIES-DIRECT PROBE	No pre-authorization is required for all providers.	N/A
87481	INFEC AGT-DNA/RNA; CANDIDA SPECIES-AMPLI PROBE	No pre-authorization is required for all providers.	N/A
87482	INFEC AGT-DNA/RNA; CANDIDA SPECIES-QUAN	No pre-authorization is required for all providers.	N/A
87483	CNS DNA/RNA AMP PROBE MULTIPLE SUBTYPES 12-25	This service is not covered by Superior HealthPlan.	N/A
87485	INFEC AGT-DNA/RNA; CHLAMYDIA PNEUMONIA-DIR PROBE	No pre-authorization is required for all providers.	N/A
87486	INFEC AGT-DNA/RNA; CHLAMYDIA PNEUMON-AMPLI PROBE	No pre-authorization is required for all providers.	N/A
87487	INFEC AGT-DNA/RNA; CHLAMYDIA PNEUMONIAE-QUAN	No pre-authorization is required for all providers.	N/A
87490	INFEC AGT-DNA/RNA; CHLAMYDIA TRACHOMATIS-DIRECT	No pre-authorization is required for all providers.	N/A
87491	INFEC AGT-DNA/RNA; CHLAMYDIA TRACHOMATIS-AMPLI	No pre-authorization is required for all providers.	N/A
87492	INFEC AGT-DNA/RNA; CHLAMYDIA TRACHOMATIS-QUAN	No pre-authorization is required for all providers.	N/A
87493	C DIFF AMPLIFIED PROBE	No pre-authorization is required for all providers.	N/A
87495	INFEC AGT-DNA/RNA; CYTOMEGALOVIRUS-DIRECT PROBE	No pre-authorization is required for all providers.	N/A
87496	INFEC AGT-DNA/RNA; CYTOMEGALOVIRUS-AMPLI PROBE	No pre-authorization is required for all providers.	N/A
87497	INFEC AGT-DNA/RNA; CYTOMEGALOVIRUS-QUAN	No pre-authorization is required for all providers.	N/A
87498	ENTEROVIRUS PROBE&REVRS TRNS	No pre-authorization is required for all providers.	N/A
87500	VANCOMYCIN DNA AMP PROBE	No pre-authorization is required for all providers.	N/A
87501	INFLUENZA DNA AMP PROB 1+	No pre-authorization is required for all providers.	N/A
87502	INFLUENZA DNA AMP PROBE	No pre-authorization is required for all providers.	N/A
87503	INFLUENZA DNA AMP PROB ADDL	No pre-authorization is required for all providers.	N/A
87505	NFCT AGENT DETECTION GI	No pre-authorization is required for all providers.	N/A
87506	IADNA-DNA/RNA PROBE TQ 6-11	No pre-authorization is required for all providers.	N/A
87507	IADNA-DNA/RNA PROBE TQ 12-25	No pre-authorization is required for all providers.	N/A
87510	INFEC AGT-DNA/RNA; GARDNERELLA VAG-DIRECT PROBE	No pre-authorization is required for all providers.	N/A
87511	INFEC AGT-DNA/RNA; GARDNERELLA VAG-AMPLI PROBE	No pre-authorization is required for all providers.	N/A
87512	INFEC AGT-DNA/RNA; GARDNERELLA VAG-QUAN	No pre-authorization is required for all providers.	N/A
87515	INFEC AGT-DNA/RNA; HEP B VIRUS-DIRECT PROBE	This is no longer a valid code.	N/A
87516	INFEC AGT-DNA/RNA; HEP B VIRUS-AMPLI PROBE	No pre-authorization is required for all providers.	N/A
87517	INFEC AGT-DNA/RNA; HEP B VIRUS-QUAN	No pre-authorization is required for all providers.	N/A
87520	INFEC AGT-DNA/RNA; HEP C-DIRECT PROBE	No pre-authorization is required for all providers.	N/A
87521	HEPATITIS C PROBE&RVRS TRNSC	No pre-authorization is required for all providers.	N/A
87522	HEPATITIS C REVRS TRNSCRPJ	No pre-authorization is required for all providers.	N/A
87525	INFEC AGT-DNA/RNA; HEP G-DIRECT PROBE	No pre-authorization is required for all providers.	N/A
87526	INFEC AGT-DNA/RNA; HEP G-AMPLI PROBE	No pre-authorization is required for all providers.	N/A
87527	INFEC AGT-DNA/RNA; HEP G-QUAN	No pre-authorization is required for all providers.	N/A
87528	INFEC AGT-DNA/RNA; HERPES SIMPLEX-DIRECT PROBE	No pre-authorization is required for all providers.	N/A
87529	INFEC AGT-DNA/RNA; HERPES SIMPLEX-AMPLI PROBE	No pre-authorization is required for all providers.	N/A
87530	INFEC AGT-DNA/RNA; HERPES SIMPLEX-QUAN	No pre-authorization is required for all providers.	N/A
87531	INFEC AGT-DNA/RNA; HERPES VIRUS-6-DIRECT PROBE	No pre-authorization is required for all providers.	N/A
87532	INFEC AGT-DNA/RNA; HERPES VIRUS-6-AMPLI PROBE	No pre-authorization is required for all providers.	N/A
87533	INFEC AGT-DNA/RNA; HERPES VIRUS-6-QUAN	No pre-authorization is required for all providers.	N/A
87534	INFEC AGT-DNA/RNA; HIV-1-DIRECT PROBE	No pre-authorization is required for all providers.	N/A
87535	HIV-1 PROBE&REVERSE TRNSCRPJ	No pre-authorization is required for all providers.	N/A
87536	HIV-1 QUANT&REVRSE TRNSCRPJ	No pre-authorization is required for all providers.	N/A
87537	INFEC AGT-DNA/RNA; HIV-2-DIRECT PROBE	No pre-authorization is required for all providers.	N/A
87538	HIV-2 PROBE&REVRSE TRNSCRPJ	No pre-authorization is required for all providers.	N/A
87539	HIV-2 QUANT&REVRSE TRNSCRPJ	No pre-authorization is required for all providers.	N/A
87540	INFEC AGT-DNA/RNA; LEGIONELLA PNEUMOPHILA-DIRECT	No pre-authorization is required for all providers.	N/A
87541	INFEC AGT-DNA/RNA; LEGIONELLA PNEUMOPHILA-AMPLI	No pre-authorization is required for all providers.	N/A
87542	INFEC AGT-DNA/RNA; LEGIONELLA PNEUMOPHILA-QUAN	No pre-authorization is required for all providers.	N/A
87550	INFEC AGT-DNA/RNA; MYCOBACTERIA-DIRECT PROBE	No pre-authorization is required for all providers.	N/A
87551	INFEC AGT-DNA/RNA; MYCOBACTERIA-AMPLI PROBE	No pre-authorization is required for all providers.	N/A
87552	INFEC AGT-DNA/RNA; MYCOBACTERIA-QUAN	No pre-authorization is required for all providers.	N/A
87555	INFEC AGT-DNA/RNA; MYCOBACTERIA TB-DIRECT PROBE	No pre-authorization is required for all providers.	N/A
87556	INFEC AGT-DNA/RNA; MYCOBACTERIA TB-AMPLI PROBE	No pre-authorization is required for all providers.	N/A
87557	INFEC AGT-DNA/RNA; MYCOBACTERIA TB-QUAN	No pre-authorization is required for all providers.	N/A
87560	INFEC AGT-DNA/RNA; MYCOBACTERIA AVIUM-DIR PROBE	No pre-authorization is required for all providers.	N/A
87561	INFEC AGT-DNA/RNA; MYCOBACTERIA AVIUM-AMPLI PROBE	No pre-authorization is required for all providers.	N/A
87562	INFEC AGT-DNA/RNA; MYCOBACTERIA AVIUM-QUAN	No pre-authorization is required for all providers.	N/A
87563	IADNA MYCOPLASMA GENITALIUM AMPLIFIED PROBE TECH	No pre-authorization is required for all providers.	N/A
87580	INFEC AGT-DNA/RNA; MYCOPLASMA PNEUMONIAE-DIRECT	No pre-authorization is required for all providers.	N/A
87581	INFEC AGT-DNA/RNA; MYCOPLASMA PNEUMONIAE-AMPLI	No pre-authorization is required for all providers.	N/A
87582	INFEC AGT-DNA/RNA; MYCOPLASMA PNEUMONIAE-QUAN	No pre-authorization is required for all providers.	N/A
87590	INFEC AGT-DNA/RNA; NEISSERIA GONORRHEA-DIR PROBE	No pre-authorization is required for all providers.	N/A
87591	INFEC AGT-DNA/RNA; NEISSERIA GONORRHEA-AMPLI PROB	No pre-authorization is required for all providers.	N/A
87592	INFEC AGT-DNA/RNA; NEISSERIA GONORRHEA-QUAN	No pre-authorization is required for all providers.	N/A
87620	INFEC AGT-DNA/RNA; PAPILLOMAVIRUS HUMAN-DIRECT	This is no longer a valid code.	N/A
87621	INFEC AGT-DNA/RNA; PAPILLOMAVIRUS HUMAN-AMPLI	This is no longer a valid code.	N/A
87622	INFEC AGT-DNA/RNA; PAPILLOMAVIRUS HUMAN-QUAN	This is no longer a valid code.	N/A
87623	HPV LOW-RISK TYPES	No pre-authorization is required for all providers.	N/A
87624	HPV HIGH-RISK TYPES	No pre-authorization is required for all providers.	N/A
87625	HPV TYPES 16 & 18 ONLY	No pre-authorization is required for all providers.	N/A
87631	RESP VIRUS 3-5 TARGETS	No pre-authorization is required for all providers.	N/A
87632	RESP VIRUS 6-11 TARGETS	No pre-authorization is required for all providers.	N/A
87633	RESP VIRUS 12-25 TARGETS	No pre-authorization is required for all providers.	N/A
87634	RSV DNA/RNA AMP PROBE	No pre-authorization is required for all providers.	N/A
87635	SARS-COV-2 COVID-19 AMP PRB	No pre-authorization is required for all providers.	N/A
87640	STAPHYLOCOCCUS AUREUS, AMPLIFIED PROBE TECHNIQUE	No pre-authorization is required for all providers.	N/A
87641	STAPHYLOCOCCUS AUREUS, METHICILLIN RESISTANT, AMPLIFIED PROBE TECHNIQUE	No pre-authorization is required for all providers.	N/A
87650	INFEC AGT-DNA/RNA; STREP GROUP A-DIRECT PROBE	No pre-authorization is required for all providers.	N/A
87651	INFEC AGT-DNA/RNA; STREP GROUP A-AMPLI PROBE	No pre-authorization is required for all providers.	N/A
87652	INFEC AGT-DNA/RNA; STREP GROUP A-QUAN	No pre-authorization is required for all providers.	N/A
87653	STREPTOCOCCUS, GROUP B, AMPLIFIED PROBE TECHNIQUE	No pre-authorization is required for all providers.	N/A
87660	INF AGT DETCT NUCLEIC ACID TRICH VAG	No pre-authorization is required for all providers.	N/A
87661	TRICHOMONAS VAGINALIS AMPLIF	No pre-authorization is required for all providers.	N/A
87662	ZIKA VIRUS DNA/RNA AMP PROBE	No pre-authorization is required for all providers.	N/A
87797	INFEC AGT-DNA/RNA; NOS-DIRECT PROBE TECH	No pre-authorization is required for all providers.	N/A
87798	INFEC AGT-DNA/RNA; NOS-AMPLIFIED PROBE TECH	No pre-authorization is required for all providers.	N/A
87799	INFEC AGT-DNA/RNA; NOS-QUAN	No pre-authorization is required for all providers.	N/A
87800	AG-NUCLEIC ACID MX ORG; DIR PROBE 0	No pre-authorization is required for all providers.	N/A
87801	AG-NUCLEIC ACID MX ORG; AMP PROBE 0	No pre-authorization is required for all providers.	N/A
87802	STREP B DETECTION IMMUNOASSAY DETECTION WITH OPTIC	No pre-authorization is required for all providers.	N/A
87803	CLOSTRIDIUM DIFFICILE TOXIN A IMMUNOASSAY DETECTION WITH OPTIC	No pre-authorization is required for all providers.	N/A
87804	INFLUENZA IMMUNOASSAY DETECTION WITH OPTIC	No pre-authorization is required for all providers.	N/A
87806	HIV ANTIGEN W/HIV ANTIBODIES	No pre-authorization is required for all providers.	N/A
87807	INF AGT ANTIG DETCT IMMUNOASSY DIR OPTICL OBS;RSV	No pre-authorization is required for all providers.	N/A
87808	TRICHOMONAS VAGINALIS	No pre-authorization is required for all providers.	N/A
87809	ADENOVIRUS ASSAY W/OPTIC	No pre-authorization is required for all providers.	N/A
87810	INFEC AGT-IMMUNOASSAY W/DIR OBSERV; CHLAMYDIA T	No pre-authorization is required for all providers.	N/A
87850	INFEC AGT-IMMUNOASSAY W/DIR OBSERV; N GONORRHEA	No pre-authorization is required for all providers.	N/A

87880	INFEC AGT-IMMUNOASSAY W/DIR OBSERV; STREP GRP A	No pre-authorization is required for all providers.	N/A
87899	INFEC AGT-IMMUNOASSAY W/DIR OBSERVATION; NOS	No pre-authorization is required for all providers.	N/A
87900	NFCT AGT DRUG SC PHEXYP PREDICT	No pre-authorization is required for all providers.	N/A
87901	GENOTYPE DNA HIV REVERSE T	No pre-authorization is required for all providers.	N/A
87902	HEPATITIS C GENOTYPE ANALYSIS	No pre-authorization is required for all providers.	N/A
87903	AG PHENO-NUCL ACID HIV1; 1-10 DRGS 0	No pre-authorization is required for all providers.	N/A
87904	AG PHENO-NUCL ACID HIV 1; EA ADD - 0	No pre-authorization is required for all providers.	N/A
87905	SIALIDASE ENZYME ASSAY	This service is not covered by Superior HealthPlan.	N/A
87906	GENOTYPE DNA HIV REVERSE T	No pre-authorization is required for all providers.	N/A
87910	GENOTYPE CYTOMEGALOVIRUS	No pre-authorization is required for all providers.	N/A
87912	GENOTYPE DNA HEPATITIS B	No pre-authorization is required for all providers.	N/A
87999	UNLISTED MICROBIOLOGY PROC	No pre-authorization is required for all providers.	N/A
88000	NECROPSY GROSS EXAM ONLY; WO CNS	This service is not covered by Superior HealthPlan.	N/A
88005	NECROPSY GROSS EXAM ONLY; W/BRAIN	This service is not covered by Superior HealthPlan.	N/A
88007	NECROPSY GROSS EXAM ONLY; W/BRAIN & SPINAL CORD	This service is not covered by Superior HealthPlan.	N/A
88012	NECROPSY GROSS EXAM ONLY; INFANT W/BRAIN	This service is not covered by Superior HealthPlan.	N/A
88014	NECROPSY GROSS EXAM ONLY; STILLBORN/NB W/BRAIN	This service is not covered by Superior HealthPlan.	N/A
88016	NECROPSY GROSS EXAM ONLY; MACERATED STILLBORN	This service is not covered by Superior HealthPlan.	N/A
88020	NECROPSY GROSS & MICRO; WO CNS	This service is not covered by Superior HealthPlan.	N/A
88025	NECROPSY GROSS & MICRO; W/BRAIN	This service is not covered by Superior HealthPlan.	N/A
88027	NECROPSY GROSS & MICRO; W/BRAIN & SPINAL CORD	This service is not covered by Superior HealthPlan.	N/A
88028	NECROPSY GROSS & MICRO; INFANT W/BRAIN	This service is not covered by Superior HealthPlan.	N/A
88029	NECROPSY GROSS & MICRO; STILLBORN/NB W/BRAIN	This service is not covered by Superior HealthPlan.	N/A
88036	NECROPSY LTD GROSS &/OR MICRO; REGIONAL	This service is not covered by Superior HealthPlan.	N/A
88037	NECROPSY LTD GROSS &/OR MICRO; SNGL ORGAN	This service is not covered by Superior HealthPlan.	N/A
88040	NECROPSY; FORENSIC EXAM	This service is not covered by Superior HealthPlan.	N/A
88045	NECROPSY; CORONER'S CALL	This service is not covered by Superior HealthPlan.	N/A
88099	UNLISTED NECROPSY PROC	This service is not covered by Superior HealthPlan.	N/A
88104	CYTOPATH NOT CERV/VAG; SMEARS W/INTERPT	No pre-authorization is required for all providers.	N/A
88106	CYTOPATH,FLUIDS,WASHINGS OR BRUSH,EXCEPT CERV OR VAG, SIMPLE FILTER PREP	No pre-authorization is required for all providers.	N/A
88108	CYTOPATH CONCENTRATION TECH-SMEARS & INTERP	No pre-authorization is required for all providers.	N/A
88112	CYTOPATH CELLR ENHANCE NO CERV/VAG	No pre-authorization is required for all providers.	N/A
88120	CYTP URNE 3-5 PROBES EA SPE	No pre-authorization is required for all providers.	N/A
88121	CYTP URINE 3-5 PROBES CMPTR	No pre-authorization is required for all providers.	N/A
88125	CYTOPATHOLOGY FORENSIC	This service is not covered by Superior HealthPlan.	N/A
88130	SEX CHROMATIN IDENT; BARR BODIES	This service is not covered by Superior HealthPlan.	N/A
88140	SEX CHROMATIN ID; PERIPHERL BLD SMEAR POLYMORPHN	This service is not covered by Superior HealthPlan.	N/A
88141	CYTOPATH CERV/VAG; REQ INTERPT PHYS	No pre-authorization is required for all providers.	N/A
88142	CYTOPATH CERV/VAG; MANUAL SCRNR PHYS SUPRV	No pre-authorization is required for all providers.	N/A
88143	CYTOPATH CERV/VAG THIN PREP; W/MAN SCREEN-RESCRN	No pre-authorization is required for all providers.	N/A
88147	CYTOPATH CERV/VAG THIN PREP; AUTO SYS-MD SUPERVI	No pre-authorization is required for all providers.	N/A
88148	CYTOPATH CERV/VAG; AUTO SCREEN-MAN RESCREEN	No pre-authorization is required for all providers.	N/A
88150	CYTPH SLIDE CERV/VAG; MANUAL SCRNR W/SUPERV	No pre-authorization is required for all providers.	N/A
88151	CYTOPATHOLOGY INTERPRETATION	No pre-authorization is required for all providers.	N/A
88152	CYTOPATH SLIDE CERV/VAG; MANUAL-COMPUTER-SUPERV	No pre-authorization is required for all providers.	N/A
88153	CYTOPATH CERV/VAG; MAN SCRNR-RESCRN-MD SUPERVIS	No pre-authorization is required for all providers.	N/A
88154	CYTOPATH CERV/VAG; MAN SCRNR-COMPUTER RESCRN-CELL	This is no longer a valid code.	N/A
88155	CYTOPATH SLIDES CERV/VAG DEFIN HORMONAL EVAL	No pre-authorization is required for all providers.	N/A
88157	TBS SMEAR (BETHESDA SYSTEM)	No pre-authorization is required for all providers.	N/A
88160	CYTOPATH SMEARS ANY OTHR SOURCE; SCREEN & INTRPT	No pre-authorization is required for all providers.	N/A
88161	CYTOPATH SMEARS OTHR SOURCE; PREP/SCREEN/INTERPT	No pre-authorization is required for all providers.	N/A
88162	CYTOPATH SMEARS OTHR SOURCE; EXTEND STDY >5 SLDS	No pre-authorization is required for all providers.	N/A
88164	CYTOPATH SLIDES-CERV/VAG; MAN SCRNR MD SUPERVIS	No pre-authorization is required for all providers.	N/A
88165	CYTOPATH SLIDES-CERV/VAG; MAN SCRNR & RESCRN	No pre-authorization is required for all providers.	N/A
88166	CYTOPATH SLIDES-CERV/VAG; MAN SCRNR COMPUT RESCRN	No pre-authorization is required for all providers.	N/A
88167	CYTOPATH SLIDES-CERV/VAG; SCRNR-COMPUT RESCR CELL	No pre-authorization is required for all providers.	N/A
88172	CYTP DX EVAL FNA 1ST EA SIT	No pre-authorization is required for all providers.	N/A
88173	EVAL FINE NEEDL ASPIRAT; INTERPT & REPORT	No pre-authorization is required for all providers.	N/A
88174	CYTOPATH CERV/VAG THIN LAY PREP;SCR	No pre-authorization is required for all providers.	N/A
88175	CYTOPATH CERV/VAG THIN PREP; RESCR	No pre-authorization is required for all providers.	N/A
88177	CYTP C/V AUTO THIN LYR ADDL	No pre-authorization is required for all providers.	N/A
88182	FLOW CYTOMETRY; CELL CYCLE/DNA ANALY	No pre-authorization is required for all providers.	N/A
88184	FLOW CYTOMETRY CELL SURF/NUCLR TC ONLY; 1 MARKER	This service is not covered by Superior HealthPlan.	N/A
88185	FLOW CYTOMETRY CELL SURF/NUCLR TC ONLY; EA ADD	This service is not covered by Superior HealthPlan.	N/A
88187	FLOW CYTOMETRY INTERPRETATION; 2 TO 8 MARKERS	No pre-authorization is required for all providers.	N/A
88188	FLOW CYTOMETRY INTERPRETATION; 9 TO 15 MARKERS	No pre-authorization is required for all providers.	N/A
88189	FLOW CYTOMETRY INTERPRETATION; 16/MORE MARKERS	No pre-authorization is required for all providers.	N/A
88199	UNLISTED CYTOPATHOLOGY PROC	No pre-authorization is required for all providers.	N/A
88230	TISS CULTURE NON-NEOPLAS DISORD; LYMPHOCYTE	Pre-authorization is required for all providers.	Prior to 09/01/2019
88233	TISS CULTURE NON-NEOPLAS DISORD; SKIN/SOLID TISS	Pre-authorization is required for all providers.	Prior to 09/01/2019
88235	TISS CULTURE NON-NEOPLAS DISORD; AMNIOTIC FLUID	Pre-authorization is required for all providers.	Prior to 09/01/2019
88237	TISS CULTURE NEOPLAS DISORD; MARROW/BLD CELLS	No pre-authorization is required for all providers.	N/A
88239	TISS CULTURE NEOPLAS DISORD; SOLID TUMOR	Pre-authorization is required for all providers.	Prior to 09/01/2019
88240	CRYOPRESERV-FREEZE & STORE CELLS EA CELL LINE	Pre-authorization is required for all providers.	Prior to 09/01/2019
88241	THAWING & EXPANSION FROZEN CELLS EA ALIQUOT	Pre-authorization is required for all providers.	Prior to 09/01/2019
88245	CHROMOSOME ANALY BREAK SYNDROM; SCE 20-25 CELLS	Pre-authorization is required for all providers.	Prior to 09/01/2019
88248	CHROMOSOME ANALY; BASELINE BREAKAGE	Pre-authorization is required for all providers.	Prior to 09/01/2019
88249	CHROMOSOME ANALY BREAK SYNDROM; CLASTOGEN STRESS	Pre-authorization is required for all providers.	Prior to 09/01/2019
88250	CHROMO ANALY FRAGIL X W/FRAGIL X-LINK MENTL RETD	No pre-authorization is required for all providers.	N/A
88261	CHROMO ANALY; CT 5 CELLS 1 KARYOTYPE W/BANDING	Pre-authorization is required for all providers.	Prior to 09/01/2019
88262	CHROMO ANALY; CT 15-20 CELLS 2 KARYOTYPES W/BAND	Pre-authorization is required for all providers.	Prior to 09/01/2019
88263	CHROMO ANALY; CT 45 CEL MOSAICISM 2 KARYO W/BAND	Pre-authorization is required for all providers.	Prior to 09/01/2019
88264	CHROMOSOME ANALY; ANALY 20-25 CELLS	Pre-authorization is required for all providers.	Prior to 09/01/2019
88267	CHROMO ANALY AMNIO FLUID CT 15 CELLS 1 KARYOTYPE	Pre-authorization is required for all providers.	Prior to 09/01/2019
88269	CHROMO ANALY AMNIO FLUID CELLS CT 6-12 COLONIES	Pre-authorization is required for all providers.	Prior to 09/01/2019
88271	MOLEC CYTOGEN; DNA PROBE EA	Pre-authorization is required for all providers.	Prior to 09/01/2019
88272	MOLEC CYTOGEN; CHROMOSOM IN SITU HYBRID 3-5 CELL	Pre-authorization is required for all providers.	Prior to 09/01/2019
88273	MOLEC CYTOGEN; CHROMOSOM HYBRID 10-30 CELLS	Pre-authorization is required for all providers.	Prior to 09/01/2019
88274	MOLEC CYTOGEN; INTERPHASE IN SITU HYBRID 25-99	Pre-authorization is required for all providers.	Prior to 09/01/2019
88275	MOLEC CYTOGEN; INTERPHASE IN SITU HYBRID 100-300	Pre-authorization is required for all providers.	Prior to 09/01/2019
88280	CHROMOSOME ANALY; ADD KARYOTYPES EA STUDY	Pre-authorization is required for all providers.	Prior to 09/01/2019
88283	CHROMOSOME ANALY; ADD SPECIALIZED BANDING TECH	Pre-authorization is required for all providers.	Prior to 09/01/2019
88285	CHROMOSOME ANALY; ADD CELLS COUNTED EA STUDY	Pre-authorization is required for all providers.	Prior to 09/01/2019
88289	CHROMOSOME ANALY; ADD HIGH RESOLUTION STUDY	Pre-authorization is required for all providers.	Prior to 09/01/2019
88291	CYTOGEN & MOLEC CYTOGEN INTERPT & REPORT	Pre-authorization is required for all providers.	Prior to 09/01/2019
88299	UNLISTED CYTOGENETIC STUDY	Pre-authorization is required for all providers.	Prior to 09/01/2019
88300	LEVEL I- SURG PATH GROSS EXAM ONLY	No pre-authorization is required for all providers.	N/A
88302	LEVEL II-SURG PATH GROSS/MICRO EXAM	No pre-authorization is required for all providers.	N/A
88304	LEVEL III-SURG PATH GROSS/MICRO EXAM	No pre-authorization is required for all providers.	N/A
88305	LEVEL IV-SURG PATH GROSS/MICRO EXAM	No pre-authorization is required for all providers.	N/A
88307	LEVEL V-SURG PATH GROSS/MICRO EXAM	No pre-authorization is required for all providers.	N/A
88309	LEVEL VI-SURG PATH GROSS/MICRO EXAM	No pre-authorization is required for all providers.	N/A
88311	DECALCIFICATION PROC	No pre-authorization is required for all providers.	N/A
88312	SPECIAL STAINS GROUP 1	No pre-authorization is required for all providers.	N/A
88313	SPECIAL STAINS GROUP 2	No pre-authorization is required for all providers.	N/A
88314	HISTOCHEMICAL STAINS ADD-ON	No pre-authorization is required for all providers.	N/A
88319	ENZYME HISTOCHEMISTRY	No pre-authorization is required for all providers.	N/A
88321	CONS & REPORT REF SLIDES PREP ELSEWHERE	This service is not covered by Superior HealthPlan.	N/A
88323	CONS & REPORT REF MAT REQUIRING PREP SLIDES	This service is not covered by Superior HealthPlan.	N/A
88325	CONS COMP W/REVIEW RECORD/SPECMN W/REPRT REF MAT	This service is not covered by Superior HealthPlan.	N/A
88329	PATH CONS DURING SURG	This service is not covered by Superior HealthPlan.	N/A

88331	PATH CONS DURING SURG; W/FROZEN SECT SNGL SPECMN	No pre-authorization is required for all providers.	N/A
88332	PATH CONSULT INTRAOP ADDL	No pre-authorization is required for all providers.	N/A
88333	PATH CONSLTJ SURG CYTOLOGIC XM 1ST SIT	This service is not covered by Superior HealthPlan.	N/A
88334	INTRAOP CYTO PATH CONSULT 2	This service is not covered by Superior HealthPlan.	N/A
88341	IMMUNOHISTO ANTB ADDL SLIDE	No pre-authorization is required for all providers.	N/A
88342	IMMUNOHISTO ANTIBODY STAIN	No pre-authorization is required for all providers.	N/A
88343	IMMUNOHISTO ANTIBOD ADD SLID	This is no longer a valid code.	N/A
88344	IMMUNOHISTO ANTIBODY SLIDE	No pre-authorization is required for all providers.	N/A
88346	IMMUNOFLUOR ANTB 1ST STAIN	No pre-authorization is required for all providers.	N/A
88347	IMMUNOFLUOR STUDY EA ANTIB; INDIRECT METHD	This is no longer a valid code.	N/A
88348	ELECTRON MICRO; DX	No pre-authorization is required for all providers.	N/A
88349	ELECTRON MICRO; SCANNING	This is no longer a valid code.	N/A
88350	IMMUNOFLUOR ANTB ADDL STAIN	No pre-authorization is required for all providers.	N/A
88355	MORPHOMETRIC ANALY; SKELETAL MUSCL	No pre-authorization is required for all providers.	N/A
88356	MORPHOMETRIC ANALY; NERV	No pre-authorization is required for all providers.	N/A
88358	MORPHOMETRIC ANALYSIS TUMOR	No pre-authorization is required for all providers.	N/A
88360	TUMOR IMMUNOHISTOCHEM/MANUAL	No pre-authorization is required for all providers.	N/A
88361	TUMOR IMMUNOHISTOCHEM/COMPUT	No pre-authorization is required for all providers.	N/A
88362	NERV TEASING PREP	No pre-authorization is required for all providers.	N/A
88363	XM ARCHIVE TISSUE MOLEC ANA	This service is not covered by Superior HealthPlan.	N/A
88364	INSITU HYBRIDIZATION (FISH)	No pre-authorization is required for all providers.	N/A
88365	INSITU HYBRIDIZATION (FISH)	No pre-authorization is required for all providers.	N/A
88366	INSITU HYBRIDIZATION (FISH)	No pre-authorization is required for all providers.	N/A
88367	INSITU HYBRIDIZATION AUTO	No pre-authorization is required for all providers.	N/A
88368	INSITU HYBRIDIZATION MANUAL	No pre-authorization is required for all providers.	N/A
88369	M/PHMTRC ALYSISHQUANT/SEMIQ	No pre-authorization is required for all providers.	N/A
88371	PROT ANALY TISS WESTERN BLOT W/INTERPT & REPORT	No pre-authorization is required for all providers.	N/A
88372	PROT ANALY W BLOT W/INTRPT/REPRT; IMMUN PROBE EA	No pre-authorization is required for all providers.	N/A
88373	M/PHMTRC ALYS ISHQUANT/SEMIQ	No pre-authorization is required for all providers.	N/A
88374	M/PHMTRC ALYS ISHQUANT/SEMIQ	No pre-authorization is required for all providers.	N/A
88375	OPTICAL ENDOMICROSCOPY INTERP	This service is not covered by Superior HealthPlan.	N/A
88377	M/PHMTRC ALYS ISHQUANT/SEMIQ	No pre-authorization is required for all providers.	N/A
88380	MICRODISSECTION PREP IDENTIFIED TARGET LASER	This service is not covered by Superior HealthPlan.	N/A
88381	MICRODISSECTION MANUAL	This service is not covered by Superior HealthPlan.	N/A
88384	RA-BASED EVAL MLT MOLEC PRBS 11 THRU 50 PRBS	This is no longer a valid code.	N/A
88385	RA-BASED EVAL MLT MOLEC PRBS 51 THRU 250 PRBS	This is no longer a valid code.	N/A
88386	RA-BASED EVAL MLT MOLEC PRBS 251 THRU 500 PRBS	This is no longer a valid code.	N/A
88387	TISS EXAM MOLECULAR STUDY	No pre-authorization is required for all providers.	N/A
88388	TISS EX MOLECUL STUDY ADD-ON	No pre-authorization is required for all providers.	N/A
88399	UNLISTED SURG PATH PROC	No pre-authorization is required for all providers.	N/A
88400	BILI TOT TRANSCUTANEOUS 0	No pre-authorization is required for all providers.	N/A
88720	BILIRUBIN TOTAL TRANSCUT	No pre-authorization is required for all providers.	N/A
88738	HGB QUANT TRANSCUTANEOUS	This service is not covered by Superior HealthPlan.	N/A
88740	TRANSCUTANEOUS CARBOXYHB	This service is not covered by Superior HealthPlan.	N/A
88741	TRANSCUTANEOUS METHB	This service is not covered by Superior HealthPlan.	N/A
88749	IN VIVO LAB SERVICE	No pre-authorization is required for all providers.	N/A
89049	CAFFEINE HALOTHANE CONTRCURE	No pre-authorization is required for all providers.	N/A
89050	CELL CT MISC BODY FLUIDS EX BLD	No pre-authorization is required for all providers.	N/A
89051	CELL CT MISC BODY FLUIDS EX BLD; W/DIFF CT	No pre-authorization is required for all providers.	N/A
89055	LEUKOCYTE ASSESS FECAL QAU/QUAN	No pre-authorization is required for all providers.	N/A
89060	CRYSTAL IDENTIF BY LIGHT MICROSC W/WO POLARIZING LENS ANALYSIS, TISS	No pre-authorization is required for all providers.	N/A
89105	DUODENL INTUB/ASPIR; COLLEC MX FRACT SPECMN 1/2	No pre-authorization is required for all providers.	N/A
89125	FAT STAIN FECES URIN/SPUTUM	No pre-authorization is required for all providers.	N/A
89130	GASTRIC INTUBAT & ASPIR DX EA SPECMN CHEM ANALY	No pre-authorization is required for all providers.	N/A
89132	GASTRIC INTUBAT & ASPIR DX EA SPECMN; AFTR STIM	No pre-authorization is required for all providers.	N/A
89141	GASTRC INTUB/ASPIR/FRCT COLLC; 3HR + GASTRC STIM	No pre-authorization is required for all providers.	N/A
89160	MEAT FIBERS FECES	No pre-authorization is required for all providers.	N/A
89190	NASAL SMEAR EOSINOPHILS	No pre-authorization is required for all providers.	N/A
89220	SPUTUM OBT SPEC AROSL INDUCD TECH	No pre-authorization is required for all providers.	N/A
89230	SWEAT COLLECTION BY IONTOPHORESIS	No pre-authorization is required for all providers.	N/A
89240	UNLISTED MISCELLANEOUS PATHOLOGY TEST	No pre-authorization is required for all providers.	N/A
89250	CULTURE OOCYTE/EMBRYO <4 DAYS	This service is not covered by Superior HealthPlan.	N/A
89251	CULT OOCYTE/EMBRYO <4 DAY CO-CULT	This service is not covered by Superior HealthPlan.	N/A
89253	ASSISTED EMBRYO HATCHING-MICROTECH	This service is not covered by Superior HealthPlan.	N/A
89254	OOCYTE ID FROM FOLLICULAR FLUID	This service is not covered by Superior HealthPlan.	N/A
89255	PREP EMBRYO FOR TRANSFER	This service is not covered by Superior HealthPlan.	N/A
89257	SPERM ID FROM ASPIR (OTH THAN SEMINAL FLUID)	This service is not covered by Superior HealthPlan.	N/A
89258	CRYOPRESERVATION EMBRYO(S)	This service is not covered by Superior HealthPlan.	N/A
89259	CRYOPRESERVATION; SPERM	This service is not covered by Superior HealthPlan.	N/A
89260	SPERM ISOLATN; SIMPL PREP-INSEM/DX W/SEMEN ANAL	This service is not covered by Superior HealthPlan.	N/A
89261	SPERM ISOLATN; CMLPX PREP-INSEM/DX W/SEMEN ANAL	This service is not covered by Superior HealthPlan.	N/A
89264	SPERM ID FROM TESTIS TISS-FRESH/CRYOPRESERV	This service is not covered by Superior HealthPlan.	N/A
89268	INSEMINATION OF OOCYTES	This service is not covered by Superior HealthPlan.	N/A
89272	EXT CULT OOCYTE/EMBRYO 4-7 DAYS	This service is not covered by Superior HealthPlan.	N/A
89280	ASSTD OOCYTE FERTILIZ <=10 OOCYTES	This service is not covered by Superior HealthPlan.	N/A
89281	ASSTD OOCYTE FERTILIZ > 10 OOCYTES	This service is not covered by Superior HealthPlan.	N/A
89290	BX OOCYTE/EMB BLASTOMERE <=5 EMB	This service is not covered by Superior HealthPlan.	N/A
89291	BX OOCYTE/EMB BLASTOMERE >5 EMB	This service is not covered by Superior HealthPlan.	N/A
89300	SEMEN ANAL; PRESENCE/MOTILITY INCL HUHNER TEST	This service is not covered by Superior HealthPlan.	N/A
89310	SEMEN ANALYSIS; MOTILITY AND COUNT	This service is not covered by Superior HealthPlan.	N/A
89320	SEMEN ANALYSIS VOLUME COUNT MOTILITY DIFFERENT	This service is not covered by Superior HealthPlan.	N/A
89321	SEMEN ANALYSIS SPERM PRESENCE&MOTILITY SPRM	This service is not covered by Superior HealthPlan.	N/A
89322	SEMEN ANAL STRICT CRITERIA	This service is not covered by Superior HealthPlan.	N/A
89325	SPERM ANTIB	This service is not covered by Superior HealthPlan.	N/A
89329	SPERM EVAL; HAMSTER PENETRATION TEST	This service is not covered by Superior HealthPlan.	N/A
89330	SPERM; CERV MUCOS PENETRAT W/WO SPINNBARKEIT	This service is not covered by Superior HealthPlan.	N/A
89331	RETROGRADE EJACULATION ANAL	This service is not covered by Superior HealthPlan.	N/A
89335	CRYOPRES REPRODIVE TISS TESTICULAR	This service is not covered by Superior HealthPlan.	N/A
89337	CRYOPRESERVATION OOCYTE(S)	This service is not covered by Superior HealthPlan.	N/A
89342	STORAGE, (PER YEAR), EMBRYO(S)	This service is not covered by Superior HealthPlan.	N/A
89343	STORAGE, SPERM/SEEMEN	This service is not covered by Superior HealthPlan.	N/A
89344	STORAGE TISS TESTICULAR/OVARIAN	This service is not covered by Superior HealthPlan.	N/A
89346	STORAGE OOCYTE	This service is not covered by Superior HealthPlan.	N/A
89352	THAWING OF CRYOPRESERVED EMBRYO	This service is not covered by Superior HealthPlan.	N/A
89353	THAW CRYOPRES SPERM/SEM EA ALIQUOT	This service is not covered by Superior HealthPlan.	N/A
89354	THAW CRYOPRES TISS TESTICULR/OVARN	This service is not covered by Superior HealthPlan.	N/A
89356	THAW CRYOPRES OOCYTES EA ALIQUOT	This service is not covered by Superior HealthPlan.	N/A
89398	UNLISTED REPROD MED LAB PROC	This service is not covered by Superior HealthPlan.	N/A
90281	IMMUNE GLOBULIN IG HUMAN IM USE	This service is not covered by Superior HealthPlan.	N/A
90283	IMMUNE GLOBULIN IGIV HUMAN IV USE	This service is not covered by Superior HealthPlan.	N/A
90284	HUMAN IG SC	Pre-authorization is required for all providers.	Prior to 09/01/2019
90287	BOTULINUM ANTITOXIN EQUINE ANY ROUTE	No pre-authorization is required for all providers.	N/A
90288	BOTULISM IMMUNE GLOBULIN HUMAN INTRAVENOUS USE	No pre-authorization is required for all providers.	N/A
90291	CYTOMEGALOVIRUS IMMUNE GLOBULIN HUMAN IV	Pre-authorization is required for all providers.	Prior to 09/01/2019
90296	DIPHThERIA ANTITOXIN EQUINE ANY ROUTE	This service is not covered by Superior HealthPlan.	N/A
90371	HEPATITIS B IMMUNE GLOBULIN HBIG HUMAN IM	No pre-authorization is required for all providers.	N/A
90375	RABIES IMMUNE GLOBULIN RIG HUMAN IM/SUBQ	No pre-authorization is required for all providers.	N/A
90376	RABIES IG HEAT-TREATED HUMAN IM/SUBQ	No pre-authorization is required for all providers.	N/A
90378	RESPIRATORY SYNCYTIAL VIRUS IG IM 50 MG E	Pre-authorization is required for all providers.	Prior to 09/01/2019
90384	RHO(D) IMMUNE GLOBULIN HUMAN FULL-DOSE IM	This service is not covered by Superior HealthPlan.	N/A
90385	RHO(D) IMMUNE GLOBULIN HUMAN MINI-DOSE IM	This service is not covered by Superior HealthPlan.	N/A

90386	RHO(D) IMMUNE GLOBULIN HUMAN IV	This service is not covered by Superior HealthPlan.	N/A
90389	TETANUS IMMUNE GLOBULIN TIG HUMAN IM	This service is not covered by Superior HealthPlan.	N/A
90393	VACCINIA IMMUNE GLOBULIN HUMAN IM	This service is not covered by Superior HealthPlan.	N/A
90396	VARICELLA-ZOSTER IMMUNE GLOBULIN HUMAN IM	This service is not covered by Superior HealthPlan.	N/A
90399	UNLISTED IMMUNE GLOBULIN	This service is not covered by Superior HealthPlan.	N/A
90460	IM ADMIN 1ST/ONLY COMPONENT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90461	IM ADMIN EACH ADDL COMPONENT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90465	IMM ADMIN < 8 YR PERQ INTDERM SUBQ/IM; 1 INJ-DAY	No pre-authorization is required for all providers.	N/A
90470	ADMINISTRATION OF H1N1 VACCINE	No pre-authorization is required for all providers.	N/A
90471	IMMUNIZ ADMIN; 1/COMBO VACCINE/TOXOID	No pre-authorization is required for all providers.	N/A
90472	IMMUNIZ ADMIN; 2/> SING/COMBO VACCINES/TOXOIDS	No pre-authorization is required for all providers.	N/A
90473	IMMUNIZATION ADMINISTRATION	No pre-authorization is required for all providers.	N/A
90474	IMMUNIZATION ADMINISTRATION	No pre-authorization is required for all providers.	N/A
90476	ADENOVIRUS VACCINE TYPE 4 LIVE ORAL	This service is not covered by Superior HealthPlan.	N/A
90477	ADENOVIRUS VACCINE TYPE 7 LIVE FOR ORAL	This service is not covered by Superior HealthPlan.	N/A
90581	ANTHRAX VACCINE SC OR IM	This service is not covered by Superior HealthPlan.	N/A
90585	BACILLUS CALMETTE-GUERIN VACC FOR TB LIVE PERQ	No pre-authorization is required for all providers.	N/A
90586	BCG BLDR CANCER LIVE INTRAVESICAL	No pre-authorization is required for all providers.	N/A
90587	DENGUE VACC QUAD 3 DOSE SUBQ	This service is not covered by Superior HealthPlan.	N/A
90619	MENACWY-TT CONJ VACC SEROGROUPS ACWY FOR IM USE	No pre-authorization is required for all providers.	N/A
90620	MENB-4C VACC 2 DOSE IM	No pre-authorization is required for all providers.	N/A
90621	MENB-FHBP VACC 2/3 DOSE IM	No pre-authorization is required for all providers.	N/A
90625	CHOLERA VACCINE LIVE ORAL	This service is not covered by Superior HealthPlan.	N/A
90630	IIV4 FLU VACC NO PRESERV ID	No pre-authorization is required for all providers.	N/A
90632	HEPATITIS A VACCINE ADULT FOR INTRAMUSCULAR USE	No pre-authorization is required for all providers.	N/A
90633	HEPATITIS A VACCINE PEDIATRIC 2 DOSE SCHEDULE IM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90634	HEPATITIS A VACCINE PEDIATRIC 3 DOSE SCHEDULE IM	This service is not covered by Superior HealthPlan.	N/A
90636	HEPATITIS A & B VACCINE HEPA-HEPB ADULT IM	No pre-authorization is required for all providers.	N/A
90644	MENINGOCOCL HIB VAC 4 DOSE IM	This service is not covered by Superior HealthPlan.	N/A
90645	HEMOPHILUS INFLUENZA B VACC HB0C CONJ 4 DOSE IM	This is no longer a valid code.	N/A
90646	HEMOPHILUS INFLUENZA B VACCINE PRP-D BOOSTER IM	This is no longer a valid code.	N/A
90647	HEMOPHILUS INFLUENZA B VACCINE PRP-OMP 3 DOSE IM	No pre-authorization is required for all providers.	N/A
90648	HEMOPHILUS INFLUENZA B VACCINE PRP-T 4 DOSE IM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90649	HUMAN PAPILLOMA VIRUS VACCINE QUADRIV 3 DOSE IM	No pre-authorization is required for all providers.	N/A
90650	HPV TYP BIVAL 3 DOSE IM	No pre-authorization is required for all providers.	N/A
90651	9VHPV VACCINE 2/3 DOSE IM	No pre-authorization is required for all providers.	N/A
90653	FLU VACCINE ADJUVANT IM	This service is not covered by Superior HealthPlan.	N/A
90654	FLU VACC IIV3 NO PRESERV ID	No pre-authorization is required for all providers.	N/A
90655	IIV3 VACC NO PRSV 0.25 ML IM	This service is not covered by Superior HealthPlan.	N/A
90656	IIV3 VACC NO PRSV 0.5 ML IM	No pre-authorization is required for all providers.	N/A
90657	IIV3 VACCINE SPLT 0.25 ML IM	No pre-authorization is required for all providers.	N/A
90658	IIV3 VACCINE SPLT 0.5 ML IM	No pre-authorization is required for all providers.	N/A
90660	FLU VACCINE NASAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90661	CCIV3 VAC NO PRSRV 0.5 ML IM	No pre-authorization is required for all providers.	N/A
90662	FLU VACC PRSV FREE INC ANTIG	No pre-authorization is required for all providers.	N/A
90664	FLU VACC PANDEMIC LIVE NASAL	This service is not covered by Superior HealthPlan.	N/A
90666	FLU VACC PANDEMIC NO PRSV IM	This service is not covered by Superior HealthPlan.	N/A
90667	FLU VACC PANDEMIC ADJ IM	This service is not covered by Superior HealthPlan.	N/A
90668	FLU VACC PANDEMIC SPLT V IM	This service is not covered by Superior HealthPlan.	N/A
90669	PNEUMOCOCCAL CONJ VACCINE POLYVALENT <5 YEARS IM	This is no longer a valid code.	N/A
90670	PNEUMOCOCCAL VACC 13 VAL IM	This service is not covered by Superior HealthPlan.	N/A
90672	FLU VACCINE 4 VALENT NASAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90674	CCIV4 VACCINE PRESERVATIVE FREE 0.5 ML IM USE	No pre-authorization is required for all providers.	N/A
90675	RABIES VACCINE INTRAMUSCULAR	No pre-authorization is required for all providers.	N/A
90676	RABIES VACCINE INTRADERMAL	This service is not covered by Superior HealthPlan.	N/A
90680	ROTAVIRUS VACCINE PENTAVALENT 3 DOSE LIVE ORAL	No pre-authorization is required for all providers.	N/A
90681	ROTAVIRUS VACC 2 DOSE ORAL	No pre-authorization is required for all providers.	N/A
90682	RIV4 VACC RECOMBINANT DNA PRSRV ANTIBIO FREE IM	No authorization required. Code is for informational purposes only.	N/A
90685	IIV4 VACC NO PRSV 0.25 ML IM	No pre-authorization is required for all providers.	N/A
90686	IIV4 VACC NO PRSV 0.5 ML IM	No pre-authorization is required for all providers.	N/A
90687	IIV4 VACCINE SPLT 0.25 ML IM	No pre-authorization is required for all providers.	N/A
90688	IIV4 VACCINE SPLT 0.5 ML IM	No pre-authorization is required for all providers.	N/A
90689	IIV4 VACC INACTIVATED PRSRV FR 0.25ML DOS IM USE	This service is not covered by Superior HealthPlan.	N/A
90690	TYPHOID VACCINE-LIVE-ORAL	This service is not covered by Superior HealthPlan.	N/A
90691	TYPHOID VACCINE VI CAPSULAR POLYSACCHARIDE IM	This service is not covered by Superior HealthPlan.	N/A
90692	TYPHOID VACC H-P INACTIVATED SUBQ/INTRADERMAL	This is no longer a valid code.	N/A
90693	TYPHOID VACCINE AKD SUBQ U.S. MILITARY	This is no longer a valid code.	N/A
90694	AIIV4 VACC INACTIVATED PRSRV FR 0.5ML DOS IM USE	No pre-authorization is required for all providers.	N/A
90696	DTAP-IPV VACC 4-6 YR IM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90697	DTAP-IPV-HIB-HEPB VACCINE IM	No pre-authorization is required for all providers.	N/A
90698	DTAP-IPV/HIB VACCINE IM	This service is not covered by Superior HealthPlan.	N/A
90700	DTAP VACCINE < 7 YR IM	No pre-authorization is required for all providers.	N/A
90702	DIPHThERIA TETANUS TOXOID ADSORBED < 7 YR IM	No pre-authorization is required for all providers.	N/A
90703	TETANUS TOXOID ADSORBED INTRAMUSCULAR	This is no longer a valid code.	N/A
90704	MUMPS VIRUS VACCINE LIVE SUBCUTANEOUS	This is no longer a valid code.	N/A
90705	MEASLES VIRUS VACCINE LIVE SUBCUTANEOUS	This is no longer a valid code.	N/A
90706	RUBELLA VIRUS VACCINE LIVE SUBCUTANEOUS	This is no longer a valid code.	N/A
90707	MEASLES MUMPS RUBELLA VIRUS VACCINE LIVE SUBQ	No pre-authorization is required for all providers.	N/A
90708	MEASLES & RUBELLA VIRUS VACCINE LIVE SUBQ	This is no longer a valid code.	N/A
90710	MEASLES MUMPS RUBELLA VARICELLA VACC LIVE SUBQ	No pre-authorization is required for all providers.	N/A
90712	POLIOVIRUS VACCINE ANY LIVE ORAL	This is no longer a valid code.	N/A
90713	POLIOVIRUS VACCINE INACTIVATED SUBQ/IM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90714	TD TOXOIDS ADSORBED PRSRV FR 7 YR + IM	No pre-authorization is required for all providers.	N/A
90715	TDAP VACCINE 7 YR + IM	No pre-authorization is required for all providers.	N/A
90716	VARICELLA VIRUS VACCINE LIVE SUBQ	No pre-authorization is required for all providers.	N/A
90717	YELLOW FEVER VACCINE LIVE SUBQ	This service is not covered by Superior HealthPlan.	N/A
90719	DIPHThERIA TOXOID INTRAMUSCULAR	This is no longer a valid code.	N/A
90720	DTP-HIB VACCINE INTRAMUSCULAR	This is no longer a valid code.	N/A
90721	DTAP/HIB VACCINE IM	This is no longer a valid code.	N/A
90723	DTAP-HEP B-IPV VACCINE IM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90725	CHOLERA VACCINE, INJECTABLE	This is no longer a valid code.	N/A
90727	PLAGUE VACCINE INTRAMUSCULAR	This is no longer a valid code.	N/A
90732	PNEUMOCOCCAL VACCINE	No pre-authorization is required for all providers.	N/A
90733	MENINGOCOCCAL POLYSAC VACCINE SUBCUTANEOUS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90734	MENACWYD/MENACWY-CRM CONJ VACC GRPS ACWY IM USE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90735	ENCEPHALITIS VACCINE, SC	This is no longer a valid code.	N/A
90736	ZOSTER VACC, SC	No pre-authorization is required for all providers.	N/A
90738	JAPANESE ENCEPHALITIS VIRUS VACCINE, INACTIVATED, FOR INTRAMUSCULAR USE	This service is not covered by Superior HealthPlan.	N/A
90739	HEP B VACC ADULT 2 DOSE IM	This service is not covered by Superior HealthPlan.	N/A
90740	HEP B VACCINE, DIALYSIS/WEAK IMMUNE, 3 DOSE	No pre-authorization is required for all providers.	N/A
90743	HEPATITIS B VACCINE, ADOLESCENT, 2 DOSE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90744	HEPATITIS B VACCINE, CHILD/ADOLESCENT, 3 DOSE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90746	HEP B VACC ADULT 3 DOSE IM	No pre-authorization is required for all providers.	N/A
90747	HEP B VACCINE, DIALYSIS/WEAK IMMUNE, 4 DOSE	No pre-authorization is required for all providers.	N/A
90748	HEPB-HIB VACCINE INTRAMUSCULAR	No pre-authorization is required for all providers.	N/A
90749	UNLISTED VACCINE/TOXOID	No pre-authorization is required for all providers.	N/A
90750	HZV VACC RECOMBINANT IM	No pre-authorization is required for all providers.	N/A
90756	CCIV4 VACC ABX FREE IM	No pre-authorization is required for all providers.	N/A
90785	PSYTX COMPLEX INTERACTIVE	This service is not covered by Superior HealthPlan.	N/A
90791	PSYCH DIAGNOSTIC EVALUATION	Allow 1 visit every 6 months, then Pre-authorization is required.	Prior to 09/01/2019
90792	PSYCH DIAG EVAL W/MED SRVCS	No pre-authorization is required for all providers.	N/A

90832	PSYTX W PT 30 MINUTES	No pre-authorization is required for all providers.	N/A
90833	PSYTX W PT W E/M 30 MIN	No pre-authorization is required for all providers.	N/A
90834	PSYTX W PT 45 MINUTES	No pre-authorization is required for all providers.	N/A
90836	PSYTX W PT W E/M 45 MIN	No pre-authorization is required for all providers.	N/A
90837	PSYTX W PT 60 MINUTES	No pre-authorization is required for all providers.	N/A
90838	PSYTX W PT W E/M 60 MIN	No pre-authorization is required for all providers.	N/A
90839	PSYTX CRISIS INITIAL 60 MIN	This service is not covered by Superior HealthPlan.	N/A
90840	PSYTX CRISIS EA ADDL 30 MIN	This service is not covered by Superior HealthPlan.	N/A
90845	PSYCHOANALYSIS	This service is not covered by Superior HealthPlan.	N/A
90846	FAMILY PSYTX W/O PT 50 MIN	This service is not covered by Superior HealthPlan.	N/A
90847	FAMILY PSYTX W/PT 50 MIN	No pre-authorization is required for all providers.	N/A
90849	MX-FAMILY GROUP PSYCHOTHERAPY	This service is not covered by Superior HealthPlan.	N/A
90853	GROUP PSYCHOTHERAPY (NOT MX-FAMILY GROUP)	No pre-authorization is required for all providers.	N/A
90863	PHARMACOLOGIC MGMT W/PSYTX	This service is not covered by Superior HealthPlan.	N/A
90865	NARCOSYNTHESIS FOR PSYCH DX & THERAP PURPOSES	No pre-authorization is required for all providers.	N/A
90867	TCRANIAL MAGN STIM TX PLAN	This service is not covered by Superior HealthPlan.	N/A
90868	TCRANIAL MAGN STIM TX DELI	This service is not covered by Superior HealthPlan.	N/A
90869	TCRAN MAGN STIM REDETERMINE	This service is not covered by Superior HealthPlan.	N/A
90870	ELEC-CONVULS THERAP; SNGL SEIZURE	Pre-authorization required for all providers.	Prior to 09/01/2019
90875	PSYCHOPHYSIOLOGICAL THERAPY	No pre-authorization is required for all providers.	N/A
90876	PSYCHOPHYSIOLOGICAL THERAPY	This service is not covered by Superior HealthPlan.	N/A
90880	HYPNOTHERAPY	This service is not covered by Superior HealthPlan.	N/A
90882	ENVIRONM INTERVEN-MED MGMT PURP-W/AGENCIES/INSTI	This service is not covered by Superior HealthPlan.	N/A
90885	PSYCH EVAL HOSP RECD/REPR/TEST-MED DX PURPOSES	This service is not covered by Superior HealthPlan.	N/A
90887	INTERPT/EXPLAN RESULTS EXAM/PROC/DATA TO FAMILY	This service is not covered by Superior HealthPlan.	N/A
90889	PREPARATION OF REPORT	This service is not covered by Superior HealthPlan.	N/A
90899	UNLISTED PSYCH SERV/PROC	No pre-authorization is required for all providers.	N/A
90901	BIOFEEDBACK TRAINING-ANY MODALITY	No pre-authorization is required for all providers.	N/A
90911	BIOFEEDBACK TRAIN-PERINEAL/ANORECTAL W/EMG/MANOM	No pre-authorization is required for all providers.	N/A
90912	BFB TRAINING W/EMG AND /MANOMETRY 1ST 15 MIN CNTCT	No pre-authorization is required for all providers.	N/A
90913	BFB TRAINING W/EMG AND /MANOMETRY EA ADDL 15 MIN CNTCT	No pre-authorization is required for all providers.	N/A
90935	HEMODIALYSIS ONE EVALUATION	No pre-authorization is required for all providers.	N/A
90937	HEMODIALYSIS PROC W/REPEAT EVAL W/WO REVIS DIALY	No pre-authorization is required for all providers.	N/A
90940	HEMODIAL ACCES FLO STDY-DILUT METHD 0	No pre-authorization is required for all providers.	N/A
90945	DIALYSIS ONE EVALUATION	No pre-authorization is required for all providers.	N/A
90947	DIALYSIS REPEATED EVAL	No pre-authorization is required for all providers.	N/A
90951	ESRD SERV 4 VISITS P MO <2YR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90952	ESRD SERV 2-3 VSTS P MO <2YR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90953	ESRD SERV 1 VISIT P MO <2YRS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90954	ESRD SERV 4 VSTS P MO 2-11	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90955	ESRD SRV 2-3 VSTS P MO 2-11	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90956	ESRD SRV 1 VISIT P MO 2-11	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90957	ESRD SRV 4 VSTS P MO 12-19	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90958	ESRD SRV 2-3 VSTS P MO 12-19	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90959	ESRD SERV 1 VST P MO 12-19	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90960	ESRD SRV 4 VISITS P MO 20+	No pre-authorization is required for all providers.	N/A
90961	ESRD SRV 2-3 VSTS P MO 20+	No pre-authorization is required for all providers.	N/A
90962	ESRD SERV 1 VISIT P MO 20+	No pre-authorization is required for all providers.	N/A
90963	ESRD HOME PT SERV P MO <2	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90964	ESRD HOME PT SERV P MO 2-11	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90965	ESRD HOME PT SERV P MO 12-19	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90966	ESRD HOME PT SERV P MO 20+	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
90967	ESRD HOME PT SERV P DAY <2	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90968	ESRD HOME PT SRV P DAY 2-11	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90969	ESRD HOME PT SRV P DAY 12-19	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
90970	ESRD HOME PT SERV P DAY 20+	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
90989	DIALYSIS TRAIN-PT-INCL HELPR WHERE APPLIC-COMPLT	No pre-authorization is required for all providers.	N/A
90993	DIALYSIS TRAIN-PT-COURSE NOT COMPLT-PER SESSION	No pre-authorization is required for all providers.	N/A
90997	HEMOPERFUSION	No pre-authorization is required for all providers.	N/A
90999	UNLISTED DIALYSIS PROC INPT/OUTPT	No pre-authorization is required for all providers.	N/A
91010	ESOPHAGUS MOTILITY STUDY	No pre-authorization is required for all providers.	N/A
91013	ESOPHGL MOTIL W/STIM/PERFUS	No pre-authorization is required for all providers.	N/A
91020	GASTRIC MOTILITY STUDIES	No pre-authorization is required for all providers.	N/A
91022	DUOL MOTILITY STD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
91030	ESOPHAGUS ACID PERFUSION TEST ESOPHAGITIS	No pre-authorization is required for all providers.	N/A
91034	ESOPH GER TEST; W/NASAL CATH PH ELEC PLCMT REC	No pre-authorization is required for all providers.	N/A
91035	ESOPH GER TEST; W/MUCOSL ATTCH PH ELEC PLCMT REC	No pre-authorization is required for all providers.	N/A
91037	ESOPH FUNCT TST GER W/NASL CATH ELEC PLCMT REC;	No pre-authorization is required for all providers.	N/A
91038	ESOPH FUNCT TST GER NASL CATH ELEC PLCMT; PROLNG	No pre-authorization is required for all providers.	N/A
91040	ESOPH BALLOON DISTENSION TST	No pre-authorization is required for all providers.	N/A
91065	BREATH HYDROGEN/METHANE TEST	No pre-authorization is required for all providers.	N/A
91110	GI TRACT CAPSULE ENDOSCOPY	No pre-authorization is required for all providers.	N/A
91111	ESOPHAGEAL CAPSULE ENDOSCOPY	No pre-authorization is required for all providers.	N/A
91112	GI WIRELESS CAPSULE MEASURE	No pre-authorization is required for all providers.	N/A
91117	COLON MOTILITY 6 HR STUDY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
91120	RECTAL SENSATION TONE AND COMPLIANCE TEST	No pre-authorization is required for all providers.	N/A
91122	ANORECTAL MANOMETRY	No pre-authorization is required for all providers.	N/A
91132	ELECTROGASTRPHY-DX-TRANSCUT; 0	This service is not covered by Superior HealthPlan.	N/A
91133	ELECTROGASTRO-DX-TRNSQ; W/PROVOC TS 0	This service is not covered by Superior HealthPlan.	N/A
91200	LIVER ELASTOGRAPHY	This service is not covered by Superior HealthPlan.	N/A
91299	UNLISTED DX GASTROENTEROLOGY PROC	No pre-authorization is required for all providers.	N/A
92002	OPHTH SERV: MED EXAM & EVAL; INTERMED NEW PT	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92004	OPHTH SERV: MED EXAM; COMP NEW PT 1/MORE VISITS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92012	OPHTH SERV: MED EXAM & EVAL; ININTERMED ESTAB PT	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92014	OPHTH SERV: MED EXAM & EVAL; COMP ESTAB PT	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92015	DETERM REFRACTIVE STATE	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92018	OPHTH EXAM & EVAL-GEN ANES; COMPLT	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92019	OPHTH EXAM & EVAL-GEN ANES; LTD	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92020	GONIOSCOPY (SEPART PROC)	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92025	COMPUTERIZED CORNEAL TOPOGRAPHY, UNILATERAL OR BILATERAL	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92060	SENSORIMOTOR EXAM W/IX MEAS OCU DEVA (SEP PROC)	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92065	ORTHOPTIC &/OR PLEOPTIC TRAIN W/MED DIRECT	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92071	CONTACT LENS FITTING FOR TX	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92072	FIT CONTAC LENS FOR MANAGMNT	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92081	VISUAL FIELD EXAM UNILAT/BILAT W/I&R; LTD	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92082	VISUAL FIELD EXAM UNI/BIL W/I&R; INTERMED	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92083	VISUAL FIELD EXAM UNILAT/BILAT W/I&R; EXTEN	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92100	SERIAL TONOMOMETRY (SEPART PROC) W/I&R SAME DA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92132	CMPTR OPHTH DX IMG ANT SEGM	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92133	CMPTR OPHTH IMG OPTIC NERVE	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92134	CPTR OPHTH DX IMG POST SEGM	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92136	OPHTHALMIC BIOMETRY	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92140	PROVOCATIVE TESTS-GLAU W/I&R WO TONOGRAPY	This is no longer a valid code.	N/A
92145	CORNEAL HYSTERESIS DETER	This service is not covered by Superior HealthPlan.	N/A
92201	OPSCPY EXTND RTA DRAWING AND SCL DEPRNS I AND R UNI/BI	No pre-authorization is required for all providers.	N/A
92202	OPSCPY EXTND OPTIC NRV/MACULA DRAWING I AND R UNI/BI	No pre-authorization is required for all providers.	N/A
92225	OPHTH EXTEN W/RETINAL DRAW W/I&R; INIT	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92226	OPHTH EXTEN W/RETINAL DRAW W/I&R; SUBSQT	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92227	REMOTE DX RETINAL IMAGING	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92228	REMOTE RETINAL IMAGING MGMT	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A

92230	FLUORESCIN ANGIOSCOPY W/I&R	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92235	FLUORESCIN ANGRPH UNI/BI	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92240	ICG ANGIOGRAPHY UNI/BI	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92242	FLUORESCIN ICG ANGRPH W/MULTIFRAME I&R UNI/BI	No pre-authorization is required for all providers.	N/A
92250	FUNDUS PHOTOGRAPHY W/I&R	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92260	OPHTHALMODYNAMOMETRY	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92265	NEEDLE OCULOECTROMYOGRAPHY 1/MORE MUSCL W/I&R	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92270	ELEC-OCULOGRAPHY W/I&R	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92273	FULL FIELD ELECTRORETINOGRAPHY W/I AND R	No pre-authorization is required for all providers.	N/A
92274	MULTIFOCAL ELECTRORETINOGRAPHY W/I AND R	No pre-authorization is required for all providers.	N/A
92275	ELECTRORETINOGRAPHY W/I&R	This is no longer a valid code.	N/A
92283	COLOR VISION EXAM EXTEN EG. ANOMALSCOPE/EQUIVAL	This service is not covered by Superior HealthPlan.	N/A
92284	DARK ADAPTATION EXAM W/I&R	This service is not covered by Superior HealthPlan.	N/A
92285	EXT OCULAR PHOTOG W/I&R-DOCUMENT MED PROGRESS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92286	INTERNAL EYE PHOTOGRAPHY	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92287	INTERNAL EYE PHOTOGRAPHY	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92310	SCRIPT & FIT CONTACT LENS; CORNEAL EX APHAKIA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92311	SCRIPT & FIT CONTACT LENS; CORNEAL-APHAKIA-1EYE	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92312	SCRIPT CONTACT LENS; CORNEAL-APHAKIA-BOTH EYES	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92313	SCRIPT & FIT CONTACT LENS; CORNEOSCLERAL LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92314	SCRIPT W/FIT BY TECH; LENS BOTH EYES EX APHAKIA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92315	SCRIPT W/FIT BY TECH; LENS-APHAKIA-1 EYE	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92316	SCRIPT W/FIT BY TECH; LENS-APHAKIA-BOTH EYES	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92317	SCRIPT W/FIT BY TECH; CORNEOSCLERAL LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92325	MODIFICAT LENS (SEP PRO) W/MED SUPERVS ADAPTAT	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92326	REPLAC CONTACT LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92330	SCRIPT FIT & SUPPLY OCULAR PROSTH W/SUPERVS ADAP	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92335	SCRIPT OCULAR PROSTH & DIRECT FIT & SUPPLY-TECH	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92340	FIT SPECTACLES EX APHAKIA; MONOFOCAL	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92341	FITTING SPECTACLES EX APHAKIA; BIFOCAL	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92342	FIT SPECTACLES EX APHAKIA; MULTIFOCAL NOT BIFOCL	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92352	FITTING SPECTACLE PROSTH APHAKIA; MONOFOCAL	This service is not covered by Superior HealthPlan.	N/A
92353	FITTING SPECTACLE PROSTH APHAKIA; MULTIFOCAL	This service is not covered by Superior HealthPlan.	N/A
92354	FIT SPECTACL MOUNTED LO VISION AID; 1 ELEMNT SYS	This service is not covered by Superior HealthPlan.	N/A
92355	FIT SPECTACL MOUNT LO VISION AID; TELESCOP/OTHER	This service is not covered by Superior HealthPlan.	N/A
92358	PROSTH SERV APHAKIA TEMPORARY	This service is not covered by Superior HealthPlan.	N/A
92370	REPR & REFITTING SPECTACLES; EX APHAKIA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92371	REPR & REFIT SPECTACLE; SPECTACLE PROSTH APHAKIA	This service is not covered by Superior HealthPlan.	N/A
92390	SUPPLY SPECTACLE EX PROSTH-APHAK & LO VISION AID	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92391	SUPPLY CONTACT LENSES EX PROSTH APHAKIA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92392	SUPPLY LOW VISION AIDS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92393	SUPPLY OCULAR PROSTH	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92395	SUPPLY PERM PROSTH-APHAKIA; SPECTACLES	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92396	SUPPLY PERM PROSTH APHAKIA; CONTACT LENSES	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92499	UNLISTED OPHTH SERV/PROC	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
92502	OTOLARYNGOLOGIC EXAM UNDER GEN ANES	No pre-authorization is required for all providers.	N/A
92504	BINOCULAR MICRO (SEPART DX PROC)	No pre-authorization is required for all providers.	N/A
92506	EVAL SPEECH/LANG/VOICE/COMMUN/AUDITORY PROCESS	This is no longer a valid code.	N/A
92507	TX SPEECH/LANG/VOICE/COMMUN/AUD DISORDER; INDIV	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
92508	TX SPEECH/LANG/VOICE/COMMUN/AUD DISORDER; 2/MORE	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
92511	NASOPHARYNGOSCOPY W/ENDO (SEPART PROC)	No pre-authorization is required for all providers.	N/A
92512	NASAL FUNCT STUDIES	This service is not covered by Superior HealthPlan.	N/A
92516	FACIAL NERV FUNCT STUDIES	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
92520	LARYNGEAL FUNCT STUDIES	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
92521	EVALUATION OF SPEECH FLUENCY	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
92522	EVALUATE SPEECH PRODUCTION	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
92523	SPEECH SOUND LANG COMPREHEN	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
92524	BEHAVRAL QUALIT ANALYS VOICE	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
92526	TX SWALLOWING DYSFUNCT & OR ORAL FUNCT-FEEDING	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
92531	SPONTANEOUS NYSTAGMUS INCL GAZE	No pre-authorization is required for all providers.	N/A
92532	POSIT NYSTAGMUS	No pre-authorization is required for all providers.	N/A
92533	CALORIC VESTIBULAR TEST EA IRRIGA	No pre-authorization is required for all providers.	N/A
92534	OPTOKINETIC NYSTAGMUS	No pre-authorization is required for all providers.	N/A
92537	CALORIC VSTBLR TEST W/REC	No pre-authorization is required for all providers.	N/A
92538	CALORIC VSTBLR TEST W/REC	No pre-authorization is required for all providers.	N/A
92540	BASIC VESTIBULAR EVALUATION	No pre-authorization is required for all providers.	N/A
92541	SPONTANEOUS NYSTAGMUS TEST W/GATE & FIX W/RECORD	No pre-authorization is required for all providers.	N/A
92542	POSIT NYSTAGMUS TEST MINI 4 POSIT W RECORDING	No pre-authorization is required for all providers.	N/A
92543	CALORIC VESTIBULAR TEST EA IRRIGA W/RECORDING	This is no longer a valid code.	N/A
92544	OPTOKINETIC NYSTAGMS BIDIRECT/FOVEAL/PERIPH STIM	No pre-authorization is required for all providers.	N/A
92545	OSCILLATING TRACKING TEST W/RECORDING	No pre-authorization is required for all providers.	N/A
92546	SINUSOIDAL VERTICAL AXIS ROTATIONAL TESTING	No pre-authorization is required for all providers.	N/A
92547	USE VERTICAL ELECTRODES	No pre-authorization is required for all providers.	N/A
92548	CDP-SOT 6 CONDITIONS W/INTERPRETATION AND REPORT	This service is not covered by Superior HealthPlan.	N/A
92549	CDP-SOT 6 CONDITIONS W/I AND R W/MCT AND ADT	This service is not covered by Superior HealthPlan.	N/A
92550	TYMPANOMETRY & REFLEX THRESH	No pre-authorization is required for all providers.	N/A
92551	SCREENING TEST PURE TONE AIR ONLY	No pre-authorization is required for all providers.	N/A
92552	PURE TONE AUDIOMETRY; AIR ONLY	No pre-authorization is required for all providers.	N/A
92553	PURE TONE AUDIOMETRY; AIR & BONE	No pre-authorization is required for all providers.	N/A
92555	SPEECH AUDIOMETRY THRESHOLD;	No pre-authorization is required for all providers.	N/A
92556	SPEECH AUDIOMETRY THRESHOLD; W/SPEECH RECOGNITN	No pre-authorization is required for all providers.	N/A
92557	COMP AUDIOMETRY THRESHOLD EVAL & SPEECH RECOGNI	No pre-authorization is required for all providers.	N/A
92558	EVOKE AUDITORY TEST QUAL	No pre-authorization is required for all providers.	N/A
92559	AUDIOMETRIC TESTING GRP	This service is not covered by Superior HealthPlan.	N/A
92560	BEKESY AUDIOMETRY; SCREENING	This service is not covered by Superior HealthPlan.	N/A
92561	BEKESY AUDIOMETRY; DX	This service is not covered by Superior HealthPlan.	N/A
92562	LOUDNESS BALANCE TEST ALTERN BINAURAL/MONAURAL	No pre-authorization is required for all providers.	N/A
92563	TONE DECAY TEST	No pre-authorization is required for all providers.	N/A
92564	SHORT INCREMENT SENSITIVITY INDX	No pre-authorization is required for all providers.	N/A
92565	STENGER TEST PURE TONE	No pre-authorization is required for all providers.	N/A
92567	TYMPANOMETRY	No pre-authorization is required for all providers.	N/A
92568	ACOUSTIC REFLEX TESTING	No pre-authorization is required for all providers.	N/A
92570	ACOUSTIC IMMITTANCE TESTING	No pre-authorization is required for all providers.	N/A
92571	FILTERED SPEECH TEST	No pre-authorization is required for all providers.	N/A
92572	STAGGERED SPONDAIC WORD TEST	No pre-authorization is required for all providers.	N/A
92575	SENSORINEURAL ACUITY LEVEL TEST	No pre-authorization is required for all providers.	N/A
92576	SYNTHETIC SENTENCE IDENT TEST	No pre-authorization is required for all providers.	N/A
92577	STENGER TEST SPEECH	No pre-authorization is required for all providers.	N/A
92579	VISUAL REINFORCEMENT AUDIOMETRY	No pre-authorization is required for all providers.	N/A
92582	CONDITIONING PLAY AUDIOMETRY	No pre-authorization is required for all providers.	N/A
92583	SELECT PICTURE AUDIOMETRY	No pre-authorization is required for all providers.	N/A
92584	ELECTROCOCHLEOGRAPHY	No pre-authorization is required for all providers.	N/A
92585	AUDITORY EVOKE POTENTIALS & OR TEST-CNS	No pre-authorization is required for all providers.	N/A
92586	AUD EVOKE POTENT & OR TEST CNS; LTD 1.96	No pre-authorization is required for all providers.	N/A
92587	EVOKE AUDITORY TEST LIMITED	No pre-authorization is required for all providers.	N/A
92588	EVOKE AUDITORY TST COMPLETE	No pre-authorization is required for all providers.	N/A
92590	HEARING AID EXAM & SELECT; MONAURAL	No pre-authorization is required for all providers.	N/A
92591	HEARING AID EXAM & SELECT; BINAURAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
92592	HEARING AID CHECK; MONAURAL	No pre-authorization is required for all providers.	N/A
92593	HEARING AID CHECK; BINAURAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
92594	ELECTROACOUSTIC EVAL HEARING AID; MONAURAL	No pre-authorization is required for all providers.	N/A
92595	ELECTROACOUSTIC EVAL HEARING AID; BINAURAL	No pre-authorization is required for all providers.	N/A

92596	EAR PROTECTOR ATTENUATION MEASUR	This service is not covered by Superior HealthPlan.	N/A
92597	EVAL AND FITG VOICE PROSTC DEV SUPLMNT ORAL SPEEC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
92601	DX ANALY CI PT UND 7 YR AGE; W/PROG	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
92602	DX ANALY CI PT <7 YR; SUBSQT REPROG	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
92603	DX ANALY COCH IMPL 7 YR/;>; W/PROG	No pre-authorization is required for all providers.	N/A
92604	DX ANALY CI 7 YR/;>; SUBSQT REPROG	No pre-authorization is required for all providers.	N/A
92605	EX FOR NONSPEECH DEVICE RX	This service is not covered by Superior HealthPlan.	N/A
92606	TX SRVC NON-SPEECH-GEN DEVC W/PROG	This service is not covered by Superior HealthPlan.	N/A
92607	EVAL RX SPCH-GEN DEVC F/F PT; 1 HR	This service is not covered by Superior HealthPlan.	N/A
92608	EVAL RX SPCH-GEN DEVC F/F PT;30 MIN	This service is not covered by Superior HealthPlan.	N/A
92609	TX SRVC USE SPCH-GEN DEVC PROG&MOD	This service is not covered by Superior HealthPlan.	N/A
92610	EVAL ORL&PHARYNGEAL SWALLWING FUNCT	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
92611	MOT FLUORO EVAL SWALLW CINE/VIDEO	No pre-authorization is required for all providers.	N/A
92612	ENDOSCOPY SWALLOW (FEES) VID	No pre-authorization is required for all providers.	N/A
92613	ENDOSCOPY SWALLOW (FEES) I&R	This service is not covered by Superior HealthPlan.	N/A
92614	LARYNGOSCOPIC SENSORY VID	No pre-authorization is required for all providers.	N/A
92615	LARYNGOSCOPIC SENSORY I&R	This service is not covered by Superior HealthPlan.	N/A
92616	FEES W/LARYNGEAL SENSE TEST	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
92617	FEES W/LARYNGEAL SENSE I&R	This service is not covered by Superior HealthPlan.	N/A
92618	EX FOR NONSPEECH DEV RX ADD	This service is not covered by Superior HealthPlan.	N/A
92620	EVAL CNTRL AUDITORY FUNCTION W/RPT; INIT 60 MIN	No pre-authorization is required for all providers.	N/A
92621	AUDITORY FUNCTION + 15 MIN	No pre-authorization is required for all providers.	N/A
92625	ASSESSMENT OF TINNITUS	No pre-authorization is required for all providers.	N/A
92626	EVAL AUD FUNCJ CAND/PO SURG IMPLT DEV 1ST HR	No pre-authorization is required for all providers.	N/A
92627	EVAL AUD FUNCJ CAND/PO SURG IMPLT DEV EA ADDL 15	No pre-authorization is required for all providers.	N/A
92630	AUD RHAB PRELNG HEARING LOSS	No pre-authorization is required for all providers.	N/A
92633	AUD RHAB POST-LNGL HEARING LOSS	No pre-authorization is required for all providers.	N/A
92640	DIAGNOSTIC ANALYSIS/ PROGRAMMING OF AUDITORY BRAINSTEM IMPLANT	No pre-authorization is required for all providers.	N/A
92700	UNLIST OTORHINOLARYNGOLOG SRVC/PROC	No pre-authorization is required for all providers.	N/A
92920	PRQ CARDIAC ANGIOPLAST 1 ART	No pre-authorization is required for all providers.	N/A
92921	PRQ CARDIAC ANGIO ADDL ART	No pre-authorization is required for all providers.	N/A
92924	PRQ CARD ANGIO/ATHRECT 1 ART	No pre-authorization is required for all providers.	N/A
92925	PRQ CARD ANGIO/ATHRECT ADDL	No pre-authorization is required for all providers.	N/A
92928	PRQ CARD STENT W/ANGIO 1 VSL	No pre-authorization is required for all providers.	N/A
92929	PRQ CARD STENT W/ANGIO ADDL	No pre-authorization is required for all providers.	N/A
92933	PRQ CARD STENT/ATH/ANGIO	No pre-authorization is required for all providers.	N/A
92934	PRQ CARD STENT/ATH/ANGIO	No pre-authorization is required for all providers.	N/A
92937	PRQ REVASC BYP GRAFT 1 VSL	No pre-authorization is required for all providers.	N/A
92938	PRQ REVASC BYP GRAFT ADDL	No pre-authorization is required for all providers.	N/A
92941	PRQ CARD REVASC MI 1 VSL	No pre-authorization is required for all providers.	N/A
92943	PRQ CARD REVASC CHRONIC 1VSL	No pre-authorization is required for all providers.	N/A
92944	PRQ CARD REVASC CHRONIC ADDL	No pre-authorization is required for all providers.	N/A
92950	CARDIOPULMONARY RESUSCITATION	No pre-authorization is required for all providers.	N/A
92953	TEMPORARY TRANSCUTANEOUS PACING	This service is not covered by Superior HealthPlan.	N/A
92960	CARDIOVERSION ELECT ELEC CONVERSION ARRHY EXT	No pre-authorization is required for all providers.	N/A
92961	CARDIOVERSION, ELECTRIC, INT	No pre-authorization is required for all providers.	N/A
92970	CARDIOASSIST-METHD CIRCULATORY ASSIST; INT	No pre-authorization is required for all providers.	N/A
92971	CARDIOASSIST-METHD CIRCULATORY ASSIST; EXT	No pre-authorization is required for all providers.	N/A
92973	PRQ CORONARY MECH THROMBECT	No pre-authorization is required for all providers.	N/A
92974	PLACEMENT OF RADIATION DELIVERY DEVICE FOR CORONARY BRACHYTHERAPY	No pre-authorization is required for all providers.	N/A
92975	THROMBOLYSIS CORON; INTRACORON INFUS INCL ANGIO	No pre-authorization is required for all providers.	N/A
92977	THROMBOLYSIS CORONARY; IV INFUSION	No pre-authorization is required for all providers.	N/A
92978	ENDOLUMINL IVUS OCT C 1ST	No pre-authorization is required for all providers.	N/A
92979	ENDOLUMINL IVUS OCT C EA	No pre-authorization is required for all providers.	N/A
92986	PERCUT BALLOON VALVULOPLASTY; AORTIC VALVE	No pre-authorization is required for all providers.	N/A
92987	PERCUT BALLOON VALVULOPLASTY; MITRAL VALV	No pre-authorization is required for all providers.	N/A
92990	PERCUT BALLOON VALVULOPLASTY; PULM VALVE	No pre-authorization is required for all providers.	N/A
92992	ATRIAL SEPTECT/SEPTOST; TRANSVEN METHD BALLOON	No pre-authorization is required for all providers.	N/A
92993	ATRIAL SEPTECT/SEPTOST; BLADE METHD	No pre-authorization is required for all providers.	N/A
92997	PERC TRNSLUM PULM ART BALLOON ANGIOPLASTY; 1 VSL	No pre-authorization is required for all providers.	N/A
92998	PERC TRNSLUM PULM ART BALLOON ANGIOPLSTY; EA ADD	No pre-authorization is required for all providers.	N/A
93000	ECG-ROUTINE W/12 LEADS; W/INTERPT & REPORT	No pre-authorization is required for all providers.	N/A
93005	ECG-ROUTINE ECG W/12 LEADS; TRACING ONLY	No pre-authorization is required for all providers.	N/A
93010	ECG-ROUTINE W/12 LEADS; INTERPT & REPORT ONLY	No pre-authorization is required for all providers.	N/A
93015	CARDIOVASCULAR STRESS TEST	No pre-authorization is required for all providers.	N/A
93016	CARDIOVASCULAR STRESS TEST	No pre-authorization is required for all providers.	N/A
93017	CV STRESS TEST W/TREADMILL; TRACING ONLY	No pre-authorization is required for all providers.	N/A
93018	CV STRESS TEST W/TREADMILL; INTERPT & REPRT ONLY	No pre-authorization is required for all providers.	N/A
93024	ERGONOVINE PROVOCATION TEST	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
93025	MICROVOLT T-WAVE ASSESSMENT	No pre-authorization is required for all providers.	N/A
93040	RHYTHM ECG 1-3 LEADS; W/INTERPT & REPORT	No pre-authorization is required for all providers.	N/A
93041	RHYTHM ECG 1-3 LEADS; TRACING ONLY	No pre-authorization is required for all providers.	N/A
93042	RHYTHM ECG 1-3 LEADS; INTERPT & REPORT ONLY	No pre-authorization is required for all providers.	N/A
93050	ART PRESSURE WAVEFORM ANALYS	This service is not covered by Superior HealthPlan.	N/A
93224	ECG MONIT/REPRT UP TO 48 HRS	No pre-authorization is required for all providers.	N/A
93225	ECG MONIT/REPRT UP TO 48 HR	No pre-authorization is required for all providers.	N/A
93226	ECG MONIT/REPRT UP TO 48 HR	No pre-authorization is required for all providers.	N/A
93227	ECG MONIT/REPRT UP TO 48 HRS	No pre-authorization is required for all providers.	N/A
93228	REMOTE 30 DAY ECG REV/REPORT	No pre-authorization is required for all providers.	N/A
93229	REMOTE 30 DAY ECG TECH SUPP	No pre-authorization is required for all providers.	N/A
93260	PRGRMG DEV EVAL IMPLTBL SYS	No pre-authorization is required for all providers.	N/A
93261	INTERROGATE SUBQ DEFIB	No pre-authorization is required for all providers.	N/A
93264	REMOTE MNTR WIRELESS P-ART PRS SNR UP TO 30 D	This service is not covered by Superior HealthPlan.	N/A
93268	ECG RECORD/REVIEW	No pre-authorization is required for all providers.	N/A
93270	REMOTE 30 DAY ECG REV/REPOR	No pre-authorization is required for all providers.	N/A
93271	ECG/MONITORING AND ANALYSIS	No pre-authorization is required for all providers.	N/A
93272	ECG/REVIEW INTERPRET ONLY	No pre-authorization is required for all providers.	N/A
93278	SIGNAL-AVERAGED ELECTROCARDIOGRAPHY W/WO ECG	No pre-authorization is required for all providers.	N/A
93279	PRGRMG DEV EVAL 1 LEAD PM/LDLS PM 1 CAR CHMBR IP	No pre-authorization is required for all providers.	N/A
93280	PM DEVICE PROGR EVAL DUAL	No pre-authorization is required for all providers.	N/A
93281	PM DEVICE PROGR EVAL MULTI	No pre-authorization is required for all providers.	N/A
93282	PRGRMG EVAL IMPLANTABLE DFB	No pre-authorization is required for all providers.	N/A
93283	PRGRMG EVAL IMPLANTABLE DFB	No pre-authorization is required for all providers.	N/A
93284	PRGRMG EVAL IMPLANTABLE DFB	No pre-authorization is required for all providers.	N/A
93285	PRGRMG DEV EVAL SCRMS PHYS/QHP IN PERSON	No pre-authorization is required for all providers.	N/A
93286	PERI-PX DEV EVAL PM/LDLS PM PHYS/QHP IN PERSON	No pre-authorization is required for all providers.	N/A
93287	PERI-PX DEVICE EVAL & PRGR	No pre-authorization is required for all providers.	N/A
93288	INTERROG DEV EVAL PM/LDLS PM PHYS/QHP IN PERSON	No pre-authorization is required for all providers.	N/A
93289	INTERROG DEVICE EVAL HEART	No pre-authorization is required for all providers.	N/A
93290	INTERROG DEV EVAL ICPMS PHYS/QHP IN PERSON	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
93291	INTERROG DEV EVAL SCRMS PHYS/QHP IN PERSON	No pre-authorization is required for all providers.	N/A
93292	WCD DEVICE INTERROGATE	No pre-authorization is required for all providers.	N/A
93293	PM PHONE R-STRIP DEVICE EVAL	No pre-authorization is required for all providers.	N/A
93294	REM INTERROG PM/LDLS PM <90 D PHYS/QHP	No pre-authorization is required for all providers.	N/A
93295	DEV INTERROG REMOTE 1/2/MLT	No pre-authorization is required for all providers.	N/A
93296	REM INTERROG PM/LDLS PM/IDS <90 D PHYS/QHP	No pre-authorization is required for all providers.	N/A
93297	REM INTERROG ICPMS <30 D PHYS/QHP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
93298	REM INTERROG SCRMS <30 D PHYS/QHP	No pre-authorization is required for all providers.	N/A
93299	REM INTERROG ICPMS/SCRMS <30 D TECH REVIEW	No pre-authorization is required for all providers.	N/A
93303	TRANSTHORACIC ECHO-CONGEN CARDIAC ANOM; COMPLT	Pre-authorization is required for long-term care members through NIA. For all other members, no pre-authorization is required.	Prior to 09/01/2019

93304	TRANSTHORACIC ECHO-CONGEN CARDIAC ANOM; F/U, LTD	Pre-authorization is required for long-term care members through NIA. For all other members, no pre-authorization is required.	Prior to 09/01/2019
93306	TTE W/DOPPLER COMPLETE	Pre-authorization is required for long-term care members through NIA. For all other members, no pre-authorization is required.	Prior to 09/01/2019
93307	TTE W/O DOPPLER COMPLETE	Pre-authorization is required for long-term care members through NIA. For all other members, no pre-authorization is required.	Prior to 09/01/2019
93308	TTE F-UP OR LMTD	Pre-authorization is required for long-term care members through NIA. For all other members, no pre-authorization is required.	Prior to 09/01/2019
93312	ECHO TRANSESOPH REAL-TIME; W/PROBE PLCMT & REPR	Pre-authorization is required for long-term care members through NIA. For all other members, no pre-authorization is required.	Prior to 09/01/2019
93313	ECHO REAL-TIME TRANSESOPH; PLCMT PROBE ONLY	Pre-authorization is required for long-term care members through NIA. For all other members, no pre-authorization is required.	Prior to 09/01/2019
93314	ECHO TRANSESOPH; IMAGE ACQUISIT INTERPT & REPORT	Pre-authorization is required for long-term care members through NIA. For all other members, no pre-authorization is required.	Prior to 09/01/2019
93315	TRANSESOPH ECHO-CONGEN CARDIAC ANOM; TOTAL SERV	Pre-authorization is required for long-term care members through NIA. For all other members, no pre-authorization is required.	Prior to 09/01/2019
93316	TRANSESOPH ECHO-CONG CARD ANOM; PLCMT PROBE ONLY	Pre-authorization is required for long-term care members through NIA. For all other members, no pre-authorization is required.	Prior to 09/01/2019
93317	TRANSESOPH ECHO-CONG CARD ANOM; IMAGE ACQUIS-I&R	Pre-authorization is required for long-term care members through NIA. For all other members, no pre-authorization is required.	Prior to 09/01/2019
93318	ECHOCARD TEE-PROB PLC/IMAG ACQ-INTE 0	Pre-authorization is required for long-term care members through NIA. For all other members, no pre-authorization is required.	Prior to 09/01/2019
93320	DOPPLER ECHO CONT WAVE W/SPECTRAL DISPLY; COMPLT	Pre-authorization is required for long-term care members through NIA. For all other members, no pre-authorization is required.	Prior to 09/01/2019
93321	DOPPLER ECHO CONT WAVE W/SPECTRL DISPLY; F/U-LTD	Pre-authorization is required for long-term care members through NIA. For all other members, no pre-authorization is required.	Prior to 09/01/2019
93325	DOPPLER ECHO COLOR FLOW VELOCITY MAPPING	Pre-authorization is required for long-term care members through NIA. For all other members, no pre-authorization is required.	Prior to 09/01/2019
93350	STRESS TTE ONLY	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
93351	STRESS TTE COMPLETE	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
93352	ADMIN ECG CONTRAST AGENT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
93355	ECHO TRANSESOPHAGEAL (TEE)	No pre-authorization is required for all providers.	N/A
93356	MYOCDR STRAIN IMG SPECKLE TRCK ASSMT MYOCDR MECH	This service is not covered by Superior HealthPlan.	N/A
93451	RIGHT HEART CATH	No pre-authorization is required for all providers.	N/A
93452	LEFT HRT CATH W/VENTRCLGRPH	No pre-authorization is required for all providers.	N/A
93453	R&L HRT CATH W/VENTRCLGRPH	No pre-authorization is required for all providers.	N/A
93454	CORONARY ARTERY ANGIO S&I	No pre-authorization is required for all providers.	N/A
93455	CORONARY ART/GRFT ANGIO S&I	No pre-authorization is required for all providers.	N/A
93456	R HRT CORONARY ARTERY ANGIO	No pre-authorization is required for all providers.	N/A
93457	R HRT ART/GRFT ANGIO	No pre-authorization is required for all providers.	N/A
93458	L HRT ARTERY/VENTRICLE ANGI	No pre-authorization is required for all providers.	N/A
93459	L HRT ART/GRFT ANGIO	No pre-authorization is required for all providers.	N/A
93460	R&L HRT ART/VENTRICLE ANGIO	No pre-authorization is required for all providers.	N/A
93461	R&L HRT ART/VENTRICLE ANGIO	No pre-authorization is required for all providers.	N/A
93462	L HRT CATH TRNSPTL PUNCTURE	No pre-authorization is required for all providers.	N/A
93463	DRUG ADMIN & HEMODYNAMIC MEAS	This service is not covered by Superior HealthPlan.	N/A
93464	EXERCISE W/HEMODYNAMIC MEAS	This service is not covered by Superior HealthPlan.	N/A
93503	INSRT & PLCMT FLO DIREC CATH-MONITOR PURPOSES	No pre-authorization is required for all providers.	N/A
93505	ENDOMYOCARDIAL BIOPSY	No pre-authorization is required for all providers.	N/A
93530	R HRT CATHETERIZATION CONGENITAL CARDIAC ANOMALY	No pre-authorization is required for all providers.	N/A
93531	CMBN R HRT & RETROGRADE L HRT CATHJ CGEN ANOMALY	No pre-authorization is required for all providers.	N/A
93532	CMBN R HRT T-SEPTAL L HRT CATHJ NTC SEPTUM CGEN	No pre-authorization is required for all providers.	N/A
93533	CMBN R HRT T-SEPTAL L HRT CATHJ SEPTAL OPNG CGEN	No pre-authorization is required for all providers.	N/A
93561	CARDIAC OUTPUT MEASUREMENT	No pre-authorization is required for all providers.	N/A
93562	CARD OUTPUT MEASURE SUBSQ	No pre-authorization is required for all providers.	N/A
93563	INJECT CONGENITAL CARD CATH	No pre-authorization is required for all providers.	N/A
93564	INJECT HRT CONGNL ART/GRFT	No pre-authorization is required for all providers.	N/A
93565	INJECT L VENTR/ATRIAL ANGIO	No pre-authorization is required for all providers.	N/A
93566	INJECT R VENTR/ATRIAL ANGIO	No pre-authorization is required for all providers.	N/A
93567	INJECT SUPRVLV AORTOGRAPHY	No pre-authorization is required for all providers.	N/A
93568	INJECT PULM ART HRT CATH	No pre-authorization is required for all providers.	N/A
93571	INTRAVASC DOPPLER DUR SCA INCL RX STRESS; INIT	No pre-authorization is required for all providers.	N/A
93572	INTRAVASC DOPPLER DUR SCA INCL RX STRESS; EA ADD	No pre-authorization is required for all providers.	N/A
93580	PERQ TRNSCATH CLO INTERATRIAL CMNCT	No pre-authorization is required for all providers.	N/A
93581	PERQ TRNSCATH CLO VENT SEPTAL DEFEC	No pre-authorization is required for all providers.	N/A
93582	PERQ TRNSCATH CLOSURE PDA	No pre-authorization is required for all providers.	N/A
93583	PERQ TRNSCATH SEPTAL REDUXN	No pre-authorization is required for all providers.	N/A
93590	PERQ TRNSCATH CLS PARAVALVR LEAK 1 MITRAL VALVE	No pre-authorization is required for all providers.	N/A
93591	PERQ TRNSCATH CLS PARAVALVR LEAK 1 AORTIC VALVE	No pre-authorization is required for all providers.	N/A
93592	PERQ TRNSCATH CLS PARAVALVR LEAK EACH OCCLS DEV	No pre-authorization is required for all providers.	N/A
93600	BUNDLE HIS RECORDING	No pre-authorization is required for all providers.	N/A
93602	INTRA-ATRIAL RECORDING	No pre-authorization is required for all providers.	N/A
93603	RT VENTRICULAR RECORDING	No pre-authorization is required for all providers.	N/A
93609	INTRAVENT/-ATRIAL MAP TACHY SITE W/CATH MANIP	No pre-authorization is required for all providers.	N/A
93610	INTRA-ATRIAL PACING	No pre-authorization is required for all providers.	N/A
93612	INTRAVENTRICULAR PACING	No pre-authorization is required for all providers.	N/A
93613	3-D INTRACARDIAC MAPPING	No pre-authorization is required for all providers.	N/A
93615	ESOPH RECORD ATRIAL ELECTROGM W/WO VENT ELECTROG	No pre-authorization is required for all providers.	N/A
93616	ESOPH RECORD ATRIAL ELECTROGM; W/PACING	No pre-authorization is required for all providers.	N/A
93618	INDUCTION ARRHY BY ELEC PACING	No pre-authorization is required for all providers.	N/A
93619	COMPRE ELECTROPHYSIOLOGIC W/O ARRHYT INDUCTION	No pre-authorization is required for all providers.	N/A
93620	COMPRE ELECTROPHYSIOLOGIC W/ ARRHYT HMIA INDUCT	No pre-authorization is required for all providers.	N/A
93621	COMP EP EVAL;LT ATRIAL COR SINUS	No pre-authorization is required for all providers.	N/A
93622	COMP EP EVAL; LFT VENT PACE&REC	No pre-authorization is required for all providers.	N/A
93623	PROGRAM STIM & PACING AFTER IV DRUG INFUSION	No pre-authorization is required for all providers.	N/A
93624	ELECTROPHYSIOLOGIC FOLLOW-UP W/PAC/REC W/ARRHYT	No pre-authorization is required for all providers.	N/A
93631	INTRA-OP PACING & MAPPING-LOCALIZ SITE OF TACHY	No pre-authorization is required for all providers.	N/A
93640	EPHYS EVAL PACG CVDFB LDS INITIAL IMPLAN/REPLACE	No pre-authorization is required for all providers.	N/A
93641	EPHYS EVAL PACG CVDFB LDS W/TSTG OF PULSE GEN	No pre-authorization is required for all providers.	N/A
93642	ELECTROPHYSIOLOGY EVALUATION	No pre-authorization is required for all providers.	N/A
93644	ELECTROPHYSIOLOGY EVALUATION	No pre-authorization is required for all providers.	N/A
93650	ICAR CATHETER ABLATION ATRIOVENTR NODE FUNCTION	No pre-authorization is required for all providers.	N/A
93653	EP & ABLATE SUPRAVENT ARRHYT	No pre-authorization is required for all providers.	N/A
93654	EP & ABLATE VENTRIC TACHY	No pre-authorization is required for all providers.	N/A
93655	ABLATE ARRHYTHMIA ADD ON	No pre-authorization is required for all providers.	N/A
93656	TX ATRIAL FIB PULM VEIN ISOL	No pre-authorization is required for all providers.	N/A
93657	TX L/R ATRIAL FIB ADDL	No pre-authorization is required for all providers.	N/A
93660	CARDIOVASCULAR FUNCTION EVAL W/TILT TABLE W/MNTR	No pre-authorization is required for all providers.	N/A
93662	CARD ECHO DUR INTERVENTN-IMAG S&I 8.19	No pre-authorization is required for all providers.	N/A
93668	REHAB PAD PER SESSION 0.01	This service is not covered by Superior HealthPlan.	N/A
93701	THORACIC BIOIMPEDANCE	No pre-authorization is required for all providers.	N/A
93702	BIS XTRACELL FLUID ANALYSIS	This service is not covered by Superior HealthPlan.	N/A
93724	ELECT ANALY ANTITACHY PACEMAKER SYST	No pre-authorization is required for all providers.	N/A
93740	TEMP GRADIENT STUDIES	No pre-authorization is required for all providers.	N/A
93745	SET-UP CARDIOVERT-DEFIBRILL	No pre-authorization is required for all providers.	N/A
93750	INTERROGATION VAD IN PERSON	No pre-authorization is required for all providers.	N/A
93770	DETERM VENOUS PRESS	No pre-authorization is required for all providers.	N/A
93784	AMBULATORY BP MNTR W/SW 24 HR+ REC SCAN ALYS I AND R	No pre-authorization is required for all providers.	N/A
93786	AMBULATORY BP MNTR W/SW 24 HR+ RECORDING ONLY	No pre-authorization is required for all providers.	N/A
93788	AMBULATORY BP MNTR W/SW 24 HR+ SCANNING A/R	No pre-authorization is required for all providers.	N/A
93790	AMBULATORY BP MNTR W/SW 24 HR+ REVIEW W/I AND R	No pre-authorization is required for all providers.	N/A
93792	PT/CAREGIVER TRAINJ HOME INR	No pre-authorization is required for all providers.	N/A
93793	ANTICOAG MGMT PT WARFARIN	No pre-authorization is required for all providers.	N/A
93797	CARDIAC REHAB	No pre-authorization is required for all providers.	N/A
93798	CARDIAC REHAB/MONITOR	No pre-authorization is required for all providers.	N/A
93799	UNLISTED CARDIOVASCULAR SERV/PROC	No pre-authorization is required for all providers.	N/A

93880	DUPLEX SCAN EXTRACRANIAL ART; COMPLT BILAT STUDY	No pre-authorization is required for all providers.	N/A
93882	DUPLEX SCAN EXTRACRAN ART; UNILAT/LTD STUDY	No pre-authorization is required for all providers.	N/A
93886	TRANSCRAN DOPPLER STDY INTRACRAN ART; COMPLT	No pre-authorization is required for all providers.	N/A
93888	TRANSCRAN DOPPLER STDY INTRACRAN ART; LTD	No pre-authorization is required for all providers.	N/A
93890	TRANSCRANIL DOPPLR INTRACRAN ART;VASOREACTV STDY	No pre-authorization is required for all providers.	N/A
93892	TRANSCRANIL DOPPLR; EMBOLI NO IV MICROBUBBLE INJ	No pre-authorization is required for all providers.	N/A
93893	TRANSCRANIL DOPPLR; EMBOLI W/IV MICROBUBBLE INJ	No pre-authorization is required for all providers.	N/A
93895	CAROTID INTIMA ATHEROMA EVAL	This service is not covered by Superior HealthPlan.	N/A
93922	UPR/L XTREMITY ART 2 LEVELS	No pre-authorization is required for all providers.	N/A
93923	UPR/LXTR ART STDY 3+ LVLS	No pre-authorization is required for all providers.	N/A
93924	LWR XTR VASC STDY BILAT	No pre-authorization is required for all providers.	N/A
93925	DUPLEX SCAN LOWR EXTREM ART/BYPASS; COMPLT BILAT	No pre-authorization is required for all providers.	N/A
93926	DUPLEX SCAN LOWR EXTREM ART/BYPASS; UNILTD STDY	No pre-authorization is required for all providers.	N/A
93930	DUPLEX SCAN UPPR EXTREM ART/BYPASS; COMPLT BILAT	No pre-authorization is required for all providers.	N/A
93931	DUPLEX SCAN UPPR EXTREM ART/BYPASS; UNILTD STDY	No pre-authorization is required for all providers.	N/A
93965	NON-INVASIV PHYSIOLOG STDIES EXTREM VEINS BILAT	This is no longer a valid code.	N/A
93970	DUPLEX SCAN-EXTREM VEINS; COMPLT BILAT STUDY	No pre-authorization is required for all providers.	N/A
93971	DUPLEX SCAN-EXTREM VEINS; UNILAT/LTD STUDY	No pre-authorization is required for all providers.	N/A
93975	DUPLEX SCAN IN-OUTFLO ABD/PELVIC ORGANS; COMPLT	No pre-authorization is required for all providers.	N/A
93976	DUPLEX SCAN IN/OUT-FLOW ABD/PELVIC ORGANS; LTD	No pre-authorization is required for all providers.	N/A
93978	DUPLEX SCAN AORTA/INFER VENA CAVAGFTS; COMPLT	No pre-authorization is required for all providers.	N/A
93979	DUPLEX SCAN AORTA/IVC/ILIAC/BYPASS GFTS; UNILTD	No pre-authorization is required for all providers.	N/A
93980	DUPLEX SCAN IN-OUT FLO PENILE VESSELS; COMPLT	No pre-authorization is required for all providers.	N/A
93981	DUPLEX SCAN IN-OUT FLO PENILE VESSELS; F/U-LTD	No pre-authorization is required for all providers.	N/A
93982	ANEURYSM PRESSURE SENS STUDY	This is no longer a valid code.	N/A
93985	DUPLEX SCAN ARTL INFL AND VEN O/F HEMO COMPL BI STD	No pre-authorization is required for all providers.	N/A
93986	DUPLEX SCAN ARTL INFL AND VEN O/F HEMO COMPL UNI STD	No pre-authorization is required for all providers.	N/A
93990	DUPLEX SCAN HEMODIALYSIS ACCESS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
93998	NONINVAS VASC DX STUDY PROC	This service is not covered by Superior HealthPlan.	N/A
94002	VENTILATION ASSIST AND MANAGEMENT	No pre-authorization is required for all providers.	N/A
94003	HOSPITAL INPATIENT/OBSERVATION, EACH SUBSEQUENT DAY	No pre-authorization is required for all providers.	N/A
94004	NURSING FACILITY, PER DAY	Pre-authorization is required Nursing Facility members.	Prior to 09/01/2019
94005	HOME VENTILATOR MANAGEMENT CARE PLAN OVERSIGHT OF A PATIENT	Pre-authorization is required Nursing Facility members.	Prior to 09/01/2019
94010	SPIROMETRY W/RECRD-TOT & TIMED VC-EXPIR FLO RATE	No pre-authorization is required for all providers.	N/A
94011	UP TO 2 YRS OLD, SPIROMETRY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
94012	= 2 YRS, SPIROMTRY W/DILATOR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
94013	= 2 YRS, LUNG VOLUMES	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
94014	PATIENT RECORDED SPIROMETRY	No pre-authorization is required for all providers.	N/A
94015	PT INIT SPIROMETRIC RECRD/30 DA; RECORDING	No pre-authorization is required for all providers.	N/A
94016	REVIEW PATIENT SPIROMETRY	No pre-authorization is required for all providers.	N/A
94060	BRONCHOSPSM EVAL: SPIROM PRE & POST BRONCHODILAT	No pre-authorization is required for all providers.	N/A
94070	PROLONGED POSTEXPOSE EVAL-BRONCHOSPSM-MX DETERM	No pre-authorization is required for all providers.	N/A
94150	VITAL CAPACITY TOT (SEPART PROC)	No pre-authorization is required for all providers.	N/A
94200	MAX BREATHING CAPACITY MAX VOLUNTARY VENTILATION	No pre-authorization is required for all providers.	N/A
94250	EXPIRED GAS COLLEC QUAN SNGL PROC (SEPART PROC)	No pre-authorization is required for all providers.	N/A
94375	RESPIRATORY FLOW VOLUM LOOP	No pre-authorization is required for all providers.	N/A
94400	BREATHING RESPONSE TO CO2	No pre-authorization is required for all providers.	N/A
94450	BREATHING RESPONSE TO HYPOXIA	No pre-authorization is required for all providers.	N/A
94452	HAST W/REPORT	No pre-authorization is required for all providers.	N/A
94453	HAST W/OXYGEN TITRATE	No pre-authorization is required for all providers.	N/A
94610	SURFACTANT ADMIN THRU TUBE	This service is not covered by Superior HealthPlan.	N/A
94617	EXERCISE TST BRNCSPSM	No pre-authorization is required for all providers.	N/A
94618	PULMONARY STRESS TESTING	No pre-authorization is required for all providers.	N/A
94620	PULMONARY STRESS TEST, SIMPLE	This is no longer a valid code.	N/A
94621	CARDIOPULM EXERCISE TESTING	No pre-authorization is required for all providers.	N/A
94640	PRESS/NONPRESS INHAL AC OBST TX DX	No pre-authorization is required for all providers.	N/A
94642	AEROSOL INHALA PENTAMIDINE PC PNEUMON TX/PROPHYL	No pre-authorization is required for all providers.	N/A
94644	CONTINUOUS INHALATION TREATMENT WITH AEROSOL MEDICATION	No pre-authorization is required for all providers.	N/A
94645	EACH ADDITIONAL HOUR	No pre-authorization is required for all providers.	N/A
94660	CONT POS AIRWAY PRESS VENTILATION INIT & MGMT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
94662	CONT NEG PRESS VENTILATION INIT & MGMT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
94664	DEM&EVAL PT ASL GEN NEB INHAL/IPPB	This service is not covered by Superior HealthPlan.	N/A
94667	MANIP CHEST WALL-FACIL LUNG FUNCT; 1ST DEMO/EVAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
94668	MANIP CHEST WALL-FACILIT LUNG FUNCT; SUBSQ	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
94669	MECHANICAL CHEST WALL OSCILL	This service is not covered by Superior HealthPlan.	N/A
94680	O2 UPTAKE EXPIRED GAS; REST/EXERCISE DIREC SIMPL	No pre-authorization is required for all providers.	N/A
94681	O2 UPTAKE EXPIRED GAS; W/CO2 OUTPUT % O2 EXTRACT	No pre-authorization is required for all providers.	N/A
94690	O2 UPTAKE EXPIRED GAS; REST INDIREC (SEP PRO)	No pre-authorization is required for all providers.	N/A
94726	PULM FUNCT TST PLETHYSMOGRAP	No pre-authorization is required for all providers.	N/A
94727	PULM FUNCTION TEST BY GAS	No pre-authorization is required for all providers.	N/A
94728	AIRWAY RESISTANCE BY OSCILLOMETRY	No pre-authorization is required for all providers.	N/A
94729	CO2/MEMBANE DIFFUSE CAPACITY	No pre-authorization is required for all providers.	N/A
94750	PULM COMPLIANCE STUDY ANY METHD	No pre-authorization is required for all providers.	N/A
94760	NONINVASIVE EAR/PULSE OXIMETRY-O2 SAT; 1 DETERM	No pre-authorization is required for all providers.	N/A
94761	NONINVASIVE EAR/PULSE OXIMETRY O2 SAT; MX DETERM	No pre-authorization is required for all providers.	N/A
94762	NONINVAS OXIMETRY-O2 SAT; OVERNITE (SEPART PROC)	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
94770	CO2 EXPIRED GAS DETERM-INFRAED ANALY	No pre-authorization is required for all providers.	N/A
94772	CIRCADIAN RESP PATTRN RECRD 12-24 HR CONT-INFANT	No pre-authorization is required for all providers.	N/A
94774	PED HOME APNEA REC COMPL	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
94775	MONITOR ATTACHMENT ONLY	This service is not covered by Superior HealthPlan.	N/A
94776	MONITORING, DOWNLOAD OF INFORMATION, RECEIPT OF TRANSMISSION	This service is not covered by Superior HealthPlan.	N/A
94777	PED HOME APNEA REC REPORT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
94780	CAR SEAT/BED TEST INFT THRU 12 MO 60 MIN	This service is not covered by Superior HealthPlan.	N/A
94781	CAR SEAT/BED TEST INFT THRU 12 MO EA ADDL 30 MIN	This service is not covered by Superior HealthPlan.	N/A
94799	UNLISTED PULM SERV/PROC	No pre-authorization is required for all providers.	N/A
95004	PERCUT ALLERGY SKIN TESTS	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95012	NITRIC OXIDE EXPIRED GAS DETERMINATION	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95017	PERQ & ICUT ALLG TEST VENOMS	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95018	PERQ&IC ALLG TEST DRUGS/BIOL	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95024	ICUT ALLERGY TEST DRUG/BUG	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95027	ICUT ALLERGY TITRATE-AIRBORN	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95028	INTRACUT W/ALLERG EXTRACT-DELAYED REACT-# TESTS	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95044	PATCH/APPLIC TEST(S)	Pre-authorization is required for all providers except when services are rendered by allergy immunology, dermatology and otolaryngology providers.	Prior to 09/01/2019
95052	PHOTO PATCH TEST(S)	Pre-authorization is required for all providers except when services are rendered by allergy immunology, dermatology and otolaryngology providers.	Prior to 09/01/2019
95056	PHOTO TESTS	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95060	OPHTH MUCOS MEMBRN TESTS	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95065	DIRECT NASAL MUCOS MEMBRN TEST	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95070	INHALA BRONCHIAL CHALLENGE; W/HISTAMINE-COMPOUND	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95071	INHALA BRONCHIAL CHALLENGE; W/ANTIG-GASES SPEC	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95076	INGEST CHALLENGE INI 120 MIN	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019

95079	INGEST CHALLENGE ADDL 60 MIN	This service is not covered by Superior HealthPlan.	N/A
95115	PROF SERV ALLERG IMMUNOTX NOT INCL EXTRACT; 1 INJ	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers and Rural Area PCPs administering the allergen.	Prior to 09/01/2019
95117	PROF SERV ALLERG IMMUNOTX WO EXTRACT; 2/MORE INJ	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers and Rural Area PCPs administering the allergen.	Prior to 09/01/2019
95120	IMMUNOTHERAPY ONE INJECTION	This service is not covered by Superior HealthPlan.	N/A
95125	IMMUNOTHERAPY 2/> INJECTIONS	This service is not covered by Superior HealthPlan.	N/A
95130	IMMNTX 1 STING INSECT	This service is not covered by Superior HealthPlan.	N/A
95131	IMMNTX 2 STING INSECTS	This service is not covered by Superior HealthPlan.	N/A
95132	IMMNTX 3 STING INSECTS	This service is not covered by Superior HealthPlan.	N/A
95133	IMMNTX 4 STING INSECTS	This service is not covered by Superior HealthPlan.	N/A
95134	IMMNTX 5 STING INSECTS	This service is not covered by Superior HealthPlan.	N/A
95144	PRO SERV SUPERVS/PROVS-IMMUNOTX; 1/MX ANTIG-1 VL	This service is not covered by Superior HealthPlan.	N/A
95145	PRO SERV SUPERVS/PROVIS-IMMUNOTX; 1 VENOM	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95146	PRO SERV-SUPERVS/PROVIS-IMMUNOTX; 2 VENOMS	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95147	PRO SERV-SUPERVS/PROVIS-IMMUNOTX; 3 VENOMS	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95148	PRO SERV-SUPERVS/PROVIS-IMMUNOTX; 4 VENOMS	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95149	PRO SERV-SUPERVS/PROVIS-IMMUNOTX; 5 VENOMS	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95165	PRO SERV-SUPERVS/PROVIS-IMMUNOTX; 1/MX ANTIG	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95170	PRO-IMMUNOTX; WHOLE BODY EXTRACT BITING INSECT	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95180	RAPID DESENZT PROC EA HR	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95199	UNLISTED ALLERG/CLINICAL IMMUNOLOGIC SERV/PROC	Pre-authorization is required for all providers except when services are rendered by allergy immunology and otolaryngology providers.	Prior to 09/01/2019
95249	CONT GLUC MNTR PT PROV EQP	No pre-authorization is required for all providers.	N/A
95250	CONT GLUC MNTR PHYS/QHP EQP	No pre-authorization is required for all providers.	N/A
95251	CONT GLUC MNTR ANALYSIS I&R	No pre-authorization is required for all providers.	N/A
95667	PHOTODYNAMIC THERAPY OF SKIN	No pre-authorization is required for all providers.	N/A
95700	EEG CONT REC W/VIDEO BY TECH MIN 8 CHANNELS	No pre-authorization is required for all providers.	N/A
95705	EEG W/O VIDEO BY TECH 2-12 HR UNMONITORED	No pre-authorization is required for all providers.	N/A
95706	EEG W/O VIDEO BY TECH 2-12 HR INTERMITTENT MNTR	No pre-authorization is required for all providers.	N/A
95707	EEG W/O VIDEO BY TECH 2-12HR CONTINUOUS R-T MNTR	No pre-authorization is required for all providers.	N/A
95708	EEG W/O VID BY TECH EA INCR 12-26HR UNMONITORED	No pre-authorization is required for all providers.	N/A
95709	EEG W/O VID BY TECH EA INCR 12-26 HR INTMT MNTR	No pre-authorization is required for all providers.	N/A
95710	EEG W/O VID TECH EA INCR 12-26 HR CONT R-T MNTR	No pre-authorization is required for all providers.	N/A
95711	VEEG BY TECH 2-12 HOURS UNMONITORED	No pre-authorization is required for all providers.	N/A
95712	VEEG BY TECH 2-12 HR INTERMITTENT MONITORING	No pre-authorization is required for all providers.	N/A
95713	VEEG BY TECH 2-12 HR CONTINUOUS R-T MONITORING	No pre-authorization is required for all providers.	N/A
95714	VEEG BY TECH EA INCR 12-26 HR UNMONITORED	No pre-authorization is required for all providers.	N/A
95715	VEEG BY TECH EA INCR 12-26 HR INTERMITTENT MNTR	No pre-authorization is required for all providers.	N/A
95716	VEEG BY TECH EA INCR 12-26 HR CONT R-T MNTR	No pre-authorization is required for all providers.	N/A
95717	EEG PHYS/QHP 2-12 HR WITHOUT VIDEO	No pre-authorization is required for all providers.	N/A
95718	EEG PHYS/QHP 2-12 HR WITH VEEG	No pre-authorization is required for all providers.	N/A
95719	EEG PHYS/QHP EA INCR>12HR<26HR AFTER 24HR WO VID	No pre-authorization is required for all providers.	N/A
95720	EEG PHYS/QHP EA INCR>12HR<26HR AFTER 24HR W/VEEG	No pre-authorization is required for all providers.	N/A
95721	EEG COMPLETE STD PHYS/QHP>36 HR<60 HR W/O VIDEO	No pre-authorization is required for all providers.	N/A
95722	EEG COMPLETE STD PHYS/QHP>36 HR<60 HR W/VEEG	No pre-authorization is required for all providers.	N/A
95723	EEG COMPLETE STD PHYS/QHP>60 HR<84 HR W/O VIDEO	No pre-authorization is required for all providers.	N/A
95724	EEG COMPLETE STD PHYS/QHP>60 HR<84 HR W/VEEG	No pre-authorization is required for all providers.	N/A
95725	EEG COMPLETE STD PHYS/QHP>84 HR W/O VID	No pre-authorization is required for all providers.	N/A
95726	EEG COMPLETE STD PHYS/QHP>84 HR W/VEEG	No pre-authorization is required for all providers.	N/A
95782	POLYSOM <6 YRS 4/> PARAMTRS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
95783	POLYSOM <6 YRS CPAP/BILVL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
95800	SLP STDY UNATTENDED	This service is not covered by Superior HealthPlan.	N/A
95801	SLP STDY UNATND W/ANAL	This service is not covered by Superior HealthPlan.	N/A
95803	ACTIGRAPHY TESTING	No pre-authorization is required for all providers.	N/A
95805	MX SLEEP LATENCY TEST-MX TRIALS-ASSESS SLEEPINES	Pre-authorization is required for all providers. If billed with a professional services modifier (26), no pre-authorization is required.	Prior to 09/01/2019
95806	SLEEP STDY VENT-RESP-ECG-02 SAT UNATTEND BY TECH	This service is not covered by Superior HealthPlan.	N/A
95807	SLEEP STDY VENT-RESP-ECG-02 SAT-ATTENDED TECH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
95808	POLYSOM ANY AGE 1-3> PARAM	Pre-authorization is required for all providers. If billed with a professional services modifier (26), no pre-authorization is required.	Prior to 09/01/2019
95810	POLYSOM 6/> YRS 4/> PARAM	Pre-authorization is required for all providers. If billed with a professional services modifier (26), no pre-authorization is required.	Prior to 09/01/2019
95811	POLYSOM 6/>YRS CPAP 4/> PARM	Pre-authorization is required for all providers. If billed with a professional services modifier (26), no pre-authorization is required.	Prior to 09/01/2019
95812	EEG EXT MONITORING; 41-60 MIN	No pre-authorization is required for all providers.	N/A
95813	EEG EXTENDED MONITORING 61-119 MINUTES	No pre-authorization is required for all providers.	N/A
95816	EEG; INCL RECORDING AWAKE&DROWSY	No pre-authorization is required for all providers.	N/A
95819	EEG; INCL RECORDING AWAKE&ASLEEP	No pre-authorization is required for all providers.	N/A
95822	EEG; RECORDING COMA/SLEEP ONLY	No pre-authorization is required for all providers.	N/A
95824	EEG; CEREBRAL DEATH EVAL ONLY	No pre-authorization is required for all providers.	N/A
95827	EEG; ALL NIGHT RECORDING	No pre-authorization is required for all providers.	N/A
95829	ELECTROCORTICOGRAM AT SURG (SEPART PROC)	No pre-authorization is required for all providers.	N/A
95830	INSERT ELECTRODES FOR EEG	No pre-authorization is required for all providers.	N/A
95831	MUSCL TEST MANUAL (SEPART PROC); EXTREM/TRUNK	No pre-authorization is required for all providers.	N/A
95832	MUSCL TEST MANUAL (SEPART PROC); HAND	No pre-authorization is required for all providers.	N/A
95833	MUSCL TEST MANUAL (SEP PRO); TOT BODY-EXCL HANDS	No pre-authorization is required for all providers.	N/A
95834	MUSCL TEST MANUAL (SEP PRO); TOT BODY-INCL HANDS	No pre-authorization is required for all providers.	N/A
95836	ECOG IMPLANTED BRAIN NPGT W/REC I AND R <30 DAYS	No pre-authorization is required for all providers.	N/A
95851	ROM MEAS-REPORT (SEP PRO); EA EXTREM/TRUNK SECT	No pre-authorization is required for all providers.	N/A
95852	ROM MEAS-REPORT (SEP PRO); HAND W/WO COMPAR	No pre-authorization is required for all providers.	N/A
95857	CHOLINESTERASE CHALLENGE	No pre-authorization is required for all providers.	N/A
95860	NDLE EMG;1 EXT W/WO REL PARASP AREA	No pre-authorization is required for all providers.	N/A
95861	NDLE EMG;2 EXT W/WO REL PARASP AREA	No pre-authorization is required for all providers.	N/A
95863	NDLE EMG;3 EXT W/WO REL PARASP AREA	No pre-authorization is required for all providers.	N/A
95864	NDLE EMG;4 EXT W/WO REL PARASP AREA	No pre-authorization is required for all providers.	N/A
95865	NDL EMG LARX	No pre-authorization is required for all providers.	N/A
95866	NDL EMG HEMIDPHRM	No pre-authorization is required for all providers.	N/A
95867	NDLE EMG; CRANIL NRV SPL MUSC UNI	No pre-authorization is required for all providers.	N/A
95868	NDLE EMG; CRANIL NRV SPL MUSC BIL	No pre-authorization is required for all providers.	N/A
95869	NDLE EMG; THORACIC PARASPINAL MUSC	No pre-authorization is required for all providers.	N/A
95870	NEEDLE EMG; OTH THAN PARASPINAL	No pre-authorization is required for all providers.	N/A
95872	NEEDLE EMG W/QUAN MEAS-ANY/ALL SITES EA MUS STDY	No pre-authorization is required for all providers.	N/A
95873	ESTIM GDN CONJUNCT CHEMODNRVTJ	No pre-authorization is required for all providers.	N/A
95874	NDL EMG GDN CONJUNCT CHEMODNRVTJ	No pre-authorization is required for all providers.	N/A
95875	ISCHEMIC LIMB EXER TST ACQN MUSC	No pre-authorization is required for all providers.	N/A
95885	MUSC TST DONE W/NERV TST LIM	No pre-authorization is required for all providers.	N/A
95886	MUSC TEST DONE W/N TEST COMP	No pre-authorization is required for all providers.	N/A
95887	MUSC TST DONE W/N TST NONEXT	No pre-authorization is required for all providers.	N/A
95905	MOTOR/SENS NRVE CONDUCT TEST	No pre-authorization is required for all providers.	N/A
95907	NVR CNDJ TST 1-2 STUDIES	No pre-authorization is required for all providers.	N/A
95908	NRV CNDJ TST 3-4 STUDIES	No pre-authorization is required for all providers.	N/A
95909	NRV CNDJ TST 5-6 STUDIES	No pre-authorization is required for all providers.	N/A
95910	NRV CNDJ TEST 7-8 STUDIES	No pre-authorization is required for all providers.	N/A
95911	NRV CNDJ TEST 9-10 STUDIES	No pre-authorization is required for all providers.	N/A
95912	NRV CNDJ TEST 11-12 STUDIES	No pre-authorization is required for all providers.	N/A
95913	NRV CNDJ TEST 13/> STUDIES	No pre-authorization is required for all providers.	N/A
95921	AUTONOM NERV SYST FUNCT TEST; CARDIOVAGAL INNERV	No pre-authorization is required for all providers.	N/A

95922	AUTONOM NERV SYST FUNCT TEST; VASOMOTOR INNERVAT	No pre-authorization is required for all providers.	N/A
95923	AUTONOM NERV SYST FUNCT TEST; SUDOMOTOR	No pre-authorization is required for all providers.	N/A
95924	ANS PARASYMP & SYMP W/TILT	No pre-authorization is required for all providers.	N/A
95925	SOMATOSENSORY TESTING 1/MORE NERV; UPPER LIMBS	No pre-authorization is required for all providers.	N/A
95926	SOMATOSENSORY TESTING 1/MORE NERV; LOWER LIMBS	No pre-authorization is required for all providers.	N/A
95927	SOMATOSENSORY TESTING 1/MORE NERV; TRUNK/HEAD	No pre-authorization is required for all providers.	N/A
95928	CENTRAL MOTOR EVOKED POTENTIAL STUDY; UPR LIMBS	No pre-authorization is required for all providers.	N/A
95929	CENTRAL MOTOR EVOKED POTENTIAL STUDY; LWER LIMBS	No pre-authorization is required for all providers.	N/A
95930	VISUAL EP TEST CNS W/I&R	No pre-authorization is required for all providers.	N/A
95933	ORBICULARIS OCULI REFLEX BY ELEC-DX TESTING	No pre-authorization is required for all providers.	N/A
95937	NEUROMUSCULAR JUNCTION TEST EA NERV ANY 1 METHD	No pre-authorization is required for all providers.	N/A
95938	SOMATOSENSORY TESTING	No pre-authorization is required for all providers.	N/A
95939	C MOTOR EVOKED UPR&LWR LIMBS	No pre-authorization is required for all providers.	N/A
95940	IONM IN OPERATNG ROOM 15 MIN	No pre-authorization is required for all providers.	N/A
95941	IONM REMOTE/>1 PT OR PER HR	No pre-authorization is required for all providers.	N/A
95943	PARASYMP&SYMP HRT RATE TEST	No pre-authorization is required for all providers.	N/A
95950	MONITOR-ID/LATERALIZA-CEREBRAL SEIZ-EEG EA 24 HR	No pre-authorization is required for all providers.	N/A
95951	MONITOR CEREBRAL SEIZ-CABLE/RADIO-EEG-EA 24 HR	No pre-authorization is required for all providers.	N/A
95953	EEG MONITORING/COMPUTER	No pre-authorization is required for all providers.	N/A
95954	EEG MONITORING/GIVING DRUGS	No pre-authorization is required for all providers.	N/A
95955	EEG DURING NONINTRACRANIAL SURG	No pre-authorization is required for all providers.	N/A
95956	EEG MONITOR TECHNOL ATTENDE	No pre-authorization is required for all providers.	N/A
95957	DIGITAL ANALY EEG	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
95958	WADA ACTIVAT TEST HEMISPHERIC FUNCT INCL EEG	No pre-authorization is required for all providers.	N/A
95961	ELECTRODE STIMULATION BRAIN	This service is not covered by Superior HealthPlan.	N/A
95962	ELECTRODE STIM BRAIN ADD-ON	This service is not covered by Superior HealthPlan.	N/A
95965	MAGNETOENCEPHALOGRAPHY	Pre-authorization is required for all providers.	Prior to 09/01/2019
95966	MAGNETOENCEPHALOGRAPHY .	Pre-authorization is required for all providers.	Prior to 09/01/2019
95967	MAGNETOENCEPHALOGRAPHY	Pre-authorization is required for all providers.	Prior to 09/01/2019
95970	ELEC ALYS IMPLT NPGT PHYS/QHP W/O PROGRAMMING	No pre-authorization is required for all providers.	N/A
95971	ELEC ALYS IMPLT NPGT SMPL SP/PN NPGT PRGRMG	No pre-authorization is required for all providers.	N/A
95972	ELEC ALYS IMPLT NPGT CPLX SP/PN PRGRMG	No pre-authorization is required for all providers.	N/A
95973	ANALYZE NEUROSTIM COMPLEX	This is no longer a valid code.	N/A
95974	CRANIAL NEUROSTIM COMPLEX	This is no longer a valid code.	N/A
95975	CRANIAL NEUROSTIM COMPLEX	This is no longer a valid code.	N/A
95976	ELEC ALYS IMPLT SMPL CN NPGT PRGRMG	No pre-authorization is required for all providers.	N/A
95977	ELEC ALYS IMPLT CPLX CN NPGT PRGRMG	No pre-authorization is required for all providers.	N/A
95978	ELEC ANALY NEUROSTIM CMLX BRAIN W/PROG; 1 HR	This is no longer a valid code.	N/A
95979	ELEC ANALY NEUROSTIM CMLX BRAIN;EA ADD 30 MIN	This is no longer a valid code.	N/A
95980	IO ANAL GAST N-STIM INIT	Pre-authorization is required for all providers.	Prior to 09/01/2019
95981	IO ANAL GAST N-STIM SUBSQ	Pre-authorization is required for all providers.	Prior to 09/01/2019
95982	IO GA N-STIM SUBSQ W/REPROG	Pre-authorization is required for all providers.	Prior to 09/01/2019
95983	ELEC ALYS IMPLT BRN NPGT PRGRMG 1ST 15 MIN	No pre-authorization is required for all providers.	N/A
95984	ELEC ALYS IMPLT BRN NPGT PRGRMG EA ADDL 15 MIN	No pre-authorization is required for all providers.	N/A
95990	SPIN/BRAIN PUMP REFIL & MAIN	No pre-authorization is required for all providers.	N/A
95991	SPIN/BRAIN PUMP REFIL & MAIN	No pre-authorization is required for all providers.	N/A
95992	CANALITH REPOSITIONING PROC	No pre-authorization is required for all providers.	N/A
95999	UNLISTED NEUROLOGICAL/NEUROMUSCULAR DX PROC	No pre-authorization is required for all providers.	N/A
96000	MOTION ANALYSIS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
96001	MOTION ANALYSIS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
96002	MOTION ANALYSIS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
96003	MOTION ANALYSIS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
96004	PHYS REVIEW OF MOTION TESTS	This service is not covered by Superior HealthPlan.	N/A
96020	FUNCTIONAL BRAIN MAPPING	This service is not covered by Superior HealthPlan.	N/A
96040	MEDICAL GENETICS AND GENETIC COUNSELING SERVICES	No pre-authorization is required for all providers.	N/A
96100	PSYCH TESTING W/I&R PER HR	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
96101	PSYCHOLOGICAL TESTING PR HR F2F TIME W/PT	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
96102	PSYCL TSTG PR HR ADMN BY TECH PR HR	This is no longer a valid code.	N/A
96103	PSYCL TSTG PR HR ADMN BY CPTR W/PROF I&R	This is no longer a valid code.	N/A
96105	ASSESS APHASIA W/I&R PER HR	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
96110	DEVELOPMENTAL SCREEN W/SCORE	No pre-authorization is required for all providers.	Prior to 09/01/2019
96111	DEVELOPMENTAL TEST EXTEND	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
96112	DEVELOPMENTAL TST ADMIN PHYS/QHP 1ST HOUR	No pre-authorization is required for all providers.	Prior to 09/01/2019
96113	DEVELOPMENTAL TST ADMIN PHYS/QHP EA ADDL 30 MIN	No pre-authorization is required for all providers.	Prior to 09/01/2019
96115	NEUROBEHAVIORAL STATUS EXAM W/I&R PER HR	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
96116	NEUROBEHAVIORAL STATUS XM PHYS/QHP 1ST HOUR	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
96117	NEUROPSYCH TESTING BATTERY W/I&R PER HR	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
96118	NUROPSYC TESTING PR HR F2F W/PT + INTERPJ TIME	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
96119	NUROPSYC TSTG WPROF I&R ADMN BY TECH PR HR	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
96120	NUROPSYC TSTG ADMN BY CPTR W/PROF I&R	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
96121	NEUROBEHAVIORAL STATUS XM PHYS/QHP EA ADDL HOUR	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
96125	COGNITIVE TEST BY HC PRO	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
96127	BRIEF EMOTIONAL/BEHAV ASSMT	This service is not covered by Superior HealthPlan.	N/A
96130	PSYCHOLOGICAL TST EVAL SVC PHYS/QHP FIRST HOUR	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
96131	PSYCHOLOGICAL TST EVAL SVC PHYS/QHP EA ADDL HOUR	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
96132	NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP 1ST HOUR	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
96133	NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP EA ADDL HR	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
96136	PSYCL/NRPSYCL TST PHYS/QHP 2+ TST 1ST 30 MIN	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
96137	PSYCL/NRPSYCL TST PHYS/QHP 2+ TST EA ADDL 30 MIN	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
96138	PSYCL/NRPSYCL TST TECH 2+ TST 1ST 30 MIN	This service is not covered by Superior HealthPlan.	N/A
96139	PSYCL/NRPSYCL TST TECH 2+ TST EA ADDL 30 MIN	This service is not covered by Superior HealthPlan.	N/A
96146	PSYCL/NRPSYCL TST ELEC PLATFORM AUTO RESULT	This service is not covered by Superior HealthPlan.	N/A
96150	HEALTH/BEHAVIOR ASSESSMENT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
96151	HEALTH/BEHAVIOR REASSESSMENT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
96152	HEALTH/BEHAVIOR INTERVENTION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
96153	HEALTH/BEHAVIOR INTERVENTION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
96154	HEALTH/BEHAVIOR INTERVENTION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
96155	HEALTH/BEHAVIOR INTERVENTION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
96156	HEALTH BEHAVIOR ASSESSMENT/RE-ASSESSMENT	No pre-authorization is required for all providers.	N/A
96158	HEALTH BEHAVIOR IVNTJ INDIV F2F 1ST 30 MIN	No pre-authorization is required for all providers.	N/A
96159	HEALTH BEHAVIOR IVNTJ INDIV F2F EA ADDL 15 MIN	No pre-authorization is required for all providers.	N/A
96160	PT-FOCUSED HLTH RISK ASSMT SCORE DOC STND INSTRM	No pre-authorization is required for all providers.	N/A
96161	CAREGIVER HLTH RISK ASSMT SCORE DOC STND INSTRM	No pre-authorization is required for all providers.	N/A
96164	HEALTH BEHAVIOR IVNTJ GROUP F2F 1ST 30 MIN	No pre-authorization is required for all providers.	N/A
96165	HEALTH BEHAVIOR IVNTJ GROUP F2F EA ADDL 15 MIN	No pre-authorization is required for all providers.	N/A
96167	HEALTH BEHAVIOR IVNTJ FAM W/PT F2F 1ST 30 MIN	No pre-authorization is required for all providers.	N/A
96168	HEALTH BEHAVIOR IVNTJ FAM W/PT F2F EA ADD 15 MIN	No pre-authorization is required for all providers.	N/A
96170	HEALTH BEHAVIOR IVNTJ FAM W/O PT F2F 1ST 30 MIN	No pre-authorization is required for all providers.	N/A
96171	HEALTH BEHAVIOR IVNTJ FAM W/O PT F2F EA ADDL 15	Pre-authorization required for all providers.	Prior to 09/01/2019

96360	HYDRATION IV INFUSION INIT	No pre-authorization is required for all providers.	N/A
96361	HYDRATE IV INFUSION ADD-ON	No pre-authorization is required for all providers.	N/A
96365	THER/PROPH/DIAG IV INF INIT	No pre-authorization is required for all providers.	N/A
96366	THER/PROPH/DIAG IV INF ADDON	No pre-authorization is required for all providers.	N/A
96367	TX/PROPH/DG ADDL SEQ IV INF	No pre-authorization is required for all providers.	N/A
96368	THER/DIAG CONCURRENT INF	No pre-authorization is required for all providers.	N/A
96369	SC THER INFUSION UP TO 1 HR	No pre-authorization is required for all providers.	N/A
96370	SC THER INFUSION ADDL HR	No pre-authorization is required for all providers.	N/A
96371	SC THER INFUSION RESET PUMP	No pre-authorization is required for all providers.	N/A
96372	THER/PROPH/DIAG INJ SC/IM	No pre-authorization is required for all providers.	N/A
96373	THER/PROPH/DIAG INJ IA	No pre-authorization is required for all providers.	N/A
96374	THER/PROPH/DIAG INJ IV PUSH	No pre-authorization is required for all providers.	N/A
96375	TX/PRO/DX INJ NEW DRUG ADDON	No pre-authorization is required for all providers.	N/A
96376	TX/PRO/DX INJ NEW DRUG ADON	No pre-authorization is required for all providers.	N/A
96377	APPL ON-BODY INJECTOR FOR TIMED SUBQ INJECTION	No pre-authorization is required for all providers.	N/A
96379	THER/PROPH/DIAG INJ/INF PROC	No pre-authorization is required for all providers.	N/A
96401	CHEMOTX ADMN SUBQ/IM NON-HORMONAL ANTI-NEO	No pre-authorization is required for all providers.	N/A
96402	CHEMOTX ADMN SUBQ/IM HORMONAL ANTI-NEO	No pre-authorization is required for all providers.	N/A
96405	CHEMOTX ADMIN INTRALES; TO & INCL 7 LES	No pre-authorization is required for all providers.	N/A
96406	CHEMOTX ADMIN INTRALES; > 7 LES	No pre-authorization is required for all providers.	N/A
96409	CHEMOTX ADMN IV PUSH TQ 1/1ST SBST/DRUG	No pre-authorization is required for all providers.	N/A
96411	CHEMOTX ADMN IV PUSH TQ EA SBST/DRUG	No pre-authorization is required for all providers.	N/A
96413	CHEMOTX ADMN IV NFS TQ UP 1 HR 1/1ST SBST/DRUG	No pre-authorization is required for all providers.	N/A
96415	CHEMO ADMIN, IV INFUSION, UP TO 1 HR, SINGLE OR INITIAL SUBSTANCE/DRUG	No pre-authorization is required for all providers.	N/A
96416	CHEMOTX ADMN TQ INIT PROLNG CHEMOTX NFUS PMP	No pre-authorization is required for all providers.	N/A
96417	CHEMOTX ADMN IV NFS TQ EA SEQL NFS TO 1 HR	No pre-authorization is required for all providers.	N/A
96420	CHEMOTX ADMIN INTRA-ART; PUSH TECH	No pre-authorization is required for all providers.	N/A
96422	CHEMOTX ADMIN INTRA-ART; INFUSION TECH TO 1 HR	No pre-authorization is required for all providers.	N/A
96423	CHEMO ADMIN, INFUSION TECHNIQUE, EACH ADDITIONAL HOUR	No pre-authorization is required for all providers.	N/A
96425	CHEMOTX INTRA-ART; INFUSION-INIT PROLONG W/PUMP	No pre-authorization is required for all providers.	N/A
96440	CHEMOTX-PLEURAL CAVITY-REQ & INCL THORACENTESIS	No pre-authorization is required for all providers.	N/A
96446	CHEMOTX ADMN PRTL CAVITY	No pre-authorization is required for all providers.	N/A
96450	CHEMOTX-CNS-REQ & INCL LUMBAR PUNCT	No pre-authorization is required for all providers.	N/A
96521	RFL/MAIN PORTABLE PMP	No pre-authorization is required for all providers.	N/A
96522	RFL/MAIN IMPLTABLE PMP/RSVR F/DRUG DLVR SYSS	No pre-authorization is required for all providers.	N/A
96523	IRRIGATION IMPLTED VAD F/DRUG DLVR SYSS	No pre-authorization is required for all providers.	N/A
96542	CHEMOTX INJ SUBARACH/INTRAVENTRIC-1/MX AGENTS	No pre-authorization is required for all providers.	N/A
96549	UNLISTED CHEMOTX PROC	No pre-authorization is required for all providers.	N/A
96567	PDT DSTR PRMLG LES SKN	No pre-authorization is required for all providers.	N/A
96570	PHOTODYNAMIC TX 30 MIN	No pre-authorization is required for all providers.	N/A
96571	PHOTODYNAMIC TX, ADDL 15 MIN	No pre-authorization is required for all providers.	N/A
96573	PDT DSTR PRMLG LES PHYS/QHP	No pre-authorization is required for all providers.	N/A
96574	DBRDMT PRMLG LES W/PDT	No pre-authorization is required for all providers.	N/A
96900	ACTINOTHERAPY	No pre-authorization is required for all providers.	N/A
96902	MICRO EXAM HAIRS-DETER TELOGEN & ANAGEN COUNTS	This service is not covered by Superior HealthPlan.	N/A
96904	WHOLE BODY INTEGUMENTARY PHOTOGRAPHY	This service is not covered by Superior HealthPlan.	N/A
96910	PHOTOCHEMOTX; TAR & UV B/PETROLATUM & UV B	No pre-authorization is required for all providers.	N/A
96912	PHOTOCHEMOTHERAPY; PSORALENS & ULTRAVIOLET A	No pre-authorization is required for all providers.	N/A
96913	PHOTOCHEMOTX REQ 4-8 HRS CARE W/SUPERV BY PHYS	No pre-authorization is required for all providers.	N/A
96920	LASR TX INFLAM SKN DZ;TOT<250 SQ CM	No pre-authorization is required for all providers.	N/A
96921	LASR TX INFLAM SKN DZ;250-500 SQ CM	No pre-authorization is required for all providers.	N/A
96922	LASR TX INFLAM SKN DZ; > 500 SQ CM	No pre-authorization is required for all providers.	N/A
96931	RCM CELULR SUBCELULR IMG SKN	This service is not covered by Superior HealthPlan.	N/A
96932	RCM CELULR SUBCELULR IMG SKN	This service is not covered by Superior HealthPlan.	N/A
96933	RCM CELULR SUBCELULR IMG SKN	This service is not covered by Superior HealthPlan.	N/A
96934	RCM CELULR SUBCELULR IMG SKN	This service is not covered by Superior HealthPlan.	N/A
96935	RCM CELULR SUBCELULR IMG SKN	This service is not covered by Superior HealthPlan.	N/A
96936	RCM CELULR SUBCELULR IMG SKN	This service is not covered by Superior HealthPlan.	N/A
96999	UNLISTED SPECIAL DERM SERV/PROC	No pre-authorization is required for all providers.	N/A
97000	PHYSICAL THERAPY	No pre-authorization is required for all providers.	N/A
97001	PHYS THERAP EVAL	This is no longer a valid code.	N/A
97002	PHYS THERAP RE-EVAL	This is no longer a valid code.	N/A
97003	OCCUPATIONAL THERAP EVAL	This is no longer a valid code.	N/A
97004	OCCUPATIONAL THERAP RE-EVAL	This is no longer a valid code.	N/A
97005	ATHLETIC TRAINING EVALUATION	This is no longer a valid code.	N/A
97006	ATHLETIC TRAINING RE-EVALUATION	This is no longer a valid code.	N/A
97010	APPLIC MODAL 1/> AREAS; HOT/COLD PACKS	This service is not covered by Superior HealthPlan.	N/A
97012	APPLIC MODAL 1/> AREAS; TRACTION-MECH	No pre-authorization is required for all providers.	N/A
97014	APPLIC MODAL 1/> AREAS; ELEC STIM	No pre-authorization is required for all providers.	N/A
97016	APPLIC MODAL 1/> AREAS; VASOPNEUMATIC DEVICES	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97018	APPLIC MODAL 1/> AREAS; PARAFFIN BATH	No pre-authorization is required for all providers.	N/A
97022	APPLIC MODAL 1/> AREAS; WHIRLPOOL	No pre-authorization is required for all providers.	N/A
97024	APPLIC MODAL 1/> AREAS; DIATHERMY	No pre-authorization is required for all providers.	N/A
97026	APPLIC MODAL 1/> AREAS; INFRARED	No pre-authorization is required for all providers.	N/A
97028	APPLIC MODAL 1/> AREAS; ULTRAVIOLET	No pre-authorization is required for all providers.	N/A
97032	APPLIC MODAL 1/> AREAS; ELEC STIM EA 15 MIN	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97033	APPLIC MODAL 1/> AREAS; IONTOPHORESIS EA 15 MIN	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97034	APPLIC MODAL 1/> AREAS; CONTRAST BATHS EA 15 MIN	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97035	APPLIC MODAL 1/> AREAS; ULTRASOUND EA 15 MIN	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97036	APPLIC MODAL 1/> AREAS; HUBBARD TANK EA 15 MIN	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97039	UNLIST MODAL (SPECIFY TYPE/TIME-CONSTANT ATTEND)	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97100	PHYSICAL THERAPY	No pre-authorization is required for all providers.	N/A
97110	THERAP PROC 1/> AREAS EA 15 MIN; EXERCISES	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97112	THERAP PROC 1/> AREAS EA 15 MIN; BALANCE/COORDIN	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97113	THERAP PROC 1/> AREAS EA 15 MIN; AQUATIC THERAP	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97116	THERAP PROC 1/> AREAS EA 15 MIN; GAIT TRAINING	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97124	THERAP PROC 1/> AREAS EA 15 MIN; MASSAGE	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97127	THER IVNTJ W/FOCUS COG FUNCJ	No pre-authorization is required for all providers.	N/A
97129	THER IVNTJ COG FUNCJ CNTCT 1ST 15 MINUTES	This service is not covered by Superior HealthPlan.	N/A
97130	THER IVNTJ COG FUNCJ CNTCT EA ADDL 15 MINUTES	This service is not covered by Superior HealthPlan.	N/A
97139	THERAP PROC 1/> AREAS EA 15 MIN; UNLISTED	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97140	MANUAL THERAP TECH-1/> REGIONS-EA 15 MIN	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97150	THERAP PROC(S)-GROUP	No pre-authorization is required for all providers.	N/A
97151	BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
97152	BEHAVIOR ID SUPPORT ASSMT BY 1 TECH EA 15 MIN	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
97153	ADAPTIVE BEHAVIOR TX BY PROTOCOL TECH EA 15 MIN	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
97154	GROUP ADAPTIVE BHV TX BY PROTOCOL TECH EA 15 MIN	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
97155	ADAPT BHV TX PRTCL MODIFICAJ PHYS/QHP EA 15 MIN	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
97156	FAMILY ADAPT BHV TX GDN PHYS/QHP EA 15 MIN	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
97157	MULTIPLE FAM GROUP BHV TX GDN PHYS/QHP EA 15 MIN	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
97158	GRP ADAPT BHV PRTCL MODIFICAJ PHYS/QHP EA 15 MIN	No pre-authorization is required for all providers if billed with behavioral diagnoses. For all other diagnoses, pre-authorization is required for all providers.	Prior to 09/01/2019
97161	PHYSICAL THERAPY EVALUATION LOW COMPLEX 20 MINS	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97162	PHYSICAL THERAPY EVALUATION MOD COMPLEX 30 MINS	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97163	PHYSICAL THERAPY EVALUATION HIGH COMPLEX 45 MINS	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97164	PHYSICAL THERAPY RE-EVAL EST PLAN CARE 20 MINS	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97165	OCCUPATIONAL THERAPY EVAL LOW COMPLEX 30 MINS	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019

97166	OCCUPATIONAL THERAPY EVAL MOD COMPLEX 45 MINS	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97167	OCCUPATIONAL THERAPY EVAL HIGH COMPLEX 60 MINS	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97168	OCCUPATIONAL THER RE-EVAL EST PLAN CARE 30 MINS	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97169	ATHLETIC TRAINING EVAL LOW COMPLEX 15 MINS	This service is not covered by Superior HealthPlan.	N/A
97170	ATHLETIC TRAINING EVAL MOD COMPLEX 30 MINS	This service is not covered by Superior HealthPlan.	N/A
97171	ATHLETIC TRAINING EVAL HIGH COMPLEX 45 MINS	This service is not covered by Superior HealthPlan.	N/A
97172	ATHLETIC TRAINING RE-EVAL EST PLAN CARE 20 MINS	This service is not covered by Superior HealthPlan.	N/A
97200	PHYSICAL THERAPY	No pre-authorization is required for all providers.	N/A
97530	THERAPEUTIC ACTIVITIES	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97532	COGNITIVE SKILLS DEVELOPMENT	This is no longer a valid code.	N/A
97533	SENSORY INTEGRATION	This service is not covered by Superior HealthPlan.	N/A
97535	SELF CARE MNGMENT TRAINING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
97537	COMMUNITY/WORK REINTEGRATION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
97542	WHEELCHAIR MGMT/PROPULSION TRAIN-EA 15 MIN	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97545	WORK HARDENING/CONDITIONING; INIT 2 HR	This service is not covered by Superior HealthPlan.	N/A
97546	WORK HARDENING/CONDITIONING; EA ADD HR	This service is not covered by Superior HealthPlan.	N/A
97597	RMVL DEVITAL TIS 20 CM/<	No pre-authorization is required for all providers.	N/A
97598	RMVL DEVITAL TIS ADDL 20 CM	No pre-authorization is required for all providers.	N/A
97602	WOUND(S) CARE NON-SELECTIVE	This service is not covered by Superior HealthPlan.	N/A
97605	NEG PRESS WOUND TX </=50 CM	This service is not covered by Superior HealthPlan.	N/A
97606	NEG PRESS WOUND TX >50 CM	This service is not covered by Superior HealthPlan.	N/A
97607	NEG PRESS WND TX </=50 SQ CM	This service is not covered by Superior HealthPlan.	N/A
97608	NEG PRESS WOUND TX >50 CM	This service is not covered by Superior HealthPlan.	N/A
97610	LOW FREQUENCY NON-THERMAL US	This service is not covered by Superior HealthPlan.	N/A
97750	PHYS PERFORMANCE TEST/MEASUR W/REPORT EA 15 MIN	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
97755	ASSISTIVE TECHNOLOGY ASSESS	This service is not covered by Superior HealthPlan.	N/A
97760	ORTHOTIC MGMT&TRAINJ 1ST ENC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
97761	PROSTHETIC TRAINJ 1ST ENC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
97762	CHECKOUT F/ORTHOTIC/PROSTC USE EST PT EA 15 MIN	This is no longer a valid code.	N/A
97763	ORTHOTIC/PROSTC MGMT SBSQ ENC	No pre-authorization is required for all providers.	N/A
97799	UNLISTED PHYS MEDS/REHAB SERV/PROC	No pre-authorization is required for all providers.	N/A
97802	NUTR THER; INIT 1:1 W/PT-EA 15 MIN 0	Pre-authorization is required except for ECI Providers treating members 0-20 years of age. All other ages will require pre-authorization.	Prior to 09/01/2019
97803	NUTR THER; F/U 1:1 W/PT-EA 15 MIN 0	Pre-authorization is required except for ECI Providers treating members 0-20 years of age. All other ages will require pre-authorization.	Prior to 09/01/2019
97804	MED NUTR THER; GRP EA 30 MIN 0	Pre-authorization is required except for ECI Providers treating members 0-20 years of age. All other ages will require pre-authorization.	Prior to 09/01/2019
97810	ACUPUNCT 1/> NDLES W/O E-STIM; INIT 15 MIN 1-1	This service is not covered by Superior HealthPlan.	N/A
97811	ACUPUNCT 1/> NDLES W/O E-STIM; EA ADD 15 MIN 1-1	This service is not covered by Superior HealthPlan.	N/A
97813	ACUPUNCT 1/> NDLES WITH E-STIM; INIT 15 MIN 1-1	This service is not covered by Superior HealthPlan.	N/A
97814	ACUPUNCT 1/> NDLES WITH E-STIM;EA ADD 15 MIN 1-1	This service is not covered by Superior HealthPlan.	N/A
98925	OSTEOPATHIC MANIP TX; 1-2 BODY REGIONS INVOLVED	Pre-authorization is required for all providers.	Prior to 09/01/2019
98926	OSTEOPATHIC MANIP TX; 3-4 BODY REGIONS INVOLVED	No pre-authorization is required for all providers.	N/A
98927	OSTEOPATHIC MANIP TX; 5-6 BODY REGIONS INVOLVED	Pre-authorization is required for all providers.	Prior to 09/01/2019
98928	OSTEOPATHIC MANIP TX; 7-8 BODY REGIONS INVOLVED	Pre-authorization is required for all providers.	Prior to 09/01/2019
98929	OSTEOPATHIC MANIP TX; 9-10 BODY REGIONS INVOLVED	Pre-authorization is required for all providers.	Prior to 09/01/2019
98940	CHIROPRACTIC MANIP TX; SPINAL 1-2 REGIONS	No authorization required for participating providers if billed with valid diagnosis. Over the benefit limitation and non-participating providers will require authorization.	Prior to 09/01/2019
98941	CHIROPRACTIC MANIP TX; SPINAL 3-4 REGIONS	No authorization required for participating providers if billed with valid diagnosis. Over the benefit limitation and non-participating providers will require authorization.	Prior to 09/01/2019
98942	CHIROPRACTIC MANIP TX; SPINAL 5 REGIONS	No authorization required for participating providers if billed with valid diagnosis. Over the benefit limitation and non-participating providers will require authorization.	Prior to 09/01/2019
98943	CHIROPRACTIC MANIP TX; EXTRASPINAL 1/> REGIONS	This service is not covered by Superior HealthPlan.	N/A
98960	EDUCAJ&TRAINJ F/PT SELF-MGMT BY NONPHYS 1 PT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
98961	EDUCAJ&TRAINJ F/PT SELF-MGMT BY NONPHYS 2-4 PT	This service is not covered by Superior HealthPlan.	N/A
98962	EDUCAJ&TRAINJ F/PT SELF-MGMT BY NONPHYS 5-8 PTS	This service is not covered by Superior HealthPlan.	N/A
98966	HC PRO PHONE CALL 5-10 MIN	This service is not covered by Superior HealthPlan.	N/A
98967	HC PRO PHONE CALL 11-20 MIN	This service is not covered by Superior HealthPlan.	N/A
98968	HC PRO PHONE CALL 21-30 MIN	This service is not covered by Superior HealthPlan.	N/A
98969	ONLINE SERVICE BY HC PRO	This service is not covered by Superior HealthPlan.	N/A
98970	QNHP ONLINE DIGITAL E/M SVC EST PT <7 D 5-10 MIN	This service is not covered by Superior HealthPlan.	N/A
98971	QNHP ONLINE DIGITAL E/M SVC EST PT <7 D 11-20MIN	This service is not covered by Superior HealthPlan.	N/A
98972	QNHP ONLINE DIGITAL E/M SVC EST PT <7 D 21+ MIN	This service is not covered by Superior HealthPlan.	N/A
99000	SPECIMEN HANDLING OFFICE-LAB	No pre-authorization is required for all providers.	N/A
99001	SPECIMEN HANDLING PT-LAB	No pre-authorization is required for all providers.	N/A
99002	DEVICE HANDLING PHYS/QHP	This service is not covered by Superior HealthPlan.	N/A
99024	POSTOP F/U VISIT E&M REL ORIG PROC	This service is not covered by Superior HealthPlan.	N/A
99026	HOS MANDATED CALL SRVC; IN-HOS HR	This service is not covered by Superior HealthPlan.	N/A
99027	HOS MANDAT CALL SRVC; OUT-OF-HOS HR	This service is not covered by Superior HealthPlan.	N/A
99050	SRVC REQUEST AFTR HRS ADD TO BASIC	No pre-authorization is required for all providers.	N/A
99051	SVC PRV OFFICE REG SCHEDD EVN WKEND/HOLIDAY HRS	This service is not covered by Superior HealthPlan.	N/A
99053	SVC PRV BTW 10 PM&8 AM AT 24-HR FAC	This service is not covered by Superior HealthPlan.	N/A
99056	SERV PROVID @ REQ OF PT @ LOCATION NOT IN OFFIC	No pre-authorization is required for all providers.	N/A
99058	OFFIC SERV PROVID-EMER BASIS	This service is not covered by Superior HealthPlan.	N/A
99060	SVC PRV EMER OUT OFFICE DISRUPTS OFFICE SVC	No pre-authorization is required for all providers.	N/A
99070	SPECIAL SUPPLIES PHYS/QHP	This service is not covered by Superior HealthPlan.	N/A
99071	PATIENT EDUCATION MATERIALS	This service is not covered by Superior HealthPlan.	N/A
99075	MED TESTIMONY	This service is not covered by Superior HealthPlan.	N/A
99078	GROUP HEALTH EDUCATION	No pre-authorization is required for all providers.	N/A
99080	SPEC REPORTS > INFO IN USUAL MED COMMUNICAT/FORM	This service is not covered by Superior HealthPlan.	N/A
99082	UNUSUAL TRAVEL	This service is not covered by Superior HealthPlan.	N/A
99090	ANALYS INFORM DATA STORED-COMPUTERS	This is no longer a valid code.	N/A
99091	COLLJ AND INTERPJ PHYSIOL DATA MIN 30 MIN EA 30 D	This service is not covered by Superior HealthPlan.	N/A
99100	ANES-PT EXT AGE UND 1 YR&OVR 70	No pre-authorization is required for all providers.	N/A
99105	STATUS 3 FOR ANESTHESIOLOGISTS	No pre-authorization is required for all providers.	N/A
99116	ANES COMPLIC BY UTILIZ TOT BODY HYPOTHERMIA	No pre-authorization is required for all providers.	N/A
99125	#N/A	No pre-authorization is required for all providers.	N/A
99135	ANES COMPLIC BY UTILIZ CONTRL HYPOTENSION	No pre-authorization is required for all providers.	N/A
99140	ANES COMPLIC BY EMER CONDITIONS	No pre-authorization is required for all providers.	N/A
99141	SEDATION W/WO ANALGESIA; IV/IM/INHALATION	No pre-authorization is required for all providers.	N/A
99142	SEDATION W/WO ANALGESIA; ORAL/RECTAL/INTRANASAL	No pre-authorization is required for all providers.	N/A
99143	MOD SEDAT PHYS/QHP <5 YRS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
99144	MOD SEDAT PHYS/QHP 5YRS/>	This is no longer a valid code.	N/A
99145	MOD SEDAT PHYS/QHP EA 15 MIN	This is no longer a valid code.	N/A
99148	MOD SED DIFF PHYS/QHP<5 YRS	This is no longer a valid code.	N/A
99149	MOD SED DIFF PHYS/QHP 5/>YRS	This is no longer a valid code.	N/A
99150	MOD SED DIFF PHYS/QHP ADD ON	This is no longer a valid code.	N/A
99151	MOD SED SAME PHYS/QHP INITIAL 15 MINS <5 YRS	No pre-authorization is required for all providers.	N/A
99152	MOD SED SAME PHYS/QHP INITIAL 15 MINS 5/> YRS	No pre-authorization is required for all providers.	N/A
99153	MOD SED SAME PHYS/QHP EACH ADDL 15 MINS	No pre-authorization is required for all providers.	N/A
99155	MOD SED OTHER PHYS/QHP INITIAL 15 MINS <5 YRS	No pre-authorization is required for all providers.	N/A
99156	MOD SED OTHER PHYS/QHP INITIAL 15 MINS 5/> YRS	No pre-authorization is required for all providers.	N/A
99157	MOD SED OTHER PHYS/QHP EACH ADDL 15 MINS	No pre-authorization is required for all providers.	N/A
99170	ANOGENITAL EXAM CHILD W IMAG	No pre-authorization is required for all providers.	N/A
99172	SCREEN VISUAL AUTO/SEMI BILAT QUAN 0	This service is not covered by Superior HealthPlan.	N/A
99173	VICUAL SCREENING TEST	This service is not covered by Superior HealthPlan.	N/A
99174	OCULAR INSTRUMNT SCREEN BIL	This service is not covered by Superior HealthPlan.	N/A
99175	IPECAC/SIMILR ADMIN FOR EMESIS & CONT OBSRV	This service is not covered by Superior HealthPlan.	N/A
99177	OCULAR INSTRUMNT SCREEN BIL	This service is not covered by Superior HealthPlan.	N/A
99183	HYPERBARIC OXYGEN THERAPY	No pre-authorization is required for all providers.	N/A
99184	HYPOTHERMIA ILL NEONATE	This service is not covered by Superior HealthPlan.	N/A
99188	APP TOPICAL FLUORIDE VARNISH	This service is not covered by Superior HealthPlan.	N/A
99190	ASSEMBLY & OPERAT-PUMP W/OXYGENATR/EXCHGR; EA HR	This service is not covered by Superior HealthPlan.	N/A

99191	ASSEMBLY & OPERAT-PUMP W/OXYGENATR/EXCHGR; 3/4HR	This service is not covered by Superior HealthPlan.	N/A
99192	ASSEMBLY &/OR PUMP W/OXYGENATOR/HEAT EXCHG	This service is not covered by Superior HealthPlan.	N/A
99195	PHLEBOTOMY THERAP (SEPART PROC)	No pre-authorization is required for all providers.	N/A
99199	UNLISTED SPECIAL SERV/REPORT	Pre-authorization is required Nursing Facility members.	Prior to 09/01/2019
99201	OFFICE/OUTPATIENT VISIT NEW	No pre-authorization is required for all providers.	N/A
99202	OFFICE/OUTPATIENT VISIT NEW	No pre-authorization is required for all providers.	N/A
99203	OFFICE/OUTPATIENT VISIT NEW	No pre-authorization is required for all providers.	N/A
99204	OFFICE/OUTPATIENT VISIT NEW	No pre-authorization is required for all providers.	N/A
99205	OFFICE/OUTPATIENT VISIT NEW	No pre-authorization is required for all providers.	N/A
99211	OFFICE/OUTPATIENT VISIT EST	No pre-authorization is required for all providers.	N/A
99212	OFFICE/OUTPATIENT VISIT EST	No pre-authorization is required for all providers.	N/A
99213	OFFICE/OUTPATIENT VISIT EST	No pre-authorization is required for all providers.	N/A
99214	OFFICE/OUTPATIENT VISIT EST	No pre-authorization is required for all providers.	N/A
99215	OFFICE/OUTPATIENT VISIT EST	No pre-authorization is required for all providers.	N/A
99217	OBSERVATION CARE DISCHARGE	No pre-authorization is required for all providers.	N/A
99218	INITIAL OBSERVATION CARE	No pre-authorization is required for all providers.	N/A
99219	INITIAL OBSERVATION CARE	No pre-authorization is required for all providers.	N/A
99220	INITIAL OBSERVATION CARE	No pre-authorization is required for all providers.	N/A
99221	INITIAL HOSPITAL CARE	No pre-authorization is required for all providers.	N/A
99222	INITIAL HOSPITAL CARE	No pre-authorization is required for all providers.	N/A
99223	INITIAL HOSPITAL CARE	No pre-authorization is required for all providers.	N/A
99224	SUBSEQUENT OBSERVATION CARE	No pre-authorization is required for all providers.	N/A
99225	SUBSEQUENT OBSERVATION CARE	No pre-authorization is required for all providers.	N/A
99226	SUBSEQUENT OBSERVATION CARE	No pre-authorization is required for all providers.	N/A
99231	SUBSEQUENT HOSPITAL CARE	No pre-authorization is required for all providers.	N/A
99232	SUBSEQUENT HOSPITAL CARE	No pre-authorization is required for all providers.	N/A
99233	SUBSEQUENT HOSPITAL CARE	No pre-authorization is required for all providers.	N/A
99234	OBSERV/HOSP SAME DATE	No pre-authorization is required for all providers.	N/A
99235	OBSERV/HOSP SAME DATE	No pre-authorization is required for all providers.	N/A
99236	OBSERV/HOSP SAME DATE	No pre-authorization is required for all providers.	N/A
99238	HOSP D/C DA MGMT; 30 MIN/LESS	No pre-authorization is required for all providers.	N/A
99239	HOSP D/C DA MGMT; MORE THAN 30 MIN	No pre-authorization is required for all providers.	N/A
99241	OFFICE CONSULTATION	Pre-authorization is required for OBGYN and Perinatology providers for Perinate members in an office or outpatient location.	Prior to 09/01/2019
99242	OFFICE CONSULTATION	Pre-authorization is required for OBGYN and Perinatology providers for Perinate members in an office or outpatient location.	Prior to 09/01/2019
99243	OFFICE CONSULTATION	Pre-authorization is required for OBGYN and Perinatology providers for Perinate members in an office or outpatient location.	Prior to 09/01/2019
99244	OFFICE CONSULTATION	Pre-authorization is required for OBGYN and Perinatology providers for Perinate members in an office or outpatient location.	Prior to 09/01/2019
99245	OFFICE CONSULTATION	Pre-authorization is required for OBGYN and Perinatology providers for Perinate members in an office or outpatient location.	Prior to 09/01/2019
99251	INPATIENT CONSULTATION	No pre-authorization is required for all providers.	N/A
99252	INPATIENT CONSULTATION	No pre-authorization is required for all providers.	N/A
99253	INPATIENT CONSULTATION	No pre-authorization is required for all providers.	N/A
99254	INPATIENT CONSULTATION	No pre-authorization is required for all providers.	N/A
99255	INPATIENT CONSULTATION	No pre-authorization is required for all providers.	N/A
99273	CONFIRM CONS NEW/ESTAB MODERATE SEVERITY	No pre-authorization is required for all providers.	N/A
99274	CONFIRM CONS NEW/ESTAB MED DECISION MOD COMPLX	No pre-authorization is required for all providers.	N/A
99281	EMERGENCY DEPT VISIT	No pre-authorization is required for all providers.	N/A
99282	EMERGENCY DEPT VISIT	No pre-authorization is required for all providers.	N/A
99283	EMERGENCY DEPT VISIT	No pre-authorization is required for all providers.	N/A
99284	EMERGENCY DEPT VISIT	No pre-authorization is required for all providers.	N/A
99285	EMERGENCY DEPT VISIT	No pre-authorization is required for all providers.	N/A
99288	DIRECT ADVANCED LIFE SUPPORT	No pre-authorization is required for all providers.	N/A
99291	CRITICAL CARE E&M-UNSTABLE PT-CONT ATTND; 1ST HR	No pre-authorization is required for all providers.	N/A
99292	CRITICAL CARE E&M-UNSTABLE PT; EA ADD 30 MIN	No pre-authorization is required for all providers.	N/A
99304	NURSING FACILITY CARE INIT	No pre-authorization is required for all providers.	N/A
99305	NURSING FACILITY CARE INIT	No pre-authorization is required for all providers.	N/A
99306	NURSING FACILITY CARE INIT	No pre-authorization is required for all providers.	N/A
99307	NURSING FAC CARE SUBSEQ	No pre-authorization is required for all providers.	N/A
99308	NURSING FAC CARE SUBSEQ	No pre-authorization is required for all providers.	N/A
99309	NURSING FAC CARE SUBSEQ	No pre-authorization is required for all providers.	N/A
99310	NURSING FAC CARE SUBSEQ	No pre-authorization is required for all providers.	N/A
99315	NURS FACIL D/C DA MGMT; 30 MIN/LESS	No pre-authorization is required for all providers.	N/A
99316	NURS FACIL D/C DA MGMT; MORE THAN 30 MIN	No pre-authorization is required for all providers.	N/A
99318	ANNUAL NURSING FAC ASSESSMNT	No pre-authorization is required for all providers.	N/A
99324	DOMICIL/R-HOME VISIT NEW PAT	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
99325	DOMICIL/R-HOME VISIT NEW PAT	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
99326	DOMICIL/R-HOME VISIT NEW PAT	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
99327	DOMICIL/R-HOME VISIT NEW PAT	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
99328	DOMICIL/R-HOME VISIT NEW PAT	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
99334	DOMICIL/R-HOME VISIT EST PAT	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
99335	DOMICIL/R-HOME VISIT EST PAT	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
99336	DOMICIL/R-HOME VISIT EST PAT	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
99337	DOMICIL/R-HOME VISIT EST PAT	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
99339	INDIV PHYS SUPVJ HOME/DOM/R-HOME MO 15-29 MIN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
99340	INDIV PHYS SUPVJ HOME/DOM/R-HOME MO 30 MIN/>	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
99341	HOME VISIT NEW PATIENT	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
99342	HOME VISIT NEW PATIENT	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
99343	HOME VISIT NEW PATIENT	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
99344	HOME VISIT NEW PATIENT	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
99345	HOME VISIT NEW PATIENT	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
99347	HOME VISIT EST PATIENT	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
99348	HOME VISIT EST PATIENT	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
99349	HOME VISIT EST PATIENT	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
99350	HOME VISIT EST PATIENT	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
99354	PROLONG E&M/PSYCTX SERV O/P	No pre-authorization is required for all providers.	N/A
99355	PROLONG E&M/PSYCTX SERV O/P	No pre-authorization is required for all providers.	N/A
99356	PROLONGED SERVICE INPATIENT	No pre-authorization is required for all providers.	N/A
99357	PROLONGED SERVICE INPATIENT	No pre-authorization is required for all providers.	N/A
99358	PROLONG SERVICE W/O CONTACT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
99359	PROLONG SERV W/O CONTACT ADD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
99360	PHYSICIAN STANDBY SERVICES	This service is not covered by Superior HealthPlan.	N/A
99363	ANTICOAGULANT MANAGEMENT FOR AN OUTPATIENT TAKING WARFARIN	This is no longer a valid code.	N/A
99364	EACH SUBSEQUENT 90 DAYS OF THERAPY	This is no longer a valid code.	N/A
99366	TEAM CONF W/PAT BY HC PRO	This service is not covered by Superior HealthPlan.	N/A
99367	TEAM CONF W/O PAT BY PHYS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
99368	TEAM CONF W/O PAT BY HC PRO	This service is not covered by Superior HealthPlan.	N/A
99374	HOME HEALTH CARE SUPERVISION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019

99375	HOME HEALTH CARE SUPERVISION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
99377	HOSPICE CARE SUPERVISION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
99378	HOSPICE CARE SUPERVISION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
99379	NURSING FAC CARE SUPERVISION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
99380	NURSING FAC CARE SUPERVISION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
99381	INIT PM E/M NEW PAT INF	No pre-authorization is required for all providers.	N/A
99382	INIT PM E/M NEW PAT 1-4 YRS	No pre-authorization is required for all providers.	N/A
99383	PREV VISIT NEW AGE 5-11	No pre-authorization is required for all providers.	N/A
99384	PREV VISIT NEW AGE 12-17	No pre-authorization is required for all providers.	N/A
99385	PREV VISIT NEW AGE 18-39	No pre-authorization is required for all providers.	N/A
99386	PREV VISIT NEW AGE 40-64	No pre-authorization is required for all providers.	N/A
99387	INIT PM E/M NEW PAT 65+ YRS	No pre-authorization is required for all providers.	N/A
99391	PER PM REEVAL EST PAT INF	No pre-authorization is required for all providers.	N/A
99392	PREV VISIT EST AGE 1-4	No pre-authorization is required for all providers.	N/A
99393	PREV VISIT EST AGE 5-11	No pre-authorization is required for all providers.	N/A
99394	PREV VISIT EST AGE 12-17	No pre-authorization is required for all providers.	N/A
99395	PREV VISIT EST AGE 18-39	No pre-authorization is required for all providers.	N/A
99396	PREV VISIT EST AGE 40-64	No pre-authorization is required for all providers.	N/A
99397	PER PM REEVAL EST PAT 65+ YR	No pre-authorization is required for all providers.	N/A
99401	PREVEN MEDS COUNSEL/RISK REDUC (SEP PRO); 15 MIN	This service is not covered by Superior HealthPlan.	N/A
99402	PREVEN MEDS COUNSEL/RISK REDUC (SEP PRO); 30 MIN	No pre-authorization is required for all providers.	N/A
99403	PREVEN MEDS COUNSEL/RISK REDUC (SEP PRO); 45 MIN	This service is not covered by Superior HealthPlan.	N/A
99404	PREVEN MEDS COUNSEL/RISK REDUC (SEP PRO); 60 MIN	No pre-authorization is required for all providers.	N/A
99406	BEHAV CHNG SMOKING 3-10 MIN	No pre-authorization is required for all providers.	N/A
99407	BEHAV CHNG SMOKING < 10 MIN	No pre-authorization is required for all providers.	N/A
99408	AUDIT/DAST 15-30 MIN	No pre-authorization is required for all providers.	N/A
99409	AUDIT/DAST OVER 30 MIN	This service is not covered by Superior HealthPlan.	N/A
99411	PREVEN MEDS COUNSEL GRP (SEPART PROC); 30 MIN	This service is not covered by Superior HealthPlan.	N/A
99412	PREVEN MEDS COUNSEL GRP (SEPART PROC); 45 MIN	This service is not covered by Superior HealthPlan.	N/A
99415	PROLONG CLINCL STAFF SVC	This service is not covered by Superior HealthPlan.	N/A
99416	PROLONG CLINCL STAFF SVC ADD	This service is not covered by Superior HealthPlan.	N/A
99420	ADMIN/INTERPT HEALTH RISK ASSESSMENT INSTRUM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
99421	ONLINE DIGITAL E/M SVC EST PT <7 D 5-10 MINUTES	No pre-authorization is required for all providers.	N/A
99422	ONLINE DIGITAL E/M SVC EST PT <7 D 11-20 MINUTES	No pre-authorization is required for all providers.	N/A
99423	ONLINE DIGITAL E/M SVC EST PT <7 D 21+ MINUTES	No pre-authorization is required for all providers.	N/A
99429	UNLISTED PREVEN MEDS SERV	No pre-authorization is required for all providers.	N/A
99441	PHONE E/M PHYS/QHP 5-10 MIN	This service is not covered by Superior HealthPlan.	N/A
99442	PHONE E/M PHYS/QHP 11-20 MIN	This service is not covered by Superior HealthPlan.	N/A
99443	PHONE E/M PHYS/QHP 21-30 MIN	This service is not covered by Superior HealthPlan.	N/A
99444	ONLINE E/M BY PHYS/QHP	Pre-authorization required for all providers.	Prior to 09/01/2019
99446	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 5-10 MIN	This service is not covered by Superior HealthPlan.	N/A
99447	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 11-20 MIN	This service is not covered by Superior HealthPlan.	N/A
99448	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 21-30 MIN	This service is not covered by Superior HealthPlan.	N/A
99449	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 31/> MIN	This service is not covered by Superior HealthPlan.	N/A
99450	BASIC LIFE &/OR DISABILITY EXAM	This service is not covered by Superior HealthPlan.	N/A
99451	NTRPROF PHONE/NTRNET/EHR ASSMT AND MGMT 5/> MIN	This service is not covered by Superior HealthPlan.	N/A
99452	NTRPROF PHONE/NTRNET/EHR REFERRAL SVC 30 MIN	No authorization required. Code is for informational purposes only.	N/A
99453	REM MNTR PHYSIOL PARAM 1ST SET UP PT EDUCAJ EQP	No pre-authorization is required for all providers.	N/A
99454	REM MNTR PHYSIOL PARAM 1ST DEV SUPPLY EA 30 D	No pre-authorization is required for all providers.	N/A
99455	WORK RELATED/MED DISABILITY EXAM BY TREATING MD	This service is not covered by Superior HealthPlan.	N/A
99456	WORK RELATED/MED DISABILITY EXAM NOT TREATING MD	This service is not covered by Superior HealthPlan.	N/A
99457	REMOTE PHYSIOLOGIC MONITORING 1ST 20 MIN MONTH	This service is not covered by Superior HealthPlan.	N/A
99458	REMOTE PHYSIOLOGIC MONITORING EA ADDL 20 MIN MO	This service is not covered by Superior HealthPlan.	N/A
99460	INIT NB EM PER DAY HOSP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
99461	INIT NB EM PER DAY NON-FAC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
99462	SBSQ NB EM PER DAY HOSP	No pre-authorization is required for all providers.	N/A
99463	SAME DAY NB DISCHARGE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
99464	ATTENDANCE AT DELIVERY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
99465	NB RESUSCITATION	No pre-authorization is required for all providers.	N/A
99466	PED CRIT CARE TRANSPORT	This service is not covered by Superior HealthPlan.	N/A
99467	PED CRIT CARE TRANSPORT ADDL	This service is not covered by Superior HealthPlan.	N/A
99468	NEONATE CRIT CARE INITIAL	No pre-authorization is required for all providers.	N/A
99469	NEONATE CRIT CARE SUBSQ	No pre-authorization is required for all providers.	N/A
99471	PED CRITICAL CARE INITIAL	No pre-authorization is required for all providers.	N/A
99472	PED CRITICAL CARE SUBSQ	No pre-authorization is required for all providers.	N/A
99473	SELF-MEAS BP PT EDUCAJ/TRAING AND DEV CALIBRATION	No pre-authorization is required for all providers.	N/A
99474	SELF-MEAS BP 2 READG 1 MIN APART BID 30 DAY PD	No pre-authorization is required for all providers.	N/A
99475	PED CRIT CARE AGE 2-5 INIT	No pre-authorization is required for all providers.	N/A
99476	PED CRIT CARE AGE 2-5 SUBSQ	No pre-authorization is required for all providers.	N/A
99477	INIT DAY HOSP NEONATE CARE	No pre-authorization is required for all providers.	N/A
99478	IC LBW INF < 1500 GM SUBSQ	No pre-authorization is required for all providers.	N/A
99479	IC LBW INF 1500-2500 G SUBSQ	No pre-authorization is required for all providers.	N/A
99480	IC INF PBW 2501-5000 G SUBSQ	No pre-authorization is required for all providers.	N/A
99481	TOT BODY SYST HYPOTHERMIA	This is no longer a valid code.	N/A
99482	SELECTIVE HEAD HYPOTHERMIA	This is no longer a valid code.	N/A
99483	ASSMT & CARE PLN PT COG IMP	No pre-authorization is required for all providers.	N/A
99484	CARE MGMT SVC BHVL HLTH COND	No pre-authorization is required for all providers.	N/A
99485	SUPRV INTERFACILITY TRANSPORT	This service is not covered by Superior HealthPlan.	N/A
99486	SUPRV INTERFAC TRNSPORT ADDL	This service is not covered by Superior HealthPlan.	N/A
99487	CMLX CHRON CARE W/O PT VSIT	This service is not covered by Superior HealthPlan.	N/A
99488	CMLX CHRON CARE W/ PT VSIT	This is no longer a valid code.	N/A
99489	CMLX CHRON CARE ADDL 30 MIN	This service is not covered by Superior HealthPlan.	N/A
99490	CHRON CARE MGMT SRVC 20 MIN	This service is not covered by Superior HealthPlan.	N/A
99491	CHRONIC CARE MGMT SVC AT LEAST 30 MIN PER MONTH	This service is not covered by Superior HealthPlan.	N/A
99492	1ST PSYC COLLAB CARE MGMT	No pre-authorization is required for all providers.	N/A
99493	SBSQ PSYC COLLAB CARE MGMT	No pre-authorization is required for all providers.	N/A
99494	1ST/SBSQ PSYC COLLAB CARE	No pre-authorization is required for all providers.	N/A
99495	TRANS CARE MGMT 14 DAY DISCH	This service is not covered by Superior HealthPlan.	N/A
99496	TRANS CARE MGMT 7 DAY DISCH	This service is not covered by Superior HealthPlan.	N/A
99497	ADVNCN CARE PLAN 30 MIN	This service is not covered by Superior HealthPlan.	N/A
99498	ADVNCN CARE PLAN ADDL 30 MIN	This service is not covered by Superior HealthPlan.	N/A
99499	UNLISTED EVAL & MGMT SERV	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
99500	HOME VISIT PRENATAL	This service is not covered by Superior HealthPlan.	N/A
99501	HOME VISIT FOR POSTNATAL ASSESSMENT	This service is not covered by Superior HealthPlan.	N/A
99502	HOME VISIT FOR NEWBORN CARE ASSESSMENT	This service is not covered by Superior HealthPlan.	N/A
99503	HOME VISIT FOR RESPIRATORY THERAPY CARE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
99504	HOME VISIT MECH VENTILATION CARE	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
99505	HOME VISIT FOR STOMA CARE	This service is not covered by Superior HealthPlan.	N/A
99506	HOME VISIT FOR INTRAMUSCULAR INJECTIONS	This service is not covered by Superior HealthPlan.	N/A
99507	HOME VISIT FOR CATHETER MAINTENANCE	This service is not covered by Superior HealthPlan.	N/A
99509	HOME VISIT FOR ASSISTANCE WITH ACTIVITIES OF DAILY LIVING	This service is not covered by Superior HealthPlan.	N/A
99510	HOME VISIT FOR INDIVIDUAL, FAMILY OR MARRIAGE COUNSELING	This service is not covered by Superior HealthPlan.	N/A
99511	HOME VISIT FOR FECAL IMPACTION	This service is not covered by Superior HealthPlan.	N/A
99512	HOME VISIT FOR HEMODIALYSIS	This service is not covered by Superior HealthPlan.	N/A
99600	UNLISTED HOME VISIT SERVICE/PROC	This service is not covered by Superior HealthPlan.	N/A
99601	HOME INFUS/SPCLTY DRUG ADMIN-VISIT	This service is not covered by Superior HealthPlan.	N/A
99602	HOM INFUS/RX-VISIT ADD HR	This service is not covered by Superior HealthPlan.	N/A
99605	MTMS BY PHARM NP 15 MIN	This service is not covered by Superior HealthPlan.	N/A
99606	MTMS BY PHARM EST 15 MIN	This service is not covered by Superior HealthPlan.	N/A
99607	MTMS BY PHARM ADDL 15 MIN	This service is not covered by Superior HealthPlan.	N/A
0001M	INFECT DISEASE, HCV PROG ALGOR	This is no longer a valid code.	N/A

0001U	RBC DNA HEA 35 AG 11 BLD GRP	Authorization is required for non-participating independent labs. For all other providers, no authorization is	Prior to 09/01/2019
0002U	ONC CLRCT 3 UR METAB ALG PLP	Pre-authorization is required for all providers.	Prior to 09/01/2019
0003U	ONC OVAR 5 PRTN SER ALG SCOR	Pre-authorization is required for all providers.	Prior to 09/01/2019
0004U	NFCT DS DNA 27 RESIST GENES	This is no longer a valid code.	N/A
0006M	HEPATIC ONCOLOGY, 161 GENES, TUMOR	Pre-authorization required for all providers.	Prior to 09/01/2019
0008M	ONC BREAST RISK SCORE	This is no longer a valid code.	N/A
0010M	ONC PROSTATE PROB SCORE	This is no longer a valid code.	N/A
0011M	ONC PRST8 CA MRNA 12 GEN ALG	Pre-authorization is required for all providers.	Prior to 09/01/2019
0012M	ONC MRNA 5 GEN RSK URTHL CA	Pre-authorization is required for all providers.	Prior to 09/01/2019
0013M	ONC MRNA 5 GEN RECR URTHL CA	Pre-authorization required for all providers.	Prior to 09/01/2019
0015U	RX METAB ADVRS RX RXN DNA	This is no longer a valid code.	N/A
0019T	EXTRACORPOREAL SHOCK WAVE THERAPY	This is no longer a valid code.	N/A
0020U	RX TEST PRSMV UR W/DEF CONF	This is no longer a valid code.	N/A
0023U	ONC AML DNA DETCJ/NONDETCJ	New procedure code. Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
0026U	ONC THYR DNA&MRNA 112 GENES	Pre-authorization is required for all providers.	Prior to 09/01/2019
0027U	JAK2 GENE TRGT SEQ ALYS	Pre-authorization is required for all providers.	Prior to 09/01/2019
0028U	CYP2D6 GENE CPY NMR CMN VRNT	This is no longer a valid code.	N/A
0029U	RX METAB ADVRS TRGT SEQ ALYS	Pre-authorization is required for all providers.	Prior to 09/01/2019
0030U	RX METAB WARF TRGT SEQ ALYS	Pre-authorization is required for all providers.	Prior to 09/01/2019
0031U	CYP1A2 GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
0032U	COMT GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
0033U	HTR2A HTR2C GENES	Pre-authorization is required for all providers.	Prior to 09/01/2019
0034U	TPMT NUDT15 GENES	Pre-authorization is required for all providers.	Prior to 09/01/2019
0036U	XOME TUM AND NML SPEC SEQ ALYS	Pre-authorization is required for all providers.	Prior to 09/01/2019
0037U	TRGT GEN SEQ DMA 324 GENES	Pre-authorization is required for all providers.	Prior to 09/01/2019
0040U	BCR/ABL1 GENE MAJOR BP QUAN	Pre-authorization is required for all providers.	Prior to 09/01/2019
0051T	IMPL TOT REPL HEART RECIP CARDIECT	This is no longer a valid code.	N/A
0052T	REPL/REPR THOR U TOT REPL HEART SYS	This is no longer a valid code.	N/A
0053T	REPL/REPR CMPNT REPL HEART NOT THOR	This is no longer a valid code.	N/A
0057U	ONC SLD ORG NEO MRNA 51 GENE	This is no longer a valid code.	N/A
0059T	CRYOPRESERVATION OOCYTE	This is no longer a valid code.	N/A
0062U	AI SLE IGG AND IGM ALYS 80 BMRK SRM ALG RSK SCORE	Pre-authorization required for all providers.	Prior to 09/01/2019
0063U	NEURO AUTISM 32 AMINES PLSM ALG METAB SIGNATURE	Pre-authorization required for all providers.	Prior to 09/01/2019
0067U	ONC BRST IMHCHEM PRTN XPRS PRFL 4 BMRK CA PRTN	Pre-authorization is required for all providers.	Prior to 09/01/2019
0069U	ONC CLRCT MICRORNA XPRS PRFL MIR-31-3P ALG	Pre-authorization is required for all providers.	Prior to 09/01/2019
0070U	CYP2D6 GENE ANALYSIS COMMON AND SELECT RARE VRNTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
0071U	CYP2D6 GENE ANALYSIS FULL GENE SEQUENCE	Pre-authorization is required for all providers.	Prior to 09/01/2019
0072U	CYP2D6 GENE TRGT SEQ ALYS CYP2D6-2D7 HYBRID GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
0073T	COMP-BASD BEAM MODULATD TX DEL TX 3/> FIELDS-TX	This is no longer a valid code.	N/A
0073U	CYP2D6 GENE TRGT SEQ ALYS CYP2D7-2D6 HYBRID GENE	Pre-authorization is required for all providers.	Prior to 09/01/2019
0074U	CYP2D6 TRGT SEQ ALYS NONDUP GENE DUPL/MLT TRANS	Pre-authorization is required for all providers.	Prior to 09/01/2019
0075U	CYP2D6 GENE TRGT SEQ ALYS 5' GENE DUPL/MLT	Pre-authorization is required Alere providers.	Prior to 09/01/2019
0076U	CYP2D6 GENE TRGT SEQ ALYS 3' GENE DUPL/MLT	Pre-authorization is required for all providers.	Prior to 09/01/2019
0078T	ENDOVASC REPR AAA FENESTRATED PROS 2 DOCK LIMBS	This is no longer a valid code.	N/A
0078U	PAIN MGT OPIOID USE DO GNOTYP PNL 16 CMN VRNTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
0079T	PLCMT VISCERAL EXTENSION PROSTH EA VISCERAL BR	This is no longer a valid code.	N/A
0079U	CMPTV DNA ALYS MLT SNPS UR AND BUCCAL SPEC ID VERIF	Pre-authorization is required for all providers.	Prior to 09/01/2019
0080T	ENDOVASC AORT REPR RAD S&I	This is no longer a valid code.	N/A
0081T	PLCMT VISCERAL EXT PROS EA VISCERAL BR RAD S&I	This is no longer a valid code.	N/A
0092T	ARTIFIC DISC ADDL	This is no longer a valid code.	N/A
0099T	IMPLTJ INTRASTROMAL CRNL RING SEG	This is no longer a valid code.	N/A
0103T	HOLOTRANSCOBALAMIN QUAN	This is no longer a valid code.	N/A
0123T	FSTLJ SCL GLC THRU CILIARY BDY	This is no longer a valid code.	N/A
0124T	CONJUNCTIVAL DRUG PLACEMENT	This is no longer a valid code.	N/A
0124U	FTL CGEN ABNOR BIOCHEM ASSAY 3 ANALYTES ALG	This is no longer a valid code.	N/A
0125U	FTL CGEN ABNOR AND PRNT COMP 5 ANALYTES ALG	This is no longer a valid code.	N/A
0126U	FTL CGEN ABNOR AND PRNT COMP 5 ANAL ASSMT Y CHRMSM	This is no longer a valid code.	N/A
0127U	OB PREECLAMPSIA BIOCHEM ASSAY 3 ANALYTES ALG	This is no longer a valid code.	N/A
0128U	OB PE BIOCHEM ASSAY 3 ANAL QUAL ASSMT Y CHRMSM	This is no longer a valid code.	N/A
0159T	COMPUTER-AIDED DETECTION INCLUDING COMPUTER ALGORITHM ANALYSIS	This is no longer a valid code.	N/A
0163T	LUMB ARTIF DISCECTOMY ADDL	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
0164T	REMOVE LUMB ARTIF DISC ADDL	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
0165T	REVISE LUMB ARTIF DISC ADDL	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
0169T	STEREOTACTIC PLACEMENT OF INFUSION CATHETER(S)	This is no longer a valid code.	N/A
0171T	LUMBAR SPINE PROCES DISTRACT	This is no longer a valid code.	N/A
0172T	LUMBAR SPINE PROCESS ADDL	This is no longer a valid code.	N/A
0178T	64 LEAD ECG W I&R	This is no longer a valid code.	N/A
0179T	64 LEAD ECG W TRACING	This is no longer a valid code.	N/A
0180T	64 LEAD ECG W I&R ONLY	This is no longer a valid code.	N/A
0181T	CORNEAL HYSTERESIS	This is no longer a valid code.	N/A
0182T	HDR ELECT BRACHYTHERAPY	This is no longer a valid code.	N/A
0183T	WOUND ULTRASOUND	This is no longer a valid code.	N/A
0185T	COMPTR PROBABILITY ANALYSIS	This is no longer a valid code.	N/A
0186T	SUPRACHOROIDAL DRUG DELIVERY	This is no longer a valid code.	N/A
0188T	REMOTE REAL TIME VIDEOCONFERENCE FOR CRITICAL CARE, 1ST 30-74 MINUTES	This is no longer a valid code.	N/A
0189T	EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO 0188T)	This is no longer a valid code.	N/A
0190T	PLACEMENT OF INTROUCULAR RADIATION SOURCE APPLICATOR	This is no longer a valid code.	N/A
0192T	INSERTION ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, EXTERNAL APPROACH	This is no longer a valid code.	N/A
0195T	ARTHROD PRESAC INTERBODY	This is no longer a valid code.	N/A
0196T	ARTHROD PRESAC INTERBODY EAC	This is no longer a valid code.	N/A
0197T	INTRAFACTION TRACK MOTION	This is no longer a valid code.	N/A
0199T	PHYSIOLOGIC TREMOR RECORD	This is no longer a valid code.	N/A
0200T	PERQ SACRAL AUGMT UNILAT INJ	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
0201T	PERQ SACRAL AUGMT BILAT INJ	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
0202T	POST VERT ARTHRPLST 1 LUMBAR	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
0207T	CLEAR EYELID GLAND W/HEAT	No prior authorization is required. Routine vision services administered by Envolv Vision services.	N/A
0219T	FUSE SPINE FACET JT CERV	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
0220T	FUSE SPINE FACET JT THOR	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
0221T	FUSE SPINE FACET JT LUMBAR	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
0222T	FUSE SPINE FACET JT ADD SEG	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
0223T	ACOUSTIC/ELECTR CARDGRPHY	This is no longer a valid code.	N/A
0224T	ACSTIC/ELEC CARDGRPHY AV/VV	This is no longer a valid code.	N/A
0225T	ACSTIC/ELEC CARDGRPHY AV+VV	This is no longer a valid code.	N/A
0226T	ANOSC HIGH RESOL DX +COLL	This is no longer a valid code.	N/A
0227T	ANOSC HIGH RESOL DX W/BX	This is no longer a valid code.	N/A
0233T	SKN AGE MEAS SPCTRSCPY	This is no longer a valid code.	N/A
0239T	BIOIMPEDANCE SPECTROSCOPY	This is no longer a valid code.	N/A
0240T	ESOPH MOTILITY 3D TOPOGRAPHY	This is no longer a valid code.	N/A
0241T	ESOPH MOTILITY W/STIM/PERF	This is no longer a valid code.	N/A
0243T	INTM MSR BRONCHODIL WHEEZE	This is no longer a valid code.	N/A
0244T	CONT MSR BRONCHODIL WHEEZE	This is no longer a valid code.	N/A
0245T	OPN TX RIB FX 1-2 RIBS	This is no longer a valid code.	N/A
0246T	OPN TX RIB FX 3-4 RIBS	This is no longer a valid code.	N/A
0247T	OPN TX RIB FX 5-6 RIBS	This is no longer a valid code.	N/A
0248T	OPN TX RIB FX 7+ RIBS	This is no longer a valid code.	N/A
0255T	EVASC RPR ILIAC ART BIFR S&	This is no longer a valid code.	N/A
0260T	TTL BODY SYSTM HYPOTHER <28 DAYS	This is no longer a valid code.	N/A
0261T	SEL HEAD HYPOTHERMIA <28 DAYS	This is no longer a valid code.	N/A
0262T	IMPLTJ PULM VLV EVASC APPR	This is no longer a valid code.	N/A
0274T	PERQ LAMOT/LAM CRV/THRC	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
0275T	PERQ LAMOT/LAM LUMBAR	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019

0280T	CTC TEST W/I & R	This is no longer a valid code.	N/A
0281T	LAA CLOSURE W/IMPLANT	This is no longer a valid code.	N/A
0282T	PERIPH FIELD STIMUL TRIAL	This is no longer a valid code.	N/A
0283T	PERIPH FIELD STIMUL PERM	This is no longer a valid code.	N/A
0284T	PERIPH FIELD STIMUL REVISE	This is no longer a valid code.	N/A
0285T	PERIPH FIELD STIMUL ANALYS	This is no longer a valid code.	N/A
0286T	NEAR IFR SPECTRSC OF WOUNDS	This is no longer a valid code.	N/A
0287T	NEAR IFR GUIDE OF VASC SITE	This is no longer a valid code.	N/A
0288T	ANOSCOPY W/RF DELIVERY	This is no longer a valid code.	N/A
0289T	LASER INC FOR PKP/LKP DONOR	This is no longer a valid code.	N/A
0291T	IV OCT FOR PROC INIT VESSEL	This is no longer a valid code.	N/A
0292T	IV OCT FOR PROC ADDL VESSEL	This is no longer a valid code.	N/A
0293T	INS LT ATRL PRESS MONITOR	This is no longer a valid code.	N/A
0294T	INS LT ATRL PRESS MONT ADDON	This is no longer a valid code.	N/A
0299T	ESW WOUND HEALING INIT WOUND	This is no longer a valid code.	N/A
0300T	ESW WOUND HEALING ADDL WOUND	This is no longer a valid code.	N/A
0301T	MW THERAPY FOR BREAST TUMOR	This is no longer a valid code.	N/A
0302T	ICAR ISCHM MNTRNG SYS COMPL	This is no longer a valid code.	N/A
0303T	ICAR ISCHM MNTRNG SYS ELTRD	This is no longer a valid code.	N/A
0304T	ICAR ISCHM MNTRNG SYS DEVICE	This is no longer a valid code.	N/A
0305T	ICAR ISCHM MNTRNG PRGRM EVAL	This is no longer a valid code.	N/A
0306T	ICAR ISCHM MNTRNG INTERR EVAL	This is no longer a valid code.	N/A
0307T	RMVL ICAR ISCHM MNTRNG DVCE	This is no longer a valid code.	N/A
0309T	PRESCLR FUSE W/ INSTR L4/L5	This is no longer a valid code.	N/A
0310T	MOTOR FUNCTION MAPPING NTMS	This is no longer a valid code.	N/A
0311T	CAL & Alys CNTRL ARTL PRESS	This is no longer a valid code.	N/A
0319T	INSERT SUBQ DEFIB W/ELTRD	This is no longer a valid code.	N/A
0320T	INSERT SUBQ DEFIB ELECTRODE	This is no longer a valid code.	N/A
0321T	INSERT SUBQ DEFIB PLS GEN	This is no longer a valid code.	N/A
0322T	RMVL SUBQ DEFIB PLS GEN	This is no longer a valid code.	N/A
0323T	RMVL & REPLC SUBQ PLS GEN	This is no longer a valid code.	N/A
0324T	RMVL SUBQ DEFIB ELECTRODE	This is no longer a valid code.	N/A
0325T	REPOS SUBQ DEFIB ELTRD & GEN	This is no longer a valid code.	N/A
0326T	EPHYS EVAL SUBQ IMPLT DEFIB	This is no longer a valid code.	N/A
0327T	IMPLT SUBQ DEFIB INTEROGAT	This is no longer a valid code.	N/A
0328T	IMPLT SUBQ DEFIB SYS DEV EVL	This is no longer a valid code.	N/A
0329T	MNTR IO PRESS 24HRS/> UNI/BI	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
0330T	TEAR FILM IMG UNI/BI W/I&R	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
0333T	VISUAL EP ACUITY SCREEN AUTO	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
0334T	PERQ STABLJ SACROILIAC JOINT	This is no longer a valid code.	N/A
0336T	LAP ABLAT UTERINE FIBROIDS	This is no longer a valid code.	N/A
0337T	ENDOTHEL FXNASSMNT NON-INVAS	This is no longer a valid code.	N/A
0340T	ABLATE PULM TUMORS + EXTNSN	This is no longer a valid code.	N/A
0341T	QUANT PUPILLOMETRY W/ RPRT	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
0343T	TRANSCATH MTRAL VLVE REPAIR	This is no longer a valid code.	N/A
0344T	TRANSCATH MTRAL VLVE REPAIR	This is no longer a valid code.	N/A
0346T	ULTRASOUND ELASTOGRAPHY	This is no longer a valid code.	N/A
0364T	BEHAVIOR TREATMENT	This is no longer a valid code.	N/A
0365T	BEHAVIOR TREATMENT ADDL	This is no longer a valid code.	N/A
0366T	GROUP BEHAVIOR TREATMENT	This is no longer a valid code.	N/A
0367T	GROUP BEHAV TREATMENT ADDL	This is no longer a valid code.	N/A
0368T	BEHAVIOR TREATMENT MODIFIED	This is no longer a valid code.	N/A
0369T	BEHAV TREATMENT MODIFY ADDL	This is no longer a valid code.	N/A
0370T	FAM BEHAV TREATMENT GUIDANCE	This is no longer a valid code.	N/A
0371T	MULT FAM BEHAV TREAT GUIDE	This is no longer a valid code.	N/A
0372T	SOCIAL SKILLS TRAINING GROUP	This is no longer a valid code.	N/A
0374T	EXPOSE BEHAV TREATMENT ADDL	This is no longer a valid code.	N/A
0387T	LEADLESS C PM INS/RPL VENTR	This is no longer a valid code.	N/A
0388T	LEADLESS PM REMOVE VENTR	This is no longer a valid code.	N/A
0389T	PROG EVAL INPER LEADLS PM	This is no longer a valid code.	N/A
0390T	PERIPROC EVAL INPER LEDLS PM	This is no longer a valid code.	N/A
0391T	INTERGT EVAL INPER LEADLS PM	This is no longer a valid code.	N/A
0392T	LAP ES SPH AUGMENT DEV PLACE	This is no longer a valid code.	N/A
0393T	ES SPH AUGMNT DEVICE REMOVAL	This is no longer a valid code.	N/A
0406T	SIN NDSC PLMT DRG ELUT MPLNT	This is no longer a valid code.	N/A
0407T	SIN NDSC PLMT DRG ELUT MPLNT	This is no longer a valid code.	N/A
0438T	TPRNL PLMT BIODEGRDABL MATRL	This is no longer a valid code.	N/A
3125F	ESOPH BX RPRT W/ DYSPL INFO	This is no longer a valid code.	N/A
A0021	AMBULANCE OUTSIDE STATE PER MILE (MEDICAID)	This service is not covered by Superior HealthPlan.	N/A
A0080	NON-EMERG TRANSPRT VOLUN NOT VESTED	This service is not covered by Superior HealthPlan.	N/A
A0090	NON-EMERG TRANSPRT IND W/VESTED INT	This service is not covered by Superior HealthPlan.	N/A
A0100	NON-EMERGENCY TRANSPORTATION; TAXI	This service is not covered by Superior HealthPlan.	N/A
A0110	NON-ER TRANSPORTATION/BUS INTRA-INTERSTATE	This service is not covered by Superior HealthPlan.	N/A
A0120	NON-EMERG TRANSPRT: MINI-BUS MTN/OTH	This service is not covered by Superior HealthPlan.	N/A
A0130	NON-ER TRANSPORTATION: WHEELCHAIR VAN	This service is not covered by Superior HealthPlan.	N/A
A0140	NON-ER TRANS & AIR TRAVEL (PVT/COMM) INTRA-INTER	This service is not covered by Superior HealthPlan.	N/A
A0160	NON-ER TRANSPORT: PER MILE - CASE/SOCIAL WORKER	This service is not covered by Superior HealthPlan.	N/A
A0170	TRNSPRT ANCILLRY: PARK FEE TOLL OTH	This service is not covered by Superior HealthPlan.	N/A
A0180	NON-ER TRANSPORT: ANCILLARY: LODGING - RECIPIENT	This service is not covered by Superior HealthPlan.	N/A
A0190	NON-ER TRANSPORT: ANCILLARY: MEALS - RECIPIENT	This service is not covered by Superior HealthPlan.	N/A
A0200	NON-ER TRANSPORT: ANCILLARY: LODGING - ESCORT	This service is not covered by Superior HealthPlan.	N/A
A0210	NON-ER TRANSPORT: ANCILLARY: MEALS - ESCORT	This service is not covered by Superior HealthPlan.	N/A
A0225	AMBULANCE SERVICE, NEONATAL TRANSPORT, BASE ONE WAY	This service is not covered by Superior HealthPlan.	N/A
A0380	BLS MILEAGE PER MILE	This service is not covered by Superior HealthPlan.	N/A
A0382	BLS ROUTINE DISPOSABLE SUPPLIES	Pre-authorization is required without an ET modifier.	Prior to 09/01/2019
A0384	BLS SPEC SERV DISP SUPPLIES; DEFIB	This service is not covered by Superior HealthPlan.	N/A
A0392	ALS SPEC SERV DISP SUPPLIES; DEFIB	This service is not covered by Superior HealthPlan.	N/A
A0394	ALS SPEC SERV DISP SUPPLIES; IV DRUG THERAPY	This service is not covered by Superior HealthPlan.	N/A
A0396	ALS SPEC SERV DISP SUPPLIES; ESOPH INTUBATION	This service is not covered by Superior HealthPlan.	N/A
A0398	ALS ROUTINE DISPOSABLE SUPPLIES	No pre-authorization is required for all providers.	N/A
A0420	AMBULANCE WAITING TIME ALS/BLS 1/2 HR INCREMENTS	No pre-authorization is required for all providers.	N/A
A0422	AMBUL ALS/BLS O2 & O2 SUPPLIES LIFE SUSTAINING	Pre-authorization is required without an ET modifier.	Prior to 09/01/2019
A0424	EXTRA AMB ATTENDANT GROUND/AIR;	Pre-authorization is required without an ET modifier.	Prior to 09/01/2019
A0425	GROUND MILEAGE P/STATUTE MILE	Pre-authorization is required without an ET modifier.	Prior to 09/01/2019
A0426	AMB SRV AD LIFE SUP NON-ER TRANS L1	Pre-authorization is required for all providers.	Prior to 09/01/2019
A0427	AMB SRV ADV LIFE SUP ER TRANS L1	No pre-authorization is required for all providers.	N/A
A0428	AMB SRV BASIC LIFE SUP NON-ER TRANS	Pre-authorization is required for all providers.	Prior to 09/01/2019
A0429	AMB SRV BASIC LIFE SUP ER TRANS	No pre-authorization is required for all providers.	N/A
A0430	AMB SRV CONV AIR TRANS 1W FIX WING	Pre-authorization is required without an ET modifier.	Prior to 09/01/2019
A0431	AMB SRV CONV AIR TRANS 1W ROT WING	Pre-authorization is required without an ET modifier.	Prior to 09/01/2019
A0432	PARAMEDIC INTERCEPT VOL AMB SRV	This service is not covered by Superior HealthPlan.	N/A
A0433	ADV LIFE SUP LEV 2 (ALS 2)	Pre-authorization is required without an ET modifier.	Prior to 09/01/2019
A0434	SPECIALTY CARE TRANS (SCT)	Pre-authorization is required without an ET modifier.	Prior to 09/01/2019
A0435	FIXED WING AIR MILEAGE P/STATUTE MI	Pre-authorization is required without an ET modifier.	Prior to 09/01/2019
A0436	ROTARY WNG AIR MILEAGE P/STATUTE MI	Pre-authorization is required without an ET modifier.	Prior to 09/01/2019
A0888	NON-COVERED AMBULANCE MILEAGE PER MILE	This service is not covered by Superior HealthPlan.	N/A
A0998	AMBULANCE RESPONSE & TREATMENT NO TRANSPORT	This service is not covered by Superior HealthPlan.	N/A
A0999	UNLISTED AMBULANCE SERVICE	No pre-authorization is required for all providers.	N/A
A4206	1 CC STERILE SYRINGE&NEEDLE	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
A4207	SYRINGE W/NEEDLE STERILE 2CC EACH	No pre-authorization is required for all providers.	N/A
A4208	SYRINGE W/NEEDLE STERILE 3CC EACH	No pre-authorization is required for all providers.	N/A

A4209	SYRINGE W/NEEDLE STERILE >=5CC EACH	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
A4210	NEEDLE-FREE INJECTION DEVICE EACH	This service is not covered by Superior HealthPlan.	N/A
A4211	SUPPLIES SELF-ADMINISTERED INJECTIONS	No pre-authorization is required for all providers.	N/A
A4212	NON CORING NEEDLE/STYLET W/WO CATHETER	No pre-authorization is required for all providers.	N/A
A4213	SYRINGE STERILE 20CC/GREATER EACH	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
A4214	STERILE SALINE/WATER 30CC VIAL	No pre-authorization is required for all providers.	N/A
A4215	NEEDLES ONLY STERILE ANY SIZE EACH	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
A4216	STERILE WATER, SALINE AND/OR DEXTROSE, DILUENT/FLUSH, 10 ML	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4217	STERILE WATER/SALINE, 500 ML	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4218	STERILE SALINE OR WATER METERED DOSE DISPENSER 10 ML	This service is not covered by Superior HealthPlan.	N/A
A4220	REFILL KIT FOR IMPLNT INFUSION PUMP	No pre-authorization is required for all providers.	N/A
A4221	SUPS MAINT NON-INS RX INFUS CATH PW	This service is not covered by Superior HealthPlan.	N/A
A4222	SUPP EXT DRUG INFUS PUMP PER CASSETTE/BAG	No pre-authorization is required for all providers.	N/A
A4223	INFUS SPL NOT USED W/EXT INFUS PUMP CASSETTE/BAG	This service is not covered by Superior HealthPlan.	N/A
A4224	SUPPLY INSULIN INF CATH/WK	No pre-authorization is required for all providers.	N/A
A4225	SUP/EXT INSULIN INF PUMP SYR	No pre-authorization is required for all providers.	N/A
A4226	SPL MAINT INS IP DR ADJ USING TX CONT G SENS WK	This service is not covered by Superior HealthPlan.	N/A
A4230	INFUS SET-EXT INSULIN PMP, NON NEEDLE CANNULA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4231	INFUS SET EXT INSULIN PMP, NEEDLE TYPE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4232	SYR W/NEEDLE-EXT INSULIN PUMP, STER, 3CC	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4233	REPLACE BATTERY ALKALINE OTH THAN J CELL USE W MED NEC HM BL GL MON	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4234	REPLACE BATTERY ALKALINE J CELL FOR USE W MED NEC HM BL GLUCOSE MONITOR	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4235	REPLACE BATTERY LITHIUM FOR USE W MED NEC HOME BLOOD GLUCOSE MONITOR	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4236	REPLACE BATTERY LITHIUM FOR USE W MED NEC HOME BLOOD GLUCOSE MONITOR	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4244	ALCOHOL/PEROXIDE PER PINT	No pre-authorization is required for all providers.	N/A
A4245	ALCOHOL WIPES PER BOX	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4246	BETADINE/PHISOHEX SOLUTION PER PINT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4247	BETADINE/IODINE SWABS/WIPE PER BOX	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4248	CHLORHEXIDINE CONTAINING ANTISEPTIC, 1 ML	No pre-authorization is required for all providers.	N/A
A4250	URINE TEST REAGENT STRIPS/TABLETS (PER 100)	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4252	BLOOD KETONE TEST OR STRIP	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4253	BLOOD GLUCOSE TEST REAGENT STRIPS HOME USE PER50	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4254	REPLAC BATT FOR HOME BLD GLU MONITOR PT-OWN, EA	This is no longer a valid code.	N/A
A4255	HOME BLOOD GLUCOSE MONITOR PLATFORMS-50 PER BOX	This service is not covered by Superior HealthPlan.	N/A
A4256	NORMAL/LOW/HIGH CALIBRATOR SOLUTION/CHIPS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4257	REPLACEMENT LENS SHIELD CARTRIDGE	This service is not covered by Superior HealthPlan.	N/A
A4258	SPRING-POWERED DEVICE FOR LANCET, EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4259	LANCETS PER BOX OF 100	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4261	CERV CAP CONTRACEPTIVE USE	No pre-authorization is required for all providers.	N/A
A4262	TEMPORARY ABSORBABLE LACRIMAL DUCT IMPLNT EA	This service is not covered by Superior HealthPlan.	N/A
A4263	PERM Long-term NONDISSOLV LACRIML DUCT IMPLNT EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4264	INTRATUBAL OCCLUSION DEVICE	No pre-authorization is required for all providers.	N/A
A4265	PARAFFIN, PER POUND	No pre-authorization is required for all providers.	N/A
A4266	DIAPHRAGM FOR CONTRACEPTIVE USE	No pre-authorization is required for all providers.	N/A
A4267	CONTRACEPTIVE SUPPLY CONDOM MALE EA	No pre-authorization is required for all providers.	N/A
A4268	CONTRACEPT SUPPLY CONDOM FEMALE EA	No pre-authorization is required for all providers.	N/A
A4269	CONTRACEPTIVE SUPPLY SPERMICIDE EA	No pre-authorization is required for all providers.	N/A
A4270	DISPOSABLE ENDOSCOPE SHEATH EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4280	ADHESIVE SKIN SUPPORT ATTACHMENT FOR USE WITH EXTERNAL BREAST PROSTHESIS	No pre-authorization is required for all providers.	N/A
A4281	TUBING FOR BREAST PUMP, REPLACEMENT	No pre-authorization is required for all providers.	N/A
A4282	ADAPTER FOR BREAST PUMP REPLACEMENT	No pre-authorization is required for all providers.	N/A
A4283	CAP BREAST PUMP BOTTLE REPLACEMENT	No pre-authorization is required for all providers.	N/A
A4284	BRST SHIELD&SPLSH PROTCTR PUMP REPL	No pre-authorization is required for all providers.	N/A
A4285	POLYCARBATE BOTTLE BREAST PUMP REPL	No pre-authorization is required for all providers.	N/A
A4286	LOCKING RING BREAST PUMP REPLCMT	No pre-authorization is required for all providers.	N/A
A4290	SAC NERV STIM TEST LEAD EA	No pre-authorization is required for all providers.	N/A
A4300	IMPLNT ACCESS CATH, EXTERNAL ACCESS	Pre-authorization is required for all providers.	Prior to 09/01/2019
A4301	IMPL ACSS TOTAL CATH PORT/RESRVOR	Pre-authorization is required for all providers.	Prior to 09/01/2019
A4305	DISPOSABLE DRUG DELIV SYST FLOW RATE >= 50ML/HR	No pre-authorization is required for all providers.	N/A
A4306	DISPOSABLE DRUG DELIVERY SYSTEM, FLOW RATE OF LESS THAN 30 ML /HOUR	No pre-authorization is required for all providers.	N/A
A4310	INSERT TRAY WO DRAIN BAG/CATHETER	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4311	INSERT TRAY WO DRAIN BAG W/INDWELL CATH LATEX	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4312	INSERT TRAY WO DRAIN BAG W/INDWELL CATH SILICON	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4313	INSERT TRAY WO DRAIN BAG W/3 WAY INDWELL CATH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4314	INSERT TRAY W/DRAIN BAG & INDWELL CATH LATEX	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4315	INSERT TRAY W/DRAIN BAG & INDWELL CATH SILICONE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4316	INSERT TRAY W/DRAIN BAG & 3/WAY INDWELL CATH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4320	IRRIGATION TRAY W/BULB/PISTON SYRINGE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4321	THERAP AGENT FOR URINARY CATHETER IRRIGATION	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
A4322	IRRIGATION SYRINGE BULB/PISTON EACH	Pre-authorization required for all providers.	Prior to 09/01/2019
A4323	STERILE SALINE IRRIGATION SOLUTION 1000 ML	No pre-authorization is required for all providers.	N/A
A4325	MALE EXT CATH W/ADHES STRIP EA	No pre-authorization is required for all providers.	N/A
A4326	MALE EXTERNAL CATHETER WITH INTEGRAL COLLECTION CHAMBER, ANY TYPE, EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4327	FEMALE EXT URINARY COLLECT DEVICE; METAL CUP EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4328	FEMALE EXT URINARY COLLECT DEVICE POUCH EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4329	EXT CATH STARTER SET MALE/FEMALE W/SUPPLIES 7DAY	No pre-authorization is required for all providers.	N/A
A4330	PERIANAL FECAL COLLECTION POUCH W/ADHESIVE EACH	No pre-authorization is required for all providers.	N/A
A4331	EXT DRAIN TUBING W/CNCTR/ADPTR EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4332	LUBE IND STR PKT-URIN CATH INS EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4333	URIN CATH ANC DEV ADHES SKIN ATT EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4334	URIN CATH ANCHRG DEV LEG STRAP EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4335	INCONTINENCE SUPPLY MISC	Pre-authorization required for all providers.	Prior to 09/01/2019
A4336	URETHRAL INSERT	This service is not covered by Superior HealthPlan.	N/A
A4337	INCONT SPL RECTAL INSRT ANY TYPE EA	This service is not covered by Superior HealthPlan.	N/A
A4338	INDW CATH FOLEY 2 WAY ATEX W/COATING EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4340	INDWELL CATH SPECIALTY TYPE EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4344	INDW CATH FOLEY 2 WAY SILICONE EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4346	INDW CATH FOLEY 3 WAY CONT IRRIGATION EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4349	MALE EXTERNAL CATHETER W/WO ADHES DISPOSABLE EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4351	INTERMITTENT URINARY CATH STRAIGHT TIP EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4352	INTERMITTENT URINARY CATH COUDE TIP EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4353	INTERMITTENT URINARY CATHETER W/INSERTION SUPP	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4354	INSERTION TRAY W/DRAIN BAG W/O CATH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4355	IRRIG TUB SET CONT IRRIG VIA FOLEY EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4356	EXT URETHRAL CLAMP/COMPRESS DEVICE EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4357	BDSD DRBG DAY/NIGHT W/WO TUB/ANTIREFLUX EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4358	URINARY LEG BAG VINYL W/WO TUB EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4360	DISPOSABLE EXT URETHRAL DEV	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4361	OSTOMY FACEPLATE, EACH	No pre-authorization is required for all providers.	N/A
A4362	SKIN BARRIER SOLID 4X4/EQUIVALENT EACH	No pre-authorization is required for all providers.	N/A
A4363	OSTOMPY CLAMP ANY TYPE, REPLACEMENT ONLY EACH	No pre-authorization is required for all providers.	N/A
A4364	ADHESIVE OSTOMY/CATH LIQUID CEMENT POWDER PER OZ	No pre-authorization is required for all providers.	N/A
A4366	OSTOMY VENT, ANY TYPE, EACH	No pre-authorization is required for all providers.	N/A
A4367	OSTOMY BELT, EACH	No pre-authorization is required for all providers.	N/A
A4368	OSTOMY FILTER ANY TYPE-EA	No pre-authorization is required for all providers.	N/A
A4369	OSTOMY SKIN BARRIER, LIQUID, (SPRAY, BRUSH, ETC), PER OZ	No pre-authorization is required for all providers.	N/A
A4370	OSTOMY SKIN BARRIER, PASTE, PER OZ	This is no longer a valid code.	N/A
A4371	OSTOMY SKIN BARRIER, POWDER, PER OZ	No pre-authorization is required for all providers.	N/A
A4372	OST SKN BARR SOL 4X4 BUILT-IN CONVX	No pre-authorization is required for all providers.	N/A

A4373	OST SKN BARR W/FLNGE BUILT-IN CONVX	No pre-authorization is required for all providers.	N/A
A4374	OSTOMY SKIN BARRIER, W FLANGE, EXTENDED WEAR, W BUILT-IN CONVEXITY ANY	No pre-authorization is required for all providers.	N/A
A4375	OSTOMY POUCH DARINABLE, W/FACEPLATE ATTACHED	No pre-authorization is required for all providers.	N/A
A4376	OSTOMY POUCH DRAINABLE W/FACEPLACE ATTACHED RUBBER	No pre-authorization is required for all providers.	N/A
A4377	OSTOMY POUCH DRAINABLE FOR USE ON FACEPLACE PLASTIC	No pre-authorization is required for all providers.	N/A
A4378	OSTOMY POUCH DRAINABLE FOR USE ON FACEPLATE RUBBER	No pre-authorization is required for all providers.	N/A
A4379	OSTOMY POUCH URINARY PLASTIC	No pre-authorization is required for all providers.	N/A
A4380	OSTOMY POUCH URINARY RUBBER	No pre-authorization is required for all providers.	N/A
A4381	OSTOMY POUCH URINARY PLASTIC	No pre-authorization is required for all providers.	N/A
A4382	OSTOMY POUCH URINARY HEAVY PLASTIC	No pre-authorization is required for all providers.	N/A
A4383	OSTOMY POUCH URINARY RUBBER	No pre-authorization is required for all providers.	N/A
A4384	OSTOMY FACEPLATE EQUIVALENT SILICONE RING	No pre-authorization is required for all providers.	N/A
A4385	OSTOMY SKIN BARRIER SOLID 4X4 OR EQUIVALENT	No pre-authorization is required for all providers.	N/A
A4387	OST POUCH CLO W/BARR BUILT-IN CONVX	No pre-authorization is required for all providers.	N/A
A4388	OST POUCH DRNABL W/EXT WEAR BARR EA	No pre-authorization is required for all providers.	N/A
A4389	OST POUCH DRNBL BARR BUILT-IN CONVX	No pre-authorization is required for all providers.	N/A
A4390	OSTOMY POUCH DRAINABLE WITH EXTENDED WEAR BARRIER ATTACHED	No pre-authorization is required for all providers.	N/A
A4391	OST POUCH URIN W/EXT WEAR BARR EA	No pre-authorization is required for all providers.	N/A
A4392	OSTOMY POUCH URINARY	No pre-authorization is required for all providers.	N/A
A4393	OSTOMY POUCH URINARY	No pre-authorization is required for all providers.	N/A
A4394	OSTOMY DEODERANT, W OR W/OUT LUBRICANT FOR USE IN OSTOMY POUCH, PER OZ	No pre-authorization is required for all providers.	N/A
A4395	OSTOMY DEODORANT FOR USE IN OSTOMY POUCH SOLIC	No pre-authorization is required for all providers.	N/A
A4396	OSTOMY BELT W/PERISTOMAL HERN SUP	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4397	IRRIGATION SUPPLY SLEEVE, EACH	No pre-authorization is required for all providers.	N/A
A4398	OSTOMY IRRIGATION SUPPLY BAG-EA	No pre-authorization is required for all providers.	N/A
A4399	OSTOMY IRRIG CONE/CATH W BRS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4400	OSTOMY IRRIGATION SET	No pre-authorization is required for all providers.	N/A
A4402	LUBRICANT PER OUNCE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4404	OSTOMY RING EACH	No pre-authorization is required for all providers.	N/A
A4405	OST SKN BARRIER NON-PECTIN PASTE-OZ	No pre-authorization is required for all providers.	N/A
A4406	OST SKN BARRIER PECTIN PASTE-OZ	No pre-authorization is required for all providers.	N/A
A4407	OST SKN BARRIER W/CONVXITY 4X4 IN/<	No pre-authorization is required for all providers.	N/A
A4408	OST SKN BARRIER W/CONVXITY > 4X4 IN	No pre-authorization is required for all providers.	N/A
A4409	OST SKN BARR EXT W/O CONVX 4X4 IN/<	No pre-authorization is required for all providers.	N/A
A4410	OST SKN BARR EXT W/O CONVX >4X4 IN	No pre-authorization is required for all providers.	N/A
A4411	OSTOMY SKIN BARRIER SOLID 4X4 OR EQUIV EXTEND WEAR W BUILT-IN CONVEX	No pre-authorization is required for all providers.	N/A
A4412	OSTOMY POUCH DRAINABLE HIGH OUTPUT FOR USE ON A BARRIER W FLANGE	No pre-authorization is required for all providers.	N/A
A4413	OST POUCH DRNABL BARRIER FLNGE/FLTR	No pre-authorization is required for all providers.	N/A
A4414	OST SKN BARRIER W/O CONVX 4X4 IN/<	No pre-authorization is required for all providers.	N/A
A4415	OST SKN BARRIER W/O CONVX >4X4 IN	No pre-authorization is required for all providers.	N/A
A4416	OSTOMY PCH, CLSED, W BARRIER ATTACHED, WITH FILTER (1 PIECE), EA	No pre-authorization is required for all providers.	N/A
A4417	OSTOMY PCH, CLSD, W BARRIER, W BUILT-IN CONVEXITY, W FILTER (1 P), EA	No pre-authorization is required for all providers.	N/A
A4418	OSTOMY PCH, CLSD W/OUT BARRIER ATT, W FILTER (ONE PIECE), EACH	No pre-authorization is required for all providers.	N/A
A4419	OSTOMY PCH, CLSD/USE ON BARR W NON-LOCKING FLNG, W FILTER (2PIECE), EA	No pre-authorization is required for all providers.	N/A
A4420	OSTOMY PCH, CLSD/USE ON BARR W LOCKING FLNG (2 PIECE), EA	No pre-authorization is required for all providers.	N/A
A4421	OSTOMY SUPPLY MISC	No pre-authorization is required for all providers.	N/A
A4422	OST ABSORB MATL THICKN LQD STOML OP	No pre-authorization is required for all providers.	N/A
A4423	OSTOMY PCH, CLSD/USE ON BARR W LOCKING FLNG, W FILTER (2PIECE), EA	No pre-authorization is required for all providers.	N/A
A4424	OSTOMY PCH, DRAINBLE, W BARRIER ATT, W FILTER (ONE PIECE), EACH	No pre-authorization is required for all providers.	N/A
A4425	OSTOMY PCH, DRNB/USE ON BARR W NON-LOCKING FLNG, W FILTER (2PC SYS), EA	No pre-authorization is required for all providers.	N/A
A4426	OSTOMY PCH, DRNB/USE ON BARR W LOCKING FLNG (2 PIECE SYS), EA	No pre-authorization is required for all providers.	N/A
A4427	OSTOMY PCH, DRNBL/USE ON BARR W LOCKING FLNG, W FILTER (2PIECE SYS), EA	No pre-authorization is required for all providers.	N/A
A4428	OSTOMY PCH, URNY/W EXTND WEAR BARR ATT/W FAUCET-TYPE TAP W VALVE (1PC)	No pre-authorization is required for all providers.	N/A
A4429	OSTOMY PCH/URNY/W BAR ATTD/W BUILT-IN CONV/W FCET-TYPE TAP W VALVE (1PC)	No pre-authorization is required for all providers.	N/A
A4430	OSTOMY PCH URNY/EXT WEAR BAR ATT/BUILT-IN CONV/W FCT-TYP TAP W VL (1PC)	No pre-authorization is required for all providers.	N/A
A4431	OSTOMY PCH/URNY/BARR ATT/FCT-TYPE TAP/VALVE (1PC)	No pre-authorization is required for all providers.	N/A
A4432	OSTOMY PCH/URNY/USE ON BARR/NON-LOCKING FLNG/FCT-TYPE TAP/VALVE (2PC)	No pre-authorization is required for all providers.	N/A
A4433	OSTOMY PCH/URNY/USE ON BARR/LOCKING FLNG (2PC)	No pre-authorization is required for all providers.	N/A
A4434	OSTOMY PCH/URNY/USE ON BARR/LOCKING FLNG/FCT - TYPE TAP/VALVE (2PC)	No pre-authorization is required for all providers.	N/A
A4435	1PC OST PCH DRAIN HGH OUTPUT	No pre-authorization is required for all providers.	N/A
A4450	TAPE NON-WATERPROOF-18 SQUARE IN	No authorization is required for Par Providers unless over the benefits limitation.	Prior to 09/01/2019
A4452	TAPE WATERPROOF PER 18 SQUARE IN	No authorization is required for Par Providers unless over the benefits limitation.	Prior to 09/01/2019
A4455	ADHESIVE REMOVER/SOLVENT (TAPE-CEMENT) PER OUNCE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4456	ADHESIVE REMOVER, WIPES	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4458	ENEMA BAG WITH TUBING, REUSABLE	This service is not covered by Superior HealthPlan.	N/A
A4459	MANUAL PUMP ENEMA, REUSABLE	This service is not covered by Superior HealthPlan.	N/A
A4461	SURGICAL DRESSING HOLDER, NON-REUSABLE, EACH	No pre-authorization is required for all providers.	N/A
A4463	SURGICAL DRESSING HOLDER, REUSABLE, EACH	This service is not covered by Superior HealthPlan.	N/A
A4465	NONELASTIC BINDER FOR EXTREM	No pre-authorization is required for all providers.	N/A
A4466	ELASTIC GARMENT/COVERING	This is no longer a valid code.	N/A
A4467	BELT STRAP SLEEV GRMNT COVER	No pre-authorization is required for all providers.	N/A
A4470	GRAVLEE JET WASHER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4480	VABRA ASPIRATOR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4481	TRACHEOSTOMA FILTER ANY TYPE ANY SIZE-EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4483	MOIST EXCHG DISP USE W/INVASIVE MECH VENT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4490	SURGICAL STOCKINGS ABOVE KNEE LENGTH EACH	No pre-authorization is required for all providers.	N/A
A4495	SURGICAL STOCKINGS THIGH LENGTH EACH	No pre-authorization is required for all providers.	N/A
A4500	SURGICAL STOCKINGS BELOW KNEE LENGTH EACH	No pre-authorization is required for all providers.	N/A
A4510	SURGICAL STOCKINGS FULL LENGTH EACH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4520	INCONTINENCE GARMENT ANY TYPE EACH	This service is not covered by Superior HealthPlan.	N/A
A4522	ADLT-SZD INCONT PROD DIAPER MED EA	No pre-authorization is required for all providers.	N/A
A4527	ADLT-SZD INCONT PROD BRF LG SZ EA	No pre-authorization is required for all providers.	N/A
A4529	CHLD-SZD INCONT DIAPER SM/MED SZ EA	This is no longer a valid code.	N/A
A4532	CHLD-SZD INCONT PROD BRF LG SZ EA	No pre-authorization is required for all providers.	N/A
A4533	YOUTH-SIZED INCONT PROD DIAPER EA	No pre-authorization is required for all providers.	N/A
A4534	YOUTH-SIZED INCONT PRODUCT BRF EA	This is no longer a valid code.	N/A
A4537	UNDER PAD REUSBL/WASHABLE ANY SZ EA	This is no longer a valid code.	N/A
A4550	SURGICAL TRAYS	This service is not covered by Superior HealthPlan.	N/A
A4553	NONDISP UNDERPADS ALL SIZES	This service is not covered by Superior HealthPlan.	N/A
A4554	DISPOSABLE UNDERPADS ALL SIZES (CHUX)	Pre-authorization required for all providers.	Prior to 09/01/2019
A4555	CA TX E-STIM ELECTR/TRANSDUC	This service is not covered by Superior HealthPlan.	N/A
A4556	ELECTRODES (APNEA MONITOR)	No pre-authorization is required for all providers.	N/A
A4557	LEAD WIRES (APNEA MONITOR)	No pre-authorization is required for all providers.	N/A
A4558	CONDUCTIVE GEL OR PASTE FOR USE WITH ELECTRICAL DEVICE	No pre-authorization is required for all providers.	N/A
A4559	COUPLING GEL OR PASTE, FOR USE W ULTRASOUND DEVICE, PER OZ	This service is not covered by Superior HealthPlan.	N/A
A4560	PESSARY	No pre-authorization is required for all providers.	N/A
A4561	PESSARY RUBBER ANY TYPE	No pre-authorization is required for all providers.	N/A
A4562	PESSARY NON RUBBER ANY TYPE	No pre-authorization is required for all providers.	N/A
A4563	RECTAL CNTRL SYS VAG INSRV LT USE ANY TYPE EA	This service is not covered by Superior HealthPlan.	N/A
A4565	SLINGS	No pre-authorization is required for all providers.	N/A
A4566	SHOULD SLING/VEST/ABRESTRAIN	No pre-authorization is required for all providers.	N/A
A4570	SPLINTS	Allow one per three rolling years then pre-authorization is required.	Prior to 09/01/2019
A4572	RIB BELT	No pre-authorization is required for all providers.	N/A
A4575	TOPICAL HYPERBARIC O2 CHAMBER, DISPOSABLE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4580	CAST SUPPLIES (E.G. PLASTER)	This service is not covered by Superior HealthPlan.	N/A
A4590	SPECIAL CASTING MAT (E.G. FIBERGLASS)	This service is not covered by Superior HealthPlan.	N/A
A4595	ELEC STIM SUPPLIES 2 LEAD PER MONTH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4600	SLEEVE FOR INTERMITTENT LIMB COMPRESSION DEVICE REPLACE ONLY EACH	No pre-authorization is required for all providers.	N/A
A4601	LITH ION NON PROSTH RECHARGE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4602	REPLACE LITHIUM BATTERY 1.5V	No pre-authorization is required for all providers.	N/A
A4604	TUBING W INTEGRATED HEATING ELEMENT USE W POSITIVE AIRWAY PRESSURE	This service is not covered by Superior HealthPlan.	N/A

A4605	TRACH SUCTION CATH CLOSE SYS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4606	O2 PROBE W/OXIMETER DEVICE REPLCMT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4608	TRANSTRACHEAL OXYGEN CATH	This service is not covered by Superior HealthPlan.	N/A
A4610	TRACH SUCTN CATH CLO SYS 72/> HR EA	No pre-authorization is required for all providers.	N/A
A4611	BATTERY HEAVY DUTY REPLACEMENT PT OWN VENTILATOR	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4612	BATTERY CABLES REPLACEMENT PT OWN VENTILATOR	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4613	BATTERY CHARGER REPLACEMENT PT OWN VENTILATOR	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4614	PEAK EXPIR FLOW RATE METER HAND HELD	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4615	CANNULA NASAL	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4616	TUBING OXYGEN PER FOOT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4617	MOUTH PIECE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4618	BREATHING CIRCUITS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4619	FACE TENT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4620	VARIABLE CONCENTRATION MASK	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4623	TRACHESTOMY, INNER CANNULA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4624	TRACHEAL SUCTN CATH NOT CLOS SYS EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4625	TRACH CARE KIT FOR NEW TRACHEOSTOMY	This service is not covered by Superior HealthPlan.	N/A
A4626	TRACHEOSTOMY CLEANING BRUSH EACH	This service is not covered by Superior HealthPlan.	N/A
A4627	SPACER/BAG/RESERVOIR W/WO MASK USE W/METER INHAL	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4628	OROPHARYNGEAL SUCTION CATHETER, EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4629	TRACH CARE KIT FOR ESTABLISHED TRACHEOSTOMY	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4630	REPLACE BATTERY MED NECESSARY TENS PT OWN	No pre-authorization is required for all providers.	N/A
A4632	REPL BATTERY EXT INFUS PUMP TYPE EA	No pre-authorization is required for all providers.	N/A
A4633	REPLCMT BULB/LAMP UV LGHT TX SYS EA	This service is not covered by Superior HealthPlan.	N/A
A4634	REPLCMT BULB TX LGHT BOX TABOP MDL	This service is not covered by Superior HealthPlan.	N/A
A4635	UNDERARM PAD CRUTCH REPLACEMENT EACH	No pre-authorization is required for all providers.	N/A
A4636	REPLACE HANDGRIP CANE CRUTCH WALKER EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4637	REPLACE TIP CANE CRUTCH WALKER EACH	No pre-authorization is required for all providers.	N/A
A4638	REPLACEMENT BATTERY FOR PATIENT-OWNED EAR PULSE GENERATOR, EACH	This service is not covered by Superior HealthPlan.	N/A
A4639	REPL PAD INFRARED HEATING PAD SYS EA	This service is not covered by Superior HealthPlan.	N/A
A4640	REPLACE PAD MED NEC ALT PRESSURE PAD PT OWN	No pre-authorization is required for all providers.	N/A
A4641	SUPPLY RADIOPHARM DX IMAGING AGENT NOS	This service is not covered by Superior HealthPlan.	N/A
A4642	SUPPLY SATUMOMAB PENDETIDE/DOSE-NM DX IMAG AGENT	This service is not covered by Superior HealthPlan.	N/A
A4646	SUPPLY LO OSMOLAR CONTRST MAT (300-399MG IODINE)	This is no longer a valid code.	N/A
A4648	LOW OSMOLAR CONTRAST MATERIAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4649	SURGICAL SUPPLY MISC	This service is not covered by Superior HealthPlan.	N/A
A4650	CENTRIFUGE (W/CALIBRATED TUBES & SEALEASE)	Pre-authorization is required for all providers.	Prior to 09/01/2019
A4651	CALIBRATED MICROCAPILLARY TUBE EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4652	MICROCAPPILARY TUBE SEALANT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4653	PERITON DIALYSIS CATH ANCHR BELT EA	This service is not covered by Superior HealthPlan.	N/A
A4655	NEEDLES & SYRINGES DIALYSIS	No pre-authorization is required for all providers.	N/A
A4657	SYRINGE WITH OR WITHOUT NEEDLE EACH	No pre-authorization is required for all providers.	N/A
A4660	SPHYGMOMANOMETER/BP W/CUFF&STETH	No pre-authorization is required for all providers.	N/A
A4663	BLOOD PRESSURE CUFF ONLY	No pre-authorization is required for all providers.	N/A
A4670	AUTOMATIC BLOOD PRESSURE MONITOR	No pre-authorization is required for all providers.	N/A
A4671	DISPOSABLE CYCLER SET USED WITH CYCLER DIALYSIS MACHINE, EACH	This service is not covered by Superior HealthPlan.	N/A
A4672	DRAINAGE EXTENSION LINE, STERILE , FOR DIALYSIS, EACH	This service is not covered by Superior HealthPlan.	N/A
A4673	EXTENSION LINE WITH EASY LOCK CONNECTORS, USED WITH DIALYSIS	This service is not covered by Superior HealthPlan.	N/A
A4674	CHEMICALS/ANTISEPTICS SLTN USED TO CLEAN/STERILIZE DIALYSIS EQUIP/8 OZ	This service is not covered by Superior HealthPlan.	N/A
A4680	ACTIVATED CARBON FILTERS DIALYSIS	No pre-authorization is required for all providers.	N/A
A4690	DIALYZERS (ARTFCL KIDNEY) ALL BRAND/SZS PER UNIT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4700	STANDARD DIALYSATE SOLUTION EACH	This is no longer a valid code.	N/A
A4705	BICARBONATE DIALYSATE SOLUTION EACH	No pre-authorization is required for all providers.	N/A
A4706	BICARBONATE CONCENTRATE, SOLU FOR HEMODIALYSIS PER GALLON	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4707	BICARBONATE CONCENTRATE, POWDER, FOR HEMODIALYSIS, PAKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4708	ACETATE CONCENTRATE SOLUTION, HEMODIALYSIS PER GALLON	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4709	ACID CONCENTRATE, SOLUTION, HEMODIALYSIS, PER GALLON	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4712	WATER STERILE INJECTION PER 10 ML	No pre-authorization is required for all providers.	N/A
A4714	TREATED WATER USED IN DIALYSIS UNIT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4719	Y SET TUBING FOR PERITONIAL DIALYSIS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4720	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4721	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4722	DIALYSATE SOLUTION ANY CONCENTRATION OF DEXTROSE, FLUID	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4723	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4724	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4725	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4726	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4728	DIALYSATE SOLUTION, NON-DEXTROSE CONTAINING, 500 ML	This service is not covered by Superior HealthPlan.	N/A
A4730	FISTULA CANNULATION SET DIALYSIS ONLY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4735	LOCAL/TOPICAL ANESTHETICS DIALYSIS ONLY	No pre-authorization is required for all providers.	N/A
A4736	TOPICAL ANESTHETIC, FOR DIALYSIS, PER GRAM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4737	INJECTABLE ANESTHETIC, FOR DIALYSIS, PER 10 ML	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4740	SHUNT ACCESSORIES DIALYSIS ONLY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4750	BLOOD TUBING ARTERIAL/VENOUS EACH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4755	BLOOD TUBING ARTERIAL & VENOUS COMBINED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4760	DIALYSATE STANDARD TESTING SOLUTION SUPPLIES	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4765	DIALYSATE CONCENTRATE ADDITIVES EACH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4766	DIALYSATE CONCENTRATE, SOLUTION ADDITIVE FOR PERIT DIALYSIS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4770	BLOOD TEST SUPPLIES (VACUTAINERS & TUBES)	This service is not covered by Superior HealthPlan.	N/A
A4771	SERUM CLOTTING TIME TUBE PER BOX	This service is not covered by Superior HealthPlan.	N/A
A4772	DEXTOSTICK/GLUCOSE TEST STRIPS PER BOX	No pre-authorization is required for all providers.	N/A
A4773	HEMOTIX PER BOTTLE	No pre-authorization is required for all providers.	N/A
A4774	AMMONIA TEST PAPER PER BOX	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4780	STERILIZING AGENT DIALYSIS EQUIPMENT PER GALLON	No pre-authorization is required for all providers.	N/A
A4790	CLEANSING AGENTS DIALYSIS EQUIPMENT ONLY	No pre-authorization is required for all providers.	N/A
A4800	HEPARIN DIAL/ANTIDOTE PORCINE/BEEF 1000U 10-30ML	No pre-authorization is required for all providers.	N/A
A4802	PROTAMINE SULFATE, FOR HEMODIALYSIS, PER 50 MG	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4820	HEMODIALYSIS KIT SUPPLIES	No pre-authorization is required for all providers.	N/A
A4850	HEMOSTATS W/RUBBER TIPS DIALYSIS	No pre-authorization is required for all providers.	N/A
A4860	DISPOSABLE CATHETER CAPS	No pre-authorization is required for all providers.	N/A
A4870	PLUMBING/ELECTRICAL WORK HOME DIALYSIS EQUIPMENT	This service is not covered by Superior HealthPlan.	N/A
A4880	STORAGE TANK W/WATER PURIFY REPLCE DIALYSIS TANK	No pre-authorization is required for all providers.	N/A
A4890	CONTRACTS/REPAIR/MAINTENANCE HOME DIALYSIS	This service is not covered by Superior HealthPlan.	N/A
A4900	CONT AMB PERITONEAL DIALYSIS SUPPLY KIT	No pre-authorization is required for all providers.	N/A
A4901	CONT CYCLING PERITONEAL DIALYSIS SUPPLY KIT	No pre-authorization is required for all providers.	N/A
A4905	INTERMITTENT PERITONEAL DIALYSIS SUPPLY KIT	No pre-authorization is required for all providers.	N/A
A4910	NON-MEDICAL SUPPLIES DIALYSIS	No pre-authorization is required for all providers.	N/A
A4911	DRAIN BAG/BOTTLE, FOR DIALYSIS, EACH	No pre-authorization is required for all providers.	N/A
A4912	GOMCO DRAIN BOTTLE	No pre-authorization is required for all providers.	N/A
A4913	MISC DIALYSIS SUPPLIES NOT IDENTIFIED BY REPORT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4914	PREPARATION KITS	No pre-authorization is required for all providers.	N/A
A4918	VENOUS PRESSURE CLAMPS EACH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4919	DIALYZER HOLDER EACH	No pre-authorization is required for all providers.	N/A
A4920	HARVARD PRESSURE CLAMP EACH	No pre-authorization is required for all providers.	N/A
A4921	MEASURING CYLINDER ANY SIZE EACH	No pre-authorization is required for all providers.	N/A
A4927	GLOVES NON-STERILE PER 100	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4928	SURGICAL MASK PER 20	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4929	TOURNIQUET FOR DIALYSIS, EACH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A4930	GLOVES STERILE PER PAIR	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A4931	ORL THERMOMETER REUSBL ANY TYPE EA	No pre-authorization is required for all providers.	N/A
A4932	RECTAL THERMOMETER REUSBL TYPE EA	No pre-authorization is required for all providers.	N/A

A5051	OST POUCH CLOS; W/BARRIER ATTCH EA	No pre-authorization is required for all providers.	N/A
A5052	OST POUCH CLOS; W/O BARR ATTACH EA	No pre-authorization is required for all providers.	N/A
A5053	OSTOMY POUCH CLOS; USE FACEPLATE EA	No pre-authorization is required for all providers.	N/A
A5054	OST POUCH CLOS; BARRIER W/FLNGE EA	No pre-authorization is required for all providers.	N/A
A5055	STOMA CAP	No pre-authorization is required for all providers.	N/A
A5056	1 PC OST POUCH W FILTER	No pre-authorization is required for all providers.	N/A
A5057	1 PC OST POU W BUILT-IN CONV	No pre-authorization is required for all providers.	N/A
A5061	OST POUCH DRNABLE; W/BARR ATTCH EA	No pre-authorization is required for all providers.	N/A
A5062	OST POUCH DRNABL; W/O BARR ATTCH EA	No pre-authorization is required for all providers.	N/A
A5063	OST POUCH DRNABLE; BARR W/FLNGE EA	No pre-authorization is required for all providers.	N/A
A5064	POUCH DRAINABLE W/ATTACH FACEPLATE PLAST/RUBBER	No pre-authorization is required for all providers.	N/A
A5071	OST POUCH URIN; W/BARRIER ATTCH EA	No pre-authorization is required for all providers.	N/A
A5072	OST POUCH URIN; W/O BARR ATTCH EA	No pre-authorization is required for all providers.	N/A
A5073	OST POUCH URIN; BARRIER W/FLNGE EA	No pre-authorization is required for all providers.	N/A
A5074	POUCH URINARY W/FACEPLATE ATTACH PLASTIC/RUBBER	No pre-authorization is required for all providers.	N/A
A5075	POUCH URINARY USE FACEPLATE PLASTIC/RUBBER	No pre-authorization is required for all providers.	N/A
A5081	CONTINENT DEVICE PLUG CONTINENT STOMA	No pre-authorization is required for all providers.	N/A
A5082	CONTINENT DEVICE CATH CONTINENT STOMA	No pre-authorization is required for all providers.	N/A
A5083	STOMA ABSORPTIVE COVER	No pre-authorization is required for all providers.	N/A
A5093	OSTOMY ACCESSORY CONVEX INSERT	No pre-authorization is required for all providers.	N/A
A5102	BEDSIDE DRAIN BTL RIGID/EXPAND W/WO TUBING EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A5105	URINARY SUSPENSORY	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A5112	URINARY LEG BAG	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A5113	LEG STRAP LATEX REPLCE ONLY PER SET	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A5114	LEG STRAP FOAM/FABRIC REPLAC ONLY PER SET	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A5120	SKIN BARRIER WIPES OR SWABS EACH	No authorization is required for Par Providers unless over the benefits limitation.	Prior to 09/01/2019
A5121	SKIN BARRIER SOLID 6X6/EQUIVALENT EACH	No pre-authorization is required for all providers.	N/A
A5122	SKIN BARRIER SOLID 8X8/EQUIVALENT EACH	No pre-authorization is required for all providers.	N/A
A5123	SKIN BARRIER W/FLANGE ANY SIZE EACH	No pre-authorization is required for all providers.	N/A
A5126	ADHESIVE DISC/FOAM PAD	No pre-authorization is required for all providers.	N/A
A5131	APPLIANCE CLEAN (INCONTINENCE/OSTOMY) PER 16 OZ	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A5200	PERCUT CATH/TUBE ANCHOR DEV ADHES SKIN ATT	Pre-authorization required for all providers.	Prior to 09/01/2019
A5500	DIABETIC ONLY-FIT/PREP/SUPP SHOE FOR INSERT/SHOE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A5501	DIABETIC ONLY-FIT/PREP/SUPP CUST MOLD SHOE/SHOE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A5502	DIABETIC ONLY-MULTI DENSITY INSERT PER SHOE	No pre-authorization is required for all providers.	N/A
A5503	DIABETIC ONLY-MOD/FIT SHOE W/ROLL/ROCK BTM/SHOE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A5504	DIABETIC ONLY-MODIFY/FIT SHOE W/WEDGE(S)/SHOE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A5505	DIABETIC ONLY-MOD/FIT SHOE W/METATARSAL BAR/SHOE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A5506	DIABETIC ONLY-MOD/FIT SHOE W/OFF-SET HEEL/SHOE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A5507	DIABETIC ONLY-NOS MODIFY/FIT SHOE-PER SHOE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A5508	FOR DIABETICS ONLYL DELUXE FEATURE OF OFF THE SHELF DEPTH INLAY	This service is not covered by Superior HealthPlan.	N/A
A5509	FOR DIABETICS ONLY, DIRECT FORMED MODELED TO FOOT W HEAT	This is no longer a valid code.	N/A
A5510	FOR DIABETICS ONLY DIRECT FORMED, COMP MODELED	This service is not covered by Superior HealthPlan.	N/A
A5512	FOR DIABETICS ONLY MULTIPLE DENSITY INSERT DIRECT FORM MOLD FOOT PREFAB	This service is not covered by Superior HealthPlan.	N/A
A5513	DIA ONLY MX DEN INSRT CSTM FRM MDL PT FT CF EA	This service is not covered by Superior HealthPlan.	N/A
A5514	DIAB ONLY MX DEN INSRT DIRECT CARV CUSTOM FAB EA	This service is not covered by Superior HealthPlan.	N/A
A6000	NON CONTACT WOUND WARMING WOUND COVER	This service is not covered by Superior HealthPlan.	N/A
A6010	COLLAGEN BASED WOUND FILLER	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6011	COLLAGEN GEL/PASTE WOUND FIL	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6021	COLLAGEN DRESSING <=16 SQ IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6022	COLLAGEN DRSG>16<=48 SQ IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6023	COLLAGEN DRESSING >48 SQ IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6024	COLLAGEN DSG WOUND FILLER	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6025	GEL SHEET FOR DERMAL OR EPIDERMAL APP, EACH	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6154	WOUND POUCH-EA	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6196	ALGINATE DRESSING <=16 SQ IN	No pre-authorization is required for all providers.	N/A
A6197	ALGINATE DRSG >16 <=48 SQ IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6198	ALGINATE DRESSING > 48 SQ IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6199	ALGINATE DRSG WOUND FILLER	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6203	COMPOSITE DRSG <= 16 SQ IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6204	COMPOSITE DRSG >16<=48 SQ IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6205	COMPOSITE DRSG > 48 SQ IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6206	CONTACT LAYER <= 16 SQ IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6207	CONTACT LAYER >16<= 48 SQ IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6208	CONTACT LAYER > 48 SQ IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6209	FOAM DRSG <=16 SQ IN W/O BDR	No pre-authorization is required for all providers.	N/A
A6210	FOAM DRG >16<=48 SQ IN W/O B	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6211	FOAM DRG > 48 SQ IN W/O BRDR	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6212	FOAM DRG <=16 SQ IN W/BORDER	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6213	FOAM DRG >16<=48 SQ IN W/BDR	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6214	FOAM DRG > 48 SQ IN W/BORDER	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6215	FOAM DRESSING WOUND FILLER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A6216	GZE NON-IMP/STER <=16 SQ IN WO ADHES BORD-EA	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6217	GZE NON-IMP/STER >16 <=48 SQ IN WO ADHES-EA	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6218	GZE NON-IMP/STER 48 SQ IN W/O ADHES BORD-EA	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6219	GAUZE <= 16 SQ IN W/BORDER	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6220	GAUZE >16 <=48 SQ IN W/BORDR	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6221	GAUZE > 48 SQ IN W/BORDER	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6222	GAUZE <=16 IN NO W/SAL W/O B	Pre-authorization required for all providers.	Prior to 09/01/2019
A6223	GAUZE >16<=48 NO W/SAL W/O B	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6224	GAUZE > 48 IN NO W/SAL W/O B	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6228	GAUZE <= 16 SQ IN WATER/SAL	Pre-authorization required for all providers.	Prior to 09/01/2019
A6229	GAUZE >16<=48 SQ IN WATR/SAL	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6230	GAUZE > 48 SQ IN WATER/SALNE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A6231	HYDROGEL DSG<=16 SQ IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6232	HYDROGEL DSG>16<=48 SQ IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6233	HYDROGEL DRESSING >48 SQ IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6234	HYDROCOLLD DRG <=16 W/O BDR	No pre-authorization is required for all providers.	N/A
A6235	HYDROCOLLD DRG >16<=48 W/O B	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6236	HYDROCOLLD DRG > 48 IN W/O B	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6237	HYDROCOLLD DRG <=16 IN W/BDR	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6238	HYDROCOLLD DRG >16<=48 W/BDR	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6239	HYDROCOLLD DRG > 48 IN W/BDR	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6240	HYDROCOLLD DRG FILLER PASTE	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6241	HYDROCOLLOID DRG FILLER DRY	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6242	HYDROGEL DRG <=16 IN W/O BDR	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6243	HYDROGEL DRG >16<=48 W/O BDR	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6244	HYDROGEL DRG >48 IN W/O BDR	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6245	HYDROGEL DRG <= 16 IN W/BDR	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6246	HYDROGEL DRG >16<=48 IN W/B	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6247	HYDROGEL DRG > 48 SQ IN W/B	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6248	HYDROGEL DRSG GEL FILLER	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6250	SKIN SEALANTS PROTECT MOISTURIZER ANY TYPE/SIZE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A6251	ABSORPT DRG <=16 SQ IN W/O B	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6252	ABSORPT DRG >16 <=48 W/O BDR	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6253	ABSORPT DRG > 48 SQ IN W/O B	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6254	ABSORPT DRG <=16 SQ IN W/BDR	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6255	ABSORPT DRG >16<=48 IN W/BDR	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6256	ABSORPT DRG > 48 SQ IN W/BDR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A6257	TRANSPARENT FILM <= 16 SQ IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A6258	TRANSPARENT FILM >16<=48 IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019

A6259	TRANSPARENT FILM > 48 SQ IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A6260	WOUND CLEANSER ANY TYPE/SIZE	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6261	WOUND FILLER GEL/PASTE /OZ	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6262	WOUND FILLER DRY FORM / GRAM	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6263	GAUZE ELAST NON-STERILE ALL TYPES PER LINEAR YD	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6266	IMPREG GAUZE NO H2O/SAL/YARD	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6402	GAUZE NON-IMPREG STER <=16 SQ IN WO ADHES-EA	No pre-authorization is required for all providers.	N/A
A6403	GAUZE NON-IMPREG STER >16- <=48 SQ IN WO ADHES-EA	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6404	GAUZE NON-IMPREG STER >48 SQ IN WO ADHES-EA	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6405	GAUZE ELASTIC STERILE-ALL TYPES/LINEAR YD	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6407	PACKING STRIPS, NON-IMPREG	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6410	EYE PAD STERILE EACH	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6411	EYE PAD NON-STERILE EACH	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6412	EYE PATCH OCCLUSIVE EACH	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6413	ADHESIVE BANDAGE FIRST-AID	This service is not covered by Superior HealthPlan.	N/A
A6422	#N/A	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6424	CONFORM BANDGE NON-STERL >= 5 IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6428	CONFORM BANDGE STERL >= 5 IN-ROLL	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6434	MOD COMPRS BANDGE >= 3/< 5 IN-ROLL	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6438	SLF-ADHERENT BANDGE >=3&<5 IN-ROLL	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6440	ZINC PASTE IMPREG BANDGE >=3&<5 IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6441	PAD BNDG/N-ELAS/N-WVN/N-KNTTD/WIDTH>OR=TO 3 ICH&LESS 5 INCH/YARD	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6442	CNFRMNG BNDG/N-ELAS, KNTTD/WVN/N-STERILE, WIDTH LESS 3 INCH/YARD	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6443	CNF BNDG/N-ELAS/KNTTD/WVN/N-STERILE/WIDTH >OR=TO 3 IN&LESS 5 IN/YARD	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6444	CNF BNDG/N-ELAS/KNTTD/WOVEN-STERILE, WIDTH >OR=TO 5 IN/YARD	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6445	CNF BNDG/N-ELAS/KNTTD/WOVEN, STERILE, WIDTH LESS 3 IN/YARD	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6446	CNF BNDG/N-ELAS/KNTTD/WOVEN, STERILE, WIDTH >OR=3 IN&LESS 5 IN/YARD	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6447	CNF BNDG/N-ELAS/KNTTD/WVN/STERILE/WIDTH >OR=TO 5 IN/YARD	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6448	LGHT CMPRSSN BNDG/ELAS/KNTTD/WVN/WIDTH LESS 3 IN/YARD	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6449	LGHT CMPRSSN BNDG/ELAS/KNTTD/WVN/WIDTH>OR=TO 3&LESS 5 IN/YARD	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6450	LGHT CMPRSSN BNDG/ELAS/KNTTD/WVN/WIDTH>OR= TO 5 IN/YARD	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6451	MDRT CMPRSSN BNDG/ELAS/KNTTD/WVN/RSST1.25-1.34 FT@50% STRECH	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6452	HGH CMPR BNDG/ELAS/KNTTD/WVN/RSST>OR=1.35FT/50%STRT/WID>OR=3IN&LESS5IN	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6453	SELF-ADHER BNDG/ELAS/N-KNTTD/N-WVN/WIDTH LESS 3 IN/YARD	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6454	SELF-ADHET BNDG/ELAS/N-KNTTD/N-WVN/WIDTH>OR=TO 3 IN&LESS 5 IN/YARD	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6455	SELF-ADHER BNDG/ELAS/N-KNTTD/N-WVN/WIDTH>OR=TO 5 IN/YARD	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6456	ZINC PST IMPRNTD BNDG/N-ELAS/KNTTD/WVN/WIDTH>OR=TO 3 IN&LESS 5 IN/YARD	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6457	TUBULAR DRESSING W OR W/O ELASTIC ANY WIDTH /LINEAR YARD	No pre-authorization is required for all providers.	N/A
A6460	SYN RSRB WND DRSG STER PAD 16 SI/< NO ADH BO EA	This service is not covered by Superior HealthPlan.	N/A
A6461	SYN RSRB STR PAD SZ >16 SI BUT<= 48 SI NO A B E	This service is not covered by Superior HealthPlan.	N/A
A6501	COMPRS BURN GARMNT BDYSUIT CSTM FAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A6502	COMPRS BRN GARMNT CHIN STRAP CSTM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A6503	COMPRS BRN GARMNT FCE HOOD CSTM FAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A6504	COMPRS BRN GARMNT GLOV WRST CSTM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A6505	COMPRS BRN GARMNT GLOV ELB CSTM FAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A6506	COMPRS BURN GARMNT GLOV AX CSTM FAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A6507	COMPRS BRN GARMNT FT KNEE LEN CSTM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A6508	COMPRS BRN GARMNT FT THI LEN CSTM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A6509	COMPRS BRN GARMNT TRNK WAIST CSTM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A6510	COMPRS BRN GARMNT TRNK ARM LEG OPN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A6511	COMPRS BRN GARMNT LW TRNK LEG OPN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A6512	COMPRESSION BURN GARMENT NOC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A6513	COMPRESSION BURN MASK FACE AND/OR NECK PLASTIC OR EQUAL CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A6530	GRADIENT COMPRESSION STOCKING BELOW KNEE 18-30 MMHG EACH	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6531	GRADIENT COMPRESSION STOCKING BELOW KNEE 30-40 MMHG EACH	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6532	GRADIENT COMPRESSION STOCKING BELOW KNEE 40-50 MMHG EACH	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6533	GRADIENT COMPRESSION STOCKING THIGH LENGTH 18-30 MMHG EACH	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6534	GRADIENT COMPRESSION STOCKING THIGH LENGTH 30-40 MMHG EACH	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6535	GRADIENT COMPRESSION STOCKING THIGH LENGTH 40-50 MMHG EACH	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6536	GRADIENT COMPRESSION STOCKING FULL LENGTH/CHAP STYLE 18-30 MMHG	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6537	GRADIENT COMPRESSION STOCKING FULL LENGTH/CHAP STYLE 30-40 MMHG EACH	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6538	GRADIENT COMPRESSION STOCKING FULL LENGTH/CHAP STYLE 40-50 MMHG EACH	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6539	GRADIENT COMPRESSION STOCKING WAIST LENGTH 18-30 MMHG EACH	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6540	GRADIENT COMPRESSION STOCKING WAIST LENGTH 30-40 MMHG EACH	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6541	GRADIENT COMPRESSION STOCKING WAIST LENGTH 40-50 MMHG EACH	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6544	GRADIENT COMPRESSION STOCKING GARTER BELT	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6545	GRAD COMP NON-ELASTIC BK	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A6549	G COMPRESSION STOCKING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A6550	DRSSNG SET/NEG PRESS WOUND THRPY ELEC PUMP/STAT OR PORTABLE	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7000	CANISTER, DISPOSABLE, USED WITH SUCTION PUMP	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7001	CANISTER NON-DISPOSABLE USED WITH SUCTION PUMP	This service is not covered by Superior HealthPlan.	N/A
A7002	TUBING USED WITH SUCTION PUMP	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7003	ADMIN SET, W/SMALL VOLUME NONFILTERED PNEUMATIC NEBULIZER	Pre-authorization is required for Dual Long-term and Dual STAR+PLUS. For all other members, pre auth is not required unless benefit limitation has exceeded.	Prior to 09/01/2019
A7004	SMALL VOLUME NONFILTERED PNEUMATIC NEBULIZER	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7005	ADMIN SET WITH SMALL LOLUME NONFILTERED PNEUMATIC	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7006	ADMIN SET WITH SMALL VOLUME FILTERED PNEUMATC NEBULIZER	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7007	LARGE VOLUME NEBULIZER, DISPOSABLE, UNFILLED AEROSOL	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7008	LARGE VOLUME NEBULIZER DISPOSABLE PREFILLED	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7009	RESERVOIR BOTTLE NON-DISPOSABLE USED W/LARGE VOLUME ULTRASONIC NEB	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7010	CORRUGATED TUBING DISPOSABLE USED W/LARGE VOLUME NEBULIZER	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7011	CORRUGATED TUBING NON-DISP USED W/LARGE VOLUME NEBULIZER 10 FT	This is no longer a valid code.	N/A
A7012	WATER COLLECTION DEVICE USED W/LARGE VOLUME NEBULIZER	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7013	DISPOSABLE COMPRESSOR FILTER	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7014	FILTER, NON-DISPOSABLE, USED W/AEROSOL COMPRESSOR OR ULTRASONIC	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7015	AEROSOL MASK, USED WITH DME NEBULIZER	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7016	DOME AND MOUTHPIECE SMALL VOLUME ULTRASONIC NEBULIZER	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7017	NEBULIZER DURABLE GLASS OR AUTOCLAVABLE PLASTIC BOTTLE	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7018	H2O DIST USE W/LG VOL NEB 1000 ML	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7020	INTERFACE, COUGH STIM DEVICE	This service is not covered by Superior HealthPlan.	N/A
A7025	HI FREQ CHST WALL OSCILAT VEST REPL	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7026	HI FREQ CHST WALL OSCILAT HOSE REPL	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7027	COMBINATION ORAL/NASAL MASK	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7028	REPL ORAL CUSHION COMBO MASK	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7029	REPL NASAL PILLOW COMB MASK	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7030	FULL FCE MASK POS ARWAY PRSS DEV EA	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019

A7031	FCE MASK INTERFCE REPL FULL MASK EA	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7032	REPLCMT CUSHN NASL APPLIC DEVICE EA	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7033	REPL PILLWS NASL APPLIC DEVC PAIR	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7034	NASL INTERFCE POS ARWAY PRSS DEVC	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7035	HEADGEAR USED W/POS ARWAY PRSS DEVC	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7036	CHINSTRAP USE W/POS ARWAY PRSS DEVC	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7037	TUBING USED W/POS ARWAY PRESS DEVC	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7038	FLTR DISPBL W/POS ARWAY PRSS DEVC	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7039	FLTR NON DISPBL POS ARWAY PRSS DEVC	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7040	ONE WAY CHEST DRAIN VALVE	This service is not covered by Superior HealthPlan.	N/A
A7041	WATER SEAL DRAINAGE CONTAINER & TUBING	This service is not covered by Superior HealthPlan.	N/A
A7042	IMPLANTED PLEURAL CATHETER, EACH	This is no longer a valid code.	N/A
A7043	VAC DRAIN BOTTLE&TUBING W/IMPL CATH	This is no longer a valid code.	N/A
A7044	ORL INTERFCE W/POS ARWAY PRSS DEVC	This service is not covered by Superior HealthPlan.	N/A
A7045	EXHALATION PORT W/WO SWIVEL REPLACEMENT ONLY	This service is not covered by Superior HealthPlan.	N/A
A7046	WATER CHAMBER/HMDFR/USED W POS AIRWAY PRESS DVCE/RPLCMNT	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
A7047	RESP SUCTION ORAL INTERFACE	This service is not covered by Superior HealthPlan.	N/A
A7048	VACUUM DRAIN BOTTLE/TUBE KIT	No pre-authorization is required for all providers.	N/A
A7501	TRACHEOSTOMA VALV INC DIAPHRAGM EA	This service is not covered by Superior HealthPlan.	N/A
A7502	REPL DIAPHR/FACEPLTE TRACH VALV EA	This service is not covered by Superior HealthPlan.	N/A
A7503	FLTR HLDR/CAP F/HEAT/MOIST EXSX EA	This service is not covered by Superior HealthPlan.	N/A
A7504	FLTR F/USE W/TRACH HT/MOIST EXSX EA	This service is not covered by Superior HealthPlan.	N/A
A7505	HSG W/O ADH HMES &/O W/TRACH VLV EA	This service is not covered by Superior HealthPlan.	N/A
A7506	ADHES DISC FOR HMES/TRACH VALV EA	This service is not covered by Superior HealthPlan.	N/A
A7507	INT FLTR & HLDR-HMES/TRACH VALV EA	This service is not covered by Superior HealthPlan.	N/A
A7508	HSG & INT ADHES-HMES/TRACH VALV EA	This service is not covered by Superior HealthPlan.	N/A
A7509	FLTR HLDR-HSG-ADH USE AS THMES EA	This service is not covered by Superior HealthPlan.	N/A
A7520	TRACHEOSTOMY/LARYNGECTOMY TUBE/N-CFFD/(PVC)/SILICONE OR EQUAL	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7521	TRACHEOSTOMY/LARYNGECTOMY TUBE/CFFD/(PVC)/SILICONE OR EQUAL	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7522	TRACHEOSTOMY/LARYNGECTOMY TUBE/STAINL STEEL OR EQUAL	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7523	TRACHEOSTOMY SHOWER PROTECTOR, EACH	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7524	TRACHEOSTOMA STENT/STUD/BUTTON, EACH	This service is not covered by Superior HealthPlan.	N/A
A7525	TRACHEOSTOMY MASK, EACH	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members. For all other members, pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A7526	TRACHEOSTOMY TUBE COLLAR/HOLDER, EACH	No authorization is required for Par Providers unless over the benefits limitation.	Prior to 09/01/2019
A7527	TRACHEOSTOMY/LARYNGECTOMY TUBE PLUG/STOP EACH	This service is not covered by Superior HealthPlan.	N/A
A8000	HELMET PROTECTIVE SOFT PREFAB INCL ALL COMPONENTS/ACCESSORIES	No pre-authorization is required for all providers.	N/A
A8001	HELMET PROTECTIVE HARD PREFAB INCL ALL COMPONENTS & ACCESS	No pre-authorization is required for all providers.	N/A
A8002	HELMET PROTECTIVE SOFT CUSTOM FABR INCL ALL COMPONENTS/ACCESSOR	No pre-authorization is required for all providers.	N/A
A8003	HELMET PROTECTIVE HARD CUSTOM FABR INCL ALL COMPONENTS/ACCESSOR	Pre-authorization is required for all providers.	Prior to 09/01/2019
A8004	SOFT INTERFACE FOR HELMET, REPLACEMENT ONLY	No pre-authorization is required for all providers.	N/A
A9150	NON PRESCRIPTION DRUGS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A9152	SINGLE VIT/MINERAL/TRACE ELEMENT ORAL-DOSE NOS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A9153	MX VIT W/WO MINERLS&TRACE ELEMS ORL PER DOSE NOS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A9155	ARTIFICIAL SALIVA	This service is not covered by Superior HealthPlan.	N/A
A9180	NATUROPATHS	This service is not covered by Superior HealthPlan.	N/A
A9270	NON COVERED ITEM/SERVICE	This service is not covered by Superior HealthPlan.	N/A
A9272	DISPOSABLE MECH WOUND SUCT	No pre-authorization is required for all providers.	N/A
A9273	COLD/HOT FL BTL ICE CAP/C HEAT AND/ COLD WRAP ANY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A9274	EXT AMB INSULIN DELIVERY SYS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A9275	HOME GLUCOSE DISPOSABLE MONITOR INCLS TEST STRIPS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A9276	DISPOSABLE SENSOR CGM SYS	This service is not covered by Superior HealthPlan.	N/A
A9277	EXTERNAL TRANSMITTER CGM	This service is not covered by Superior HealthPlan.	N/A
A9278	EXTERNAL RECEIVER CGM SYS	This service is not covered by Superior HealthPlan.	N/A
A9279	MONITOR FEATURE/DEVICE STAND-ALONE OR INTEGRAT ANY TYPE INCL ALL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A9280	ALERT OR ALARM DEVICE, NOT OTHERWISE CLASSIFIED	This service is not covered by Superior HealthPlan.	N/A
A9281	REACHING/GRABBING DEVICE ANY TYPE ANY LENGTH EACH	This service is not covered by Superior HealthPlan.	N/A
A9282	WIG ANY TYPE EACH	This service is not covered by Superior HealthPlan.	N/A
A9283	FOOT PRESS OFF LOAD SUPP DEV	This service is not covered by Superior HealthPlan.	N/A
A9284	NON-ELECTRONIC SPIROMETER	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
A9285	INVERSION EVERSION COR DEVIC	This service is not covered by Superior HealthPlan.	N/A
A9286	ANY HYGIENIC ITEM DEVICE	This service is not covered by Superior HealthPlan.	N/A
A9300	EXERCISE EQUIPMENT	This service is not covered by Superior HealthPlan.	N/A
A9500	TC99M SESTAMIBI	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
A9501	TECHNETIUM TC-99M TEBOROXIME	This service is not covered by Superior HealthPlan.	N/A
A9502	TC99M TETROFOSMIN	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
A9503	RADIOPHARM-TECHNETIUM TC 99M MEDRONATE <=30MCI	No pre-authorization is required for all providers.	N/A
A9504	SUPPLY OF RADIOPHARMACEUTICAL DIAG IMAGING AGENT	No pre-authorization is required for all providers.	N/A
A9505	RADIOPHARM DIAG-THALLOUS CHLORIDE TL 201/MCI	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
A9507	RP DX INDIUM IN 111 CAPROMABPENDETIDE /DOSE	Pre-authorization is required for all providers.	Prior to 09/01/2019
A9508	RDIA IOBENGUANE SUL I-131P/0.5 MCI	No pre-authorization is required for all providers.	N/A
A9509	IODINE I-123 SOD IODIDE MIL	This service is not covered by Superior HealthPlan.	N/A
A9510	SUP RDIA TECHNETIUM TC99M DIS P/VL	No pre-authorization is required for all providers.	N/A
A9511	SUPPLY OF RADIOPHARMACEUTICAL DX IMAGING AGENT	No pre-authorization is required for all providers.	N/A
A9512	RADOPHRM DX TC-99M PERTECHNETAT-MCI	This service is not covered by Superior HealthPlan.	N/A
A9513	LUTETIUM LU 177 DOTATATE THERAPEUTIC 1 MCI	This service is not covered by Superior HealthPlan.	N/A
A9515	RADOPHRM DX TC-99M PENTETATE-MCI	Authorization is required for non-participating independent labs. For all other providers, no authorization is	Prior to 09/01/2019
A9516	IODINE I-123 SOD IODIDE MIC	This service is not covered by Superior HealthPlan.	N/A
A9517	RADPHRM TX I-131 SODIM IOD CAP-MCI	This service is not covered by Superior HealthPlan.	N/A
A9520	TC99 TILMANOCEPT DIAG 0.5MCI	No pre-authorization is required for all providers.	N/A
A9521	RADPHRM DX TC-99M EXETAZINE-DOSE	This service is not covered by Superior HealthPlan.	N/A
A9523	RADOPHRM TX 90-Y IBRIT TIUXETAN-MCI	No pre-authorization is required for all providers.	N/A
A9524	RADOPHRM DX I-131 SERUM ALB 5 UCI	This service is not covered by Superior HealthPlan.	N/A
A9525	SUPPLY OF LOW OR ISO-OSMOLAR CONTRAST MATERIAL, 10 MG OF IODINE	This is no longer a valid code.	N/A
A9526	SPPLY OF RADIOPHARM DIAGNOS IMAGING AGNT, AMMONIA N-13/DOSE	This service is not covered by Superior HealthPlan.	N/A
A9527	IODINE I-125 SODIUM IODIDE SOLUTION THERAPEUTIC PER MILLICURIE	This service is not covered by Superior HealthPlan.	N/A
A9528	SPPLY OF RADIOPHARM DIAGNOSTIC AGNT, I-131 SOD IODIDE CAPS/MILLICURIE	This service is not covered by Superior HealthPlan.	N/A
A9529	SPPLY OF RADIOPHARM DIAGNOS AGNT, I-131 SOD IODIDE SLTN/MILLICURIE	This service is not covered by Superior HealthPlan.	N/A
A9530	SPPLY OF RADIOPHARM THRPTC AGNT, I-131 SOD IODIDE SLTN/MILLICURIE	This service is not covered by Superior HealthPlan.	N/A
A9531	SPPLY OF RADIOPHARM DIAGNOS AGNT, I-131 SOD IODIDE/MICROCURI	This service is not covered by Superior HealthPlan.	N/A
A9532	SPLY/RADIOPHARM THRPTC AGNT, IODINTD I-125, SER ALBUMIN, 5 MICROCURIES	This service is not covered by Superior HealthPlan.	N/A
A9533	SPLY/RADIOPHARM DIAGNOS IMAGING AGNT, I-131 TOSITUMOMAB/MILLICURIE	No pre-authorization is required for all providers.	N/A
A9536	TECHNETIUM TC-99M DEPREOTIDE DIAGN STUDY DOSE UP TO 35 MILLICURIES	This service is not covered by Superior HealthPlan.	N/A
A9537	TECHNETIUM TC-99M MEBROFENIN DIAGN STUDY DOSE UP TO 15 MILLICURIES	This service is not covered by Superior HealthPlan.	N/A
A9538	TECHNETIUM TC-99M PYROPHOSPHATE DIAGNOSTIC /STUDY DOSE UP TO 25	This service is not covered by Superior HealthPlan.	N/A
A9539	TECHNETIUM TC-99M PENTETATE DIAGN STUDY DOSE UP TO 25 MILLICURIES	This service is not covered by Superior HealthPlan.	N/A
A9540	TECHNETIUM TC-99M MACROAGGREGATED ALBUMIN DIAGN STUDY DOSE UP TO 10	This service is not covered by Superior HealthPlan.	N/A
A9541	TECHNETIUM TC-99M SULFUR COLLOID ALBUMIN DIAGN STUDY DOSE UP TO 20	This service is not covered by Superior HealthPlan.	N/A
A9542	INDIUM IN-111 IBRITUMOMAB TIUXETAN DIAGNOSTIC /STUDY DOSE UP TO 5	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
A9543	YTTRIUM Y-90 IBRITUMOMAB TIUXETAN THERAPEUTIC TREATMENT DOSE UP TO 40	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A9544	IODINE I-131 TOSITUMOMAB DIAGNOSTIC /STUDY DOSE	This is no longer a valid code.	N/A
A9545	IODINE I-131 TOSITUMOMAB THERAPEUTIC /TREATMENT DOSE	This is no longer a valid code.	N/A

A9546	COBALT CO-57/58 CYANOCOBALAMIN DIAGN STUDY DOSE UP TO 1 MICROCURIE	This service is not covered by Superior HealthPlan.	N/A
A9547	INDIUM IN-111 OXYQUINOLINE DIAGNOSTIC /0.5 MILLICURIE	This service is not covered by Superior HealthPlan.	N/A
A9548	INDIUM IN-111 PENTETATE DIAGNOSTIC /0.5 MILLICURIE	This service is not covered by Superior HealthPlan.	N/A
A9549	TECHNETIUM TC-99M ARCITUMOMAB DIAGN STUDY DOSE UP TO 25 MILLICURIES	This is no longer a valid code.	N/A
A9550	TECHNETIUM TC-99M SODIUM GLUCEPTATE DIAGNOSTIC /STUDY DOSE UP TO 25	This service is not covered by Superior HealthPlan.	N/A
A9551	TECHNETIUM TC-99M SUCCIMER DIAGN STUDY DOSE UP TO 10 MILLICURIES	This service is not covered by Superior HealthPlan.	N/A
A9552	FLUORODEOXYGLUCOSE F-18 FDG DIAGN STUDY DOSE UP TO 45 MILLICURIES	This service is not covered by Superior HealthPlan.	N/A
A9553	MICROCURIUMS	This service is not covered by Superior HealthPlan.	N/A
A9554	IODINE I-125 SODIUM IOTHALAMATE DIAGNOSTIC /STUDY DOSE UP TO 10	This service is not covered by Superior HealthPlan.	N/A
A9555	RUBIDIUM RB-82 DIAGNOSTIC /STUDY DOSE UP TO 60 MILLICURIES	This service is not covered by Superior HealthPlan.	N/A
A9556	GALLIUM GA-67 CITRATE DIAGNOSTIC /MILLICURIE	This service is not covered by Superior HealthPlan.	N/A
A9557	TECHNETIUM TC-99M BICISATE DIAGNOSTIC /STUDY DOSE UP TO 25 MILLICURIES	This service is not covered by Superior HealthPlan.	N/A
A9558	XENON XE-133 GAS DIAGNOSTIC /10 MILLICURIES	This service is not covered by Superior HealthPlan.	N/A
A9559	COBALT CO-57 CYANOCOBALAMIN ORAL DIAGNOSTIC /STUDY DOSE UP TO 1	This service is not covered by Superior HealthPlan.	N/A
A9560	TECHNETIUM TC-99M LABELED RED BLOOD CELLS DIAGN STUDY DOSE UP TO 30	This service is not covered by Superior HealthPlan.	N/A
A9561	TECHNETIUM TC-99M OXIDRONATE DIAGN STUDY DOSE UP TO 30 MILLICURIES	This service is not covered by Superior HealthPlan.	N/A
A9562	TECHNETIUM TC-99M MERTIATIDE DIAGN STUDY DOSE UP TO 15 MILLICURIES	This service is not covered by Superior HealthPlan.	N/A
A9563	SODIUM PHOSPHATE P-32 THERAPEUTIC /MILLICURIE	No pre-authorization is required for all providers.	N/A
A9564	CHROMIC PHOSPHATE P-32 SUSPENSION THERAPEUTIC /MILLICURIE	No pre-authorization is required for all providers.	N/A
A9566	TECHNETIUM TC-99M FANOLESOMAB DIAGN STUDY DOSE UP TO 25 MILLICURIES	This service is not covered by Superior HealthPlan.	N/A
A9567	TECHNETIUM TC-99M PENTETATE DIAGNOSTIC AEROSOL /STUDY DOSE UP TO 75	This service is not covered by Superior HealthPlan.	N/A
A9568	TECHNETIUM TC-99M ARCITUMOMAB DIAGN PER STDOSE UP TO 45 MILLICURIES	This service is not covered by Superior HealthPlan.	N/A
A9569	TECHNETIUM TC-99M AUTO WBC	This service is not covered by Superior HealthPlan.	N/A
A9570	INDIUM IN-111 AUTO WBC	This service is not covered by Superior HealthPlan.	N/A
A9571	INDIUM IN-111 AUTO PLATELET	This service is not covered by Superior HealthPlan.	N/A
A9572	INDIUM IN-111 PENTETREOTIDE	This service is not covered by Superior HealthPlan.	N/A
A9576	INJ PROHANCE MULTIPACK	This service is not covered by Superior HealthPlan.	N/A
A9577	INJ MULTIHANCE	This service is not covered by Superior HealthPlan.	N/A
A9578	INJ MULTIHANCE MULTIPACK	This service is not covered by Superior HealthPlan.	N/A
A9579	GAD-BASE MR CONTRAST NOS 1ML	This service is not covered by Superior HealthPlan.	N/A
A9580	SODIUM FLUORIDE F-18	This service is not covered by Superior HealthPlan.	N/A
A9581	GADOXETATE DISODIUM INJ	This service is not covered by Superior HealthPlan.	N/A
A9582	IODINE I-123 IOBENGUANE	This service is not covered by Superior HealthPlan.	N/A
A9583	GADOFOSVESET TRISODIUM INJ	This service is not covered by Superior HealthPlan.	N/A
A9584	IODINE I-123 IOFLUPANE	This service is not covered by Superior HealthPlan.	N/A
A9585	GADOBUTROL INJECTION	This service is not covered by Superior HealthPlan.	N/A
A9586	FLORBETAPIR F18	This service is not covered by Superior HealthPlan.	N/A
A9587	GALLIUM GA-68	Authorization is required for non-participating independent labs. For all other providers, no authorization is	Prior to 09/01/2019
A9588	FLUCICLOVINE F-18	This service is not covered by Superior HealthPlan.	N/A
A9589	INSTILLATION HEXAMINOLEVULINATE HCI 100 MG	No pre-authorization is required for all providers.	N/A
A9590	IODINE I-131 IOBENGUANE 1 MCI	No pre-authorization is required for all providers.	N/A
A9597	PET DX FOR TUMOR ID NOC	Authorization is required for non-participating independent labs. For all other providers, no authorization is	Prior to 09/01/2019
A9598	PET DX FOR NON-TUMOR ID NOC	Authorization is required for non-participating independent labs. For all other providers, no authorization is	Prior to 09/01/2019
A9599	RP DX BETA-AL PET IMAG PER S D NOS	This is no longer a valid code.	N/A
A9600	SUPP THERAP RADIOPHRM STRONTIUM-89 CL PER MCI	Pre-authorization is required for all providers.	Prior to 09/01/2019
A9604	SM 153 LEXIDRONAM	This service is not covered by Superior HealthPlan.	N/A
A9605	RP THERAP SAMARIUM SM 153 LEXIDRONAMM 50 MCL	No pre-authorization is required for all providers.	N/A
A9606	RADIUM RA223 DICHLORIDE THER	No pre-authorization is required for all providers.	N/A
A9698	NON-RADIOACTIVE CONTRAST IMAGING MATERIAL NOC /STUDY	This service is not covered by Superior HealthPlan.	N/A
A9699	SPL RADOPHRM TX IMAG AGT NOC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A9700	SUP OF INJ CONTRST MAT-ECHO P/STUDY	No pre-authorization is required for all providers.	N/A
A9900	MISC SUPPLY ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
A9901	DELIVERY SET UP AND/OR DISPENSING SERVICE	This service is not covered by Superior HealthPlan.	N/A
A9999	MISCELLANEOUS DME SUPPLY OR ACCESSORY, NOT OTHERWISE SPECIFIED	This service is not covered by Superior HealthPlan.	N/A
B4034	ENTER FEED SUPKIT SYR BY DAY	Pre-authorization required for all providers.	Prior to 09/01/2019
B4035	ENTERAL FEED SUPP PUMP PER D	Pre-authorization required for all providers.	Prior to 09/01/2019
B4036	ENTERAL FEED SUP KIT GRAV BY	Pre-authorization required for all providers.	Prior to 09/01/2019
B4053	PUMP BAGS - 30 PER CASE	No pre-authorization is required for all providers.	N/A
B4081	NASOGASTRIC TUBING W/STYLET	Pre-authorization required for all providers.	Prior to 09/01/2019
B4082	NASOGASTRIC TUBING WO STYLET	Pre-authorization required for all providers.	Prior to 09/01/2019
B4083	STOMACH TUBE LEVINE TYPE	Pre-authorization required for all providers.	Prior to 09/01/2019
B4084	GASTROSTOMY/JEJUNOSTOMY TUBING	No pre-authorization is required for all providers.	N/A
B4085	GASTROSTOMY TUBE, SLCN W/SLIDING RING, EA	No pre-authorization is required for all providers.	N/A
B4086	GASTROSTOMY/JEJUNOSTOMY TUBE ANY MATERIAL	No pre-authorization is required for all providers.	N/A
B4087	GASTRO/JEJUNO TUBE STD	Pre-authorization required for all providers.	Prior to 09/01/2019
B4088	GASTRO/JEJUNO TUBE LOW-PRO	Pre-authorization required for all providers.	Prior to 09/01/2019
B4100	FOOD THICKENER ADMINED ORALLY-OUNCE	Pre-authorization required for all providers.	Prior to 09/01/2019
B4102	ENTRAL FORMULA ADLT REPL FLS&LYTES 500 ML = 1 U	This service is not covered by Superior HealthPlan.	N/A
B4103	ENTRAL FORMULA PED REPL FLS&LYTES 500 ML = 1 U	Pre-authorization required for all providers.	Prior to 09/01/2019
B4104	ADDITIVE FOR ENTERAL FORMULA	Pre-authorization required for all providers.	Prior to 09/01/2019
B4105	IN-LINE CART CTG DIG ENZYME ENTERAL FEEDING EA	This service is not covered by Superior HealthPlan.	N/A
B4149	ENTRAL F BLENDERIZD NAT FOODS W/INTACT NUTRIENTS	Pre-authorization required for all providers.	Prior to 09/01/2019
B4150	ENTRL FRMLA CATEG I SEMI-SYN PROTEIN 100 CAL=1U	Pre-authorization required for all providers.	Prior to 09/01/2019
B4152	ENTRL FRMLA CATEG II INTACT PROT ISO 100 CAL=1U	Pre-authorization required for all providers.	Prior to 09/01/2019
B4153	ENTRL FRMLA CATEG III HYDROLIZE PROT 100 CAL=1U	Pre-authorization required for all providers.	Prior to 09/01/2019
B4154	ENTRL FRMLA CATEG IV DEFINED FORMULA 100 CAL=1U	Pre-authorization required for all providers.	Prior to 09/01/2019
B4155	ENTRL FRMLA CATEG V MODULAR COMPONENT 100 CAL=1U	Pre-authorization required for all providers.	Prior to 09/01/2019
B4157	ENTRAL F NUTRITION CMPL INHERITED DZ METAB	Pre-authorization required for all providers.	Prior to 09/01/2019
B4158	ENTRAL F PED NUTRITION CMPL W/INTACT NUTRNTS	Pre-authorization required for all providers.	Prior to 09/01/2019
B4159	ENTRAL F PED NUTRITN CMPL SOY BASD INTCT NUTRNTS	Pre-authorization required for all providers.	Prior to 09/01/2019
B4160	ENTRAL F PED NUTRITION CMPL CAL DENSE NUTRNTS	Pre-authorization required for all providers.	Prior to 09/01/2019
B4161	ENTRAL F PED HYDROLYZED/AA&PEPTIDE CHAIN PROT	Pre-authorization required for all providers.	Prior to 09/01/2019
B4162	ENTRAL F PED SPCL METAB NEEDS INHERITED DZ METAB	Pre-authorization required for all providers.	Prior to 09/01/2019
B4164	PARENTERAL NUTRITION CARBO 50% /LESS HOMEMIX	Pre-authorization required for all providers.	Prior to 09/01/2019
B4168	PARENTERAL NUTRITION AMINO ACID 3.5% HOMEMIX	Pre-authorization required for all providers.	Prior to 09/01/2019
B4172	PARENTERAL NUTRITION AMINO ACID 5.5-7% HOMEMIX	Pre-authorization required for all providers.	Prior to 09/01/2019
B4176	PARENTERAL NUTRITION AMINO ACID 7-8.5% HOMEMIX	Pre-authorization required for all providers.	Prior to 09/01/2019
B4178	PARENTERAL NUTRITION AMINO ACID 8.5% MIN HOMEMIX	Pre-authorization required for all providers.	Prior to 09/01/2019
B4180	PARENTERAL NUTRITION CARBO MORE 50% HOMEMIX	Pre-authorization required for all providers.	Prior to 09/01/2019
B4184	PARENTERAL NUTRITION LIPIDS 10% W/ADMIN SET	This is no longer a valid code.	N/A
B4185	PARENTERAL NUTRITION SOL NOS 10 GRAMS LIPIDS	Pre-authorization required for all providers.	Prior to 09/01/2019
B4186	PARENTERAL NUTRITION LIPIDS 20% W/ADMIN SET	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
B4187	OMEGAVEN 10 G LIPIDS	Pre-authorization required for all providers.	Prior to 09/01/2019
B4189	PARENTERAL NUTRITION COMPOUND 10-51 GMS PROTEIN	Pre-authorization required for all providers.	Prior to 09/01/2019
B4193	PARENTERAL NUTRITION COMPOUND 52-73 GMS PROTEIN	Pre-authorization required for all providers.	Prior to 09/01/2019
B4197	PARENTERAL NUTRITION COMPOUND 74-100 GMS PROTEIN	Pre-authorization required for all providers.	Prior to 09/01/2019
B4199	PARENTERAL NUTRITION COMPOUND OVER 100 GM PROT	Pre-authorization required for all providers.	Prior to 09/01/2019
B4216	PARENTERAL NUTRITION ADDITIVES HOMEMIX PER DAY	Pre-authorization required for all providers.	Prior to 09/01/2019
B4220	PARENTERAL NUTRITION SUPPLY KIT PREMIX PER DAY	Pre-authorization required for all providers.	Prior to 09/01/2019
B4222	PARENTERAL NUTRITION SUPPLY KIT HOME MIX PER DAY	Pre-authorization required for all providers.	Prior to 09/01/2019
B4224	PARENTERAL NUTRITION ADMIN KIT PER DAY	Pre-authorization required for all providers.	Prior to 09/01/2019
B4804	ENTERAL THERAPY SUPPLY-GASTR/JEJU TUBE-SPEC LNGTH/MANUF/BRAND	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
B5000	PARENTERAL SOL RENAL-AMIROSY	Pre-authorization required for all providers.	Prior to 09/01/2019
B5100	PARENTERAL SOLUTION HEPATIC	Pre-authorization required for all providers.	Prior to 09/01/2019
B5200	PARENTERAL SOL HEPATIC FREAM	Pre-authorization required for all providers.	Prior to 09/01/2019
B9000	ENTERAL NUTRITION INFUSION PUMP WO ALARM	Pre-authorization required for all providers.	Prior to 09/01/2019
B9002	ENTERAL NUTR INFUSION PUMP ANY TYPE	Pre-authorization required for all providers.	Prior to 09/01/2019
B9004	PARENTERAL NUTRITION INFUSION PUMP PORTABLE	Pre-authorization required for all providers.	Prior to 09/01/2019
B9006	PARENTERAL NUTRITION INFUSION PUMP STATIONARY	Pre-authorization required for all providers.	Prior to 09/01/2019
B9998	NOC ENTERAL SUPPLIES	Pre-authorization is required for all providers.	Prior to 09/01/2019
B9999	NOC PARENTERAL SUPPLIES	Pre-authorization required for all providers.	Prior to 09/01/2019

C1000	PERCLOSE CLO ART VAS CLO DEV	No pre-authorization is required for all providers.	N/A
C1001	Amp lower extremity M >=64.50.,comorbidity in tier 2	No pre-authorization is required for all providers.	N/A
C1003	Amp lower extremity M >=47.50 and M <55.50.,comorbidity in tier 2	No pre-authorization is required for all providers.	N/A
C1004	Amp lower extremity M <47.50.,comorbidity in tier 2	No pre-authorization is required for all providers.	N/A
C1006	ARRAY MUL SIL POST CHMBR IO LENS	No pre-authorization is required for all providers.	N/A
C1007	PENILE PROSTH	No pre-authorization is required for all providers.	N/A
C1008	STENT URETHRAL PERMANENT UROLUME	No pre-authorization is required for all providers.	N/A
C1009	PLASMA CRYOPRECIPITATE REDUC EA	No pre-authorization is required for all providers.	N/A
C1011	PLTLT HLA-MTCHD LEUKORD A-/PHERESIS	No pre-authorization is required for all providers.	N/A
C1012	PLATELET CONC LEUKOREDUC IRRAD	No pre-authorization is required for all providers.	N/A
C1016	WHOL BLD/RBCS LEUKORDUC FRZN WASH	No pre-authorization is required for all providers.	N/A
C1019	PLTLT LEUKOREDUC IRRAD A-/PHERESIS	No pre-authorization is required for all providers.	N/A
C1021	RBCS LEUKOCYTE-RDUC CMV NEG EA U	No pre-authorization is required for all providers.	N/A
C1024	QUINOPRISTIN/DALFOPRISTIN 10ML	No pre-authorization is required for all providers.	N/A
C1025	CATH MARINR CS CATH	No pre-authorization is required for all providers.	N/A
C1026	CATH ABLATN RF PRFRMR 5F RF MARINR	No pre-authorization is required for all providers.	N/A
C1027	MAGIC SLF-EXPD COR X/SHORT RAD 14MM	No pre-authorization is required for all providers.	N/A
C1028	PRECISION TWIST TRANSVAG ANCHOR SYS	No pre-authorization is required for all providers.	N/A
C1029	CNTRL RAD EXP BALL DIL CATH	No pre-authorization is required for all providers.	N/A
C1030	CATH BALL DIL MARSHAL BLUE MAX 20	No pre-authorization is required for all providers.	N/A
C1031	MR COMPAT/MOD LEVEEN NDL ELECTRODE	This is no longer a valid code.	N/A
C1033	SONICATH US IMG CATH	No pre-authorization is required for all providers.	N/A
C1034	COR ANGIOP SURPASS SUPRFUSN CATH	No pre-authorization is required for all providers.	N/A
C1035	INTRACARD ECHO ULTRA ICE CATH	No pre-authorization is required for all providers.	N/A
C1036	PORT/RESRVR IMPLNTD VAS ACCESS SYS	No pre-authorization is required for all providers.	N/A
C1037	VAXCEL CHRONIC DIALYSIS CATH	No pre-authorization is required for all providers.	N/A
C1038	ULTRACROSS COR IMAGING CATH	No pre-authorization is required for all providers.	N/A
C1039	TRACHBR ENDOPROS STNT W/UNISTEP +	No pre-authorization is required for all providers.	N/A
C1040	WALLSTENT TIPS W/UNISTEP + DEL SYS	No pre-authorization is required for all providers.	N/A
C1042	BILI ENDOPROSTH W/UNISTEP + DEL SYS	No pre-authorization is required for all providers.	N/A
C1043	ATHERECTOMY SYST COR	No pre-authorization is required for all providers.	N/A
C1045	SUP RDI A I-131 MIBG P/0.5 MCI	No pre-authorization is required for all providers.	N/A
C1047	NAVI/NOGA STAR DX DEFLECT TIP CATH	No pre-authorization is required for all providers.	N/A
C1048	GEN BIPOLAR PULSE-PROSTH GEN	No pre-authorization is required for all providers.	N/A
C1050	PROT A IMMUNOADSORP PROSORBA COL	No pre-authorization is required for all providers.	N/A
C1051	OASIS THROMBECTOMY CATH	No pre-authorization is required for all providers.	N/A
C1053	CATH DX ENSITE 3000	No pre-authorization is required for all providers.	N/A
C1054	HYDROLYSER 6F/7F MECH THROMBEC CATH	No pre-authorization is required for all providers.	N/A
C1055	TRANSESOPH 210/210-S PACNG CATH	No pre-authorization is required for all providers.	N/A
C1056	GYNECARE THERMACHOICE II CATH	No pre-authorization is required for all providers.	N/A
C1057	11-GA MICROMARK II TISS MRKR	No pre-authorization is required for all providers.	N/A
C1058	SUPPLY OF RADIOPHARMACEUTICAL DIAGNOSTIC IMAGING AGENT	No pre-authorization is required for all providers.	N/A
C1059	AUTOL CHNDROCYTS-IMPLNT-CARTICEL	No pre-authorization is required for all providers.	N/A
C1060	ACS MULTI-LNK CORON STENT+DEL SYS	No pre-authorization is required for all providers.	N/A
C1061	ACS VIKING CORONARY GUID CATH	No pre-authorization is required for all providers.	N/A
C1063	LEAD DEFIB ENDOTAK ENDURANCE EZ/RX	No pre-authorization is required for all providers.	N/A
C1064	SUPPLY OF RADIOPHARMACEUTICAL DX IMAGING AGENT	No pre-authorization is required for all providers.	N/A
C1065	SUPPLY OF RADIOPHARMACEUTICAL DX IMAGING AGENT	No pre-authorization is required for all providers.	N/A
C1067	STENT BILIARY MEGALINK BILIARY STNT	No pre-authorization is required for all providers.	N/A
C1068	PACEMAKER DUAL CHMBR PULSAR DDD	No pre-authorization is required for all providers.	N/A
C1069	PACEMAKER DUAL CHMBR DISCOVERY DR	No pre-authorization is required for all providers.	N/A
C1071	PACEMKR SC PULSAR MAX SR PULSAR SR	No pre-authorization is required for all providers.	N/A
C1072	CORONARY BALLOON DILAT CATH	No pre-authorization is required for all providers.	N/A
C1073	GYNECARE X-TRACT LAP MORCELLATOR	No pre-authorization is required for all providers.	N/A
C1074	RX14/OTW VIATRAC 18 PRPHRL DIL CATH	No pre-authorization is required for all providers.	N/A
C1075	PACEMAKER GUID LEADS	No pre-authorization is required for all providers.	N/A
C1076	VENTAK MINI SNGL CHMBR DEFIB	No pre-authorization is required for all providers.	N/A
C1077	VENTAK PRIZM VR SNGL CHMBR DEFIB	No pre-authorization is required for all providers.	N/A
C1078	DUAL CHMBR AUTO IMPLNTBL DEFIB	No pre-authorization is required for all providers.	N/A
C1080	SPLY/RADIOPHARM THRPTC IMAGING AGNT, I-131 TOSITUMAMAB/DOSE	This is no longer a valid code.	N/A
C1081	SPLY/RADIOPHARM THRPTC IMAGING AGNT, I-131 TOSITUMAMAB/DOSE	No pre-authorization is required for all providers.	N/A
C1082	SPLY/RADIOPHARM DIAG IMAGING AGNT, INDIUM-111 IBTITUMOMAB TIUXETAN/DOSE	No pre-authorization is required for all providers.	N/A
C1088	LASER OPTIC TX SYS	This is no longer a valid code.	N/A
C1089	SUP RDIAT CYNCLBLMN CO 57 .5 MCI CP	This is no longer a valid code.	N/A
C1090	SUP RDIAT INDIUM 111 CHLRIDE P/MCI	No pre-authorization is required for all providers.	N/A
C1091	SUP RDIAT INDIUM 111 OXYQLN P5/MCI	No pre-authorization is required for all providers.	N/A
C1093	TC 99M FANOLESOMAB	This is no longer a valid code.	N/A
C1094	SUP RDI A TCH TC99M ALB AGG P/VIAL	No pre-authorization is required for all providers.	N/A
C1095	SUP RDI A TECH TC 99M DEP P/VIAL	No pre-authorization is required for all providers.	N/A
C1099	SUP RDI A TECH TC 99M PYRO P/VIAL	No pre-authorization is required for all providers.	N/A
C1100	PERCUT TRNSLMNL COR ANGIO GUID WR	No pre-authorization is required for all providers.	N/A
C1101	Amp non-lower extremity M >=58.50.,comorbidity in tier 2	No pre-authorization is required for all providers.	N/A
C1102	Amp non-lower extremity M >=52.50 and M <58.50.,comorbidity in tier 2	No pre-authorization is required for all providers.	N/A
C1103	Amp non-lower extremity M <52.50.,comorbidity in tier 2	No pre-authorization is required for all providers.	N/A
C1104	CATH ABLATION RF CNDUCTR-MC4/MC5 MM	No pre-authorization is required for all providers.	N/A
C1105	PMKR DUAL CHMBR SIGMA 300 VDD	No pre-authorization is required for all providers.	N/A
C1106	NEUROSTIM PT PROGRAM	No pre-authorization is required for all providers.	N/A
C1107	CATH DX EP TORQR SOLOIST	No pre-authorization is required for all providers.	N/A
C1109	IMPLNT MITEK ANCHOR	No pre-authorization is required for all providers.	N/A
C1110	CATH DX EP STABLE MAPPER	No pre-authorization is required for all providers.	N/A
C1111	ANEURX AORTO-UNI-LIAC-STNT GFT SYS	No pre-authorization is required for all providers.	N/A
C1112	ANEURX STENT GFT SYS	No pre-authorization is required for all providers.	N/A
C1113	TALENT ENDOLUM SPRNG STNT GFT SYS	No pre-authorization is required for all providers.	N/A
C1114	TALENT SPRING STENT GFT SYS	No pre-authorization is required for all providers.	N/A
C1115	LEAD PMKR 5038S 5038 5038L	No pre-authorization is required for all providers.	N/A
C1116	LEAD PMKR CAPSURE SP NOVUS	No pre-authorization is required for all providers.	N/A
C1117	ENDOGFT SYS ANCURE ENDOGFT DEL SYS	No pre-authorization is required for all providers.	N/A
C1118	PMKR DC SIGMA 300 DR LEGACY II DR	No pre-authorization is required for all providers.	N/A
C1119	LEAD DEFIB SPRINT 6932 SPRINT 6943	No pre-authorization is required for all providers.	N/A
C1120	LEAD DEFIB SPRINT 6942 SPRINT 6945	No pre-authorization is required for all providers.	N/A
C1121	DEFIBRILLATOR IMPLNT GEM	No pre-authorization is required for all providers.	N/A
C1122	SUP RDI A TCH TC99M ARCIT P/VIAL	No pre-authorization is required for all providers.	N/A
C1123	DEFIBRILLATOR IMPLNT GEM II VR	No pre-authorization is required for all providers.	N/A
C1124	LEAD NEUROSTIM/INTERSTIM TEST KIT	No pre-authorization is required for all providers.	N/A
C1126	PMKR DUAL CHMBR KAPPA 700 DR	No pre-authorization is required for all providers.	N/A
C1129	PMKR KAPPA 700 VDD	No pre-authorization is required for all providers.	N/A
C1132	PMKR SC SIGMA 200 SR LEGACY II SR	No pre-authorization is required for all providers.	N/A
C1135	PMKR DC RATE-RESP ENTITY DR 5326L/R	No pre-authorization is required for all providers.	N/A
C1136	PMKR DC RATE-RESP AFFIN DR 5330L/R	No pre-authorization is required for all providers.	N/A
C1143	PMKR DUAL CHMBR ADDVENT 2060BL	No pre-authorization is required for all providers.	N/A
C1148	DEFIB SNGL CHMBR IMPLNT	No pre-authorization is required for all providers.	N/A
C1151	PASSIVE PLUS DX LEAD PMKR - 10 MDLS	No pre-authorization is required for all providers.	N/A
C1154	LEAD DEFIB SPL SP01 SP02 SPL 04	No pre-authorization is required for all providers.	N/A
C1156	PMKR SC AFFINITY/TEMPO/TRILOGY	No pre-authorization is required for all providers.	N/A
C1157	PMKR DUAL CHMBR TRILOGY DC+2318L	No pre-authorization is required for all providers.	N/A
C1160	LEAD DEFIB TVL-ADX 1559/65	No pre-authorization is required for all providers.	N/A
C1164	BRACHYTHERAP SEED I-125 SEED	No pre-authorization is required for all providers.	N/A
C1170	BX DEVICE BREAST ABBI DEVICE	No pre-authorization is required for all providers.	N/A
C1174	BARD BRACHSTAR BRACHYTHERAP NEEDLE	No pre-authorization is required for all providers.	N/A
C1175	BX DEVICE MIBB DEVICE	This is no longer a valid code.	N/A
C1176	MAMMOTOME HH HND-HLD PRB W/SMRTVAC	This is no longer a valid code.	N/A

C1178	INJECTION BUSULFAN PER 6 MG	This is no longer a valid code.	N/A
C1179	14-GA MAMMOTOME PROBE W/VACUUM CAN	No pre-authorization is required for all providers.	N/A
C1188	SODIUM IODIDE I-131 PER UCI	No pre-authorization is required for all providers.	N/A
C1200	SUP RDIAT TC99M NA GLUCOHEPTONATE	This is no longer a valid code.	N/A
C1300	HYPRB O2 UNDR PRES FBC P/30 MIN	This is no longer a valid code.	N/A
C1305	Rheumatoid other arthritis M <51.50 and A <64.50.,comorbidity in tier 2	This is no longer a valid code.	N/A
C1306	NEUROSTIM CYBRNCS NEURCYB PROS LEAD	No pre-authorization is required for all providers.	N/A
C1315	PACEMAKER DC VIGOR DR MERIDIAN DR	No pre-authorization is required for all providers.	N/A
C1319	STNT ENT ENDOPROS &UNISTEP DEL-60MM	No pre-authorization is required for all providers.	N/A
C1321	ELECTRDE DISP PALATE/BASE OF TONGUE	This is no longer a valid code.	N/A
C1322	DIS TURBinate SOMNPLSTY COAG ELCTRDR	No pre-authorization is required for all providers.	N/A
C1323	DIS VAPR ELECTROD/T THERML ELECTROD	No pre-authorization is required for all providers.	N/A
C1324	LIGASURE DISPOSABLE ELECTRODE	This is no longer a valid code.	N/A
C1326	ANGIOJET RHEOLYTIC THROMBECT CATH	No pre-authorization is required for all providers.	N/A
C1329	VERSAPOINT RESECTOSCP DIS ELECTRDE	This is no longer a valid code.	N/A
C1333	PALMAZ CORINTHIAN BILI STNT + DEL	No pre-authorization is required for all providers.	N/A
C1335	MESH PROLENE POLYPROPYLENE HERN SYS	No pre-authorization is required for all providers.	N/A
C1336	CNSTNT FLW IMP INFUS PMP W/SAFTY VA	No pre-authorization is required for all providers.	N/A
C1350	BRACHYTHER P/SOUCE PROSTASEED I-125	No pre-authorization is required for all providers.	N/A
C1353	ITREL III/SOLETRA IMP NEUROSTIM&EXT	No pre-authorization is required for all providers.	N/A
C1354	PMKR DC KAPPA 400DR DIAMOND I182DR	No pre-authorization is required for all providers.	N/A
C1355	PMKR DC KAPPA 600 DR VITA DR	No pre-authorization is required for all providers.	N/A
C1356	DEFIB SC IMPLNT PROFILE MD V-186HV3	No pre-authorization is required for all providers.	N/A
C1357	DEFIB SC IMPLNT ANGSTROM V-190HV3	No pre-authorization is required for all providers.	N/A
C1358	DC PMKR NON-RATE RESP AFFINITY DC	No pre-authorization is required for all providers.	N/A
C1359	PMKR DC PULSAR DR PULSAR MAX DR	No pre-authorization is required for all providers.	N/A
C1360	OCULAR PHOTODYN THERAP	No pre-authorization is required for all providers.	N/A
C1361	RECORDER CARD EVENT IMPLNT	No pre-authorization is required for all providers.	N/A
C1362	HERCULINK 14/OTW SDS BILI STNT	No pre-authorization is required for all providers.	N/A
C1363	DEFIB IMPLNT DUAL CHMBR GEM DR	No pre-authorization is required for all providers.	N/A
C1364	DEFIB DUAL CHMBR PHOTON DR V-230HV3	No pre-authorization is required for all providers.	N/A
C1365	GUID WR PERIPH HI-TORQUE 14/18/35	No pre-authorization is required for all providers.	N/A
C1366	GUID WR PTCA HI-TORQUE	No pre-authorization is required for all providers.	N/A
C1367	GUID WR PTCA HI-TORQUE CROSS IT	No pre-authorization is required for all providers.	N/A
C1369	INTRNL RECVR NEUROSTIM SYST	No pre-authorization is required for all providers.	N/A
C1370	TENSION-FREE VAG TAPE FE URIN INCON	No pre-authorization is required for all providers.	N/A
C1371	SYMPHONY NITINOL BIL STNT W/MRKR	No pre-authorization is required for all providers.	N/A
C1372	SMAR CORDIS NITINOL BILI STNT + DEL	No pre-authorization is required for all providers.	N/A
C1375	NIR RANGER COR STNT DEL SYS +	No pre-authorization is required for all providers.	N/A
C1376	ANS RENEW SPINAL CORD STIM SYS LEAD	No pre-authorization is required for all providers.	N/A
C1377	LEAD NEUROSTIM SPEC 3988 LEAD	No pre-authorization is required for all providers.	N/A
C1378	INERSTIM THERAP 3080/3886 LEAD	No pre-authorization is required for all providers.	N/A
C1379	LEAD PISCES-QUAD COMPACT 3887 LEAD	No pre-authorization is required for all providers.	N/A
C1420	STAPLETAC2 BONE ANCHOR SYS W/DERMIS	No pre-authorization is required for all providers.	N/A
C1421	STAPLETAC2 BONE ANCHR SYS WO DERMIS	No pre-authorization is required for all providers.	N/A
C1450	ORTHOPHR SPHRCL INTRPOS ARTHRPLSTY	No pre-authorization is required for all providers.	N/A
C1451	ORTHO SPHRCL INTRPOS ARTHRPLSTY KIT	No pre-authorization is required for all providers.	N/A
C1500	ATHERECTOMY SYST PERIPHERAL	No pre-authorization is required for all providers.	N/A
C1700	AUTHENTIC MICK TP BRACHYTHERAP NDL	No pre-authorization is required for all providers.	N/A
C1701	Mjr multi trauma wout brain or SCI M >=57.50.,comorb in tier 2	No pre-authorization is required for all providers.	N/A
C1702	Mjr multi trauma wout brain or SCI M >=50.50 & M<57.50.,comorb in tier 2	No pre-authorization is required for all providers.	N/A
C1703	Mjr multi trauma wout brain or SCI M >=41.50 & M<50.50.,comorb in tier 2	No pre-authorization is required for all providers.	N/A
C1704	Mjr multi trauma wout brain or SCI M >=36.50 & M<41.50.,comorb in tier 2	No pre-authorization is required for all providers.	N/A
C1705	Mjr multi trauma wout brain or SCI M <36.50.,comorb in tier 2	No pre-authorization is required for all providers.	N/A
C1706	NDL BRACHYTHER INDIGO PROS SEED NDL	No pre-authorization is required for all providers.	N/A
C1707	BRACHY VARISOURCE INTRST IMPLNT NDL	No pre-authorization is required for all providers.	N/A
C1708	BRACHY UROMED PROS SEEDING NEEDLE	No pre-authorization is required for all providers.	N/A
C1709	REMINGTON MED BRACHYTHER NEEDLE	No pre-authorization is required for all providers.	N/A
C1710	BRACHY US BX PROS SEEDING NDL	No pre-authorization is required for all providers.	N/A
C1711	MD TECH P.S.S. PROST SDG SET-NDL	No pre-authorization is required for all providers.	N/A
C1712	IMAGYN MED TECH ISOTAR PROS/BT NDL	No pre-authorization is required for all providers.	N/A
C1713	ANCHOR/SCREW FOR OPPOSING BONE TO BONE OR SOFT TISSUE	This service is not covered by Superior HealthPlan.	N/A
C1714	CATHETER, TRANSLUMINAL ATHERECTOMY, DIRECTIONAL	This service is not covered by Superior HealthPlan.	N/A
C1715	BRACHYTHERAPY NEEDLE	This service is not covered by Superior HealthPlan.	N/A
C1716	BRACHYTHERAPY SOURCE, GOLD 198	This service is not covered by Superior HealthPlan.	N/A
C1717	BRACHYTHERAPY SEED, HIGH DOSE RATE IRIIDIUM 192	No pre-authorization is required for all providers.	N/A
C1718	BRACHYTHERAPY SOURCE, IODINE 125	This service is not covered by Superior HealthPlan.	N/A
C1719	BRACHYTHERAPY SOURCE, NON-HIGH DOSE RATE IRIIDIUM 192	This service is not covered by Superior HealthPlan.	N/A
C1720	BRACHYTHERAPY SOURCE, PALLADIUM 103	No pre-authorization is required for all providers.	N/A
C1721	CARDIOVERTER-DEFIBRILLATOR, DUAL CHAMBER (IMPLANTABLE)	Pre-authorization is required for all providers.	Prior to 09/01/2019
C1722	CARDIOVERTER-DEFIBRILLATOR, SINGLE CHAMBER (IMPLANTABLE)	This service is not covered by Superior HealthPlan.	N/A
C1724	CATHETER, TRANSLUMINAL ATHERECTOMY, ROTATIONAL	This service is not covered by Superior HealthPlan.	N/A
C1725	CATHETER TRANSLUMINAL ANGIOPLASTY, NON LASER	This service is not covered by Superior HealthPlan.	N/A
C1726	CATHETER, BALLOON DILATATION, NON-VASCULAR	This service is not covered by Superior HealthPlan.	N/A
C1727	CATHETER, BALLOON TISSUE DISSECTOR, NON-VASCULAR (INSERTABLE)	This service is not covered by Superior HealthPlan.	N/A
C1728	CATHETER, BRACHYTHERAPY SEED ADMINISTRATION	This service is not covered by Superior HealthPlan.	N/A
C1729	CATHETER, DRAINAGE	This service is not covered by Superior HealthPlan.	N/A
C1730	CATHETER, ELECTROPHYSIOLOGY, DX OTHER THAN 3D MAPPING	This service is not covered by Superior HealthPlan.	N/A
C1731	CATHETER, ELECTROPHYSIOLOGY DX, OTHER THAN 3D MAPPING	This service is not covered by Superior HealthPlan.	N/A
C1732	CATHETER, ELECTROPHYSIOLOGY, DX/ABLATION 3D OR VECTOR MAPPING	This service is not covered by Superior HealthPlan.	N/A
C1733	CATHETER ELECTROPHYSIOLOGY, DX/ABLATION OTHER THAN 3D	This service is not covered by Superior HealthPlan.	N/A
C1734	ORTHOPEDIC/DEVCDX MATRIX OPP BTB/SFT TISS-TO BN	This service is not covered by Superior HealthPlan.	N/A
C1748	ENDOSCOPE SINGLE-USE UPPER GI IMAG/ILLUM DEVC	This service is not covered by Superior HealthPlan.	N/A
C1749	ENDO, COLON, RETRO IMAGING	This service is not covered by Superior HealthPlan.	N/A
C1750	CATHETER, HEMODIALYSIS, LONG-TERM	This service is not covered by Superior HealthPlan.	N/A
C1751	CATHETER, INFUSION INSERTED PERIPHERALLY,CENTRALLY OR MIDDLE	This service is not covered by Superior HealthPlan.	N/A
C1752	CATHETER, HEMODIALYSIS, SHORT-TERM	This service is not covered by Superior HealthPlan.	N/A
C1753	CATHETER, INTRAVASCULAR ULTRASOUND	This service is not covered by Superior HealthPlan.	N/A
C1754	CATHETER, INTRADISCAL	This service is not covered by Superior HealthPlan.	N/A
C1755	CATHETER, INTRASPINAL	This service is not covered by Superior HealthPlan.	N/A
C1756	CATHETER, PACING, TRANSESOPHAGEAL	This service is not covered by Superior HealthPlan.	N/A
C1757	CATHETER, THROMBECTOMY/EMBOLECTOMY	This service is not covered by Superior HealthPlan.	N/A
C1758	CATHETER, URETERAL	This service is not covered by Superior HealthPlan.	N/A
C1759	CATHETER, INTRACARDIAC ECHOCARDIOGRAPHY	This service is not covered by Superior HealthPlan.	N/A
C1760	CLOSURE DEVICE, VASCULAR (IMPLANTABLE/INSERTABLE)	This service is not covered by Superior HealthPlan.	N/A
C1762	CONNECTIVE TISSUE, HUMAN (INCLUDES FASCIA LATA)	This service is not covered by Superior HealthPlan.	N/A
C1763	CONNECTIVE TISSUE, NON-HUMAN (INCLUDES SYNTHETIC)	This service is not covered by Superior HealthPlan.	N/A
C1764	EVENT RECORDER, CARDIAC (IMPLANTABLE)	This service is not covered by Superior HealthPlan.	N/A
C1765	ADHESION BARRIER	This service is not covered by Superior HealthPlan.	N/A
C1766	INTRODUCER / SHEATH	This service is not covered by Superior HealthPlan.	N/A
C1767	GENERATOR, NEUROSTIMULATOR (IMPLANTABLE)	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
C1768	GRAFT, VASCULAR	This service is not covered by Superior HealthPlan.	N/A
C1769	GUIDE WIRE	This service is not covered by Superior HealthPlan.	N/A
C1770	IMAGING COIL, MAGNETIC RESONANCE (INSERTABLE)	This service is not covered by Superior HealthPlan.	N/A
C1771	REPAIR DEVICE, URINARY, INCONTINENCE, WITH SLING GRAFT	This service is not covered by Superior HealthPlan.	N/A
C1772	INFUSION PUMP, PROGRAMMABLE (IMPLANTABLE)	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
C1773	RETRIEVAL DEVICE	This service is not covered by Superior HealthPlan.	N/A
C1775	RADOPHRM DX FLUORODEOXYGLU F18-DOSE	No pre-authorization is required for all providers.	N/A
C1776	JOINT DEVICE (IMPLANTABLE)	This service is not covered by Superior HealthPlan.	N/A
C1777	LEAD, CARDIOVERTER-DEFIBRILLATOR,ENDO SINGLE COLL	This service is not covered by Superior HealthPlan.	N/A
C1778	LEAD, NEUROSTIMULATOR (IMPLANTABLE)	This service is not covered by Superior HealthPlan.	N/A

C1779	LEAD, PACEMAKER, TRANSVENOUS VDD SINGLE PASS	This service is not covered by Superior HealthPlan.	N/A
C1780	LENS, INTRAOCULAR (NEW TECHNOLOGY)	This service is not covered by Superior HealthPlan.	N/A
C1781	MESH (IMPLANTABLE)	This service is not covered by Superior HealthPlan.	N/A
C1782	MORCELLATOR	This service is not covered by Superior HealthPlan.	N/A
C1783	OCULAR IMPL AQUEOUS DRAIN ASST DEVC	This service is not covered by Superior HealthPlan.	N/A
C1784	OCULAR DEVICE, INTRAOPERATIVE, DETACHED RETINA	This service is not covered by Superior HealthPlan.	N/A
C1785	PACEMAKER, DUAL CHAMBER, RATE-RESPONSIVE (IMPLANTABLE)	This service is not covered by Superior HealthPlan.	N/A
C1786	PACEMAKER, SINGLE CHAMBER, RATE-RESPONSIVE (IMPLANTABLE)	This service is not covered by Superior HealthPlan.	N/A
C1787	PATIENT PROGRAMMER, NEUROSTIMULATOR	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
C1788	PORT, INDWELLING (IMPLANTABLE)	This service is not covered by Superior HealthPlan.	N/A
C1789	PROSTHESIS, BREAST (IMPLANTABLE)	This service is not covered by Superior HealthPlan.	N/A
C1790	BT SEED NUCLETROM IRIIDIUM 192 HDR	No pre-authorization is required for all providers.	N/A
C1791	BRACHY SEED NYCOMED AMERSHAM I-125	No pre-authorization is required for all providers.	N/A
C1792	BRACHY SEED UROMED SYMMETRA I-125	No pre-authorization is required for all providers.	N/A
C1793	BRD INSRC 103 PALLAD SD 1031L/1031C	No pre-authorization is required for all providers.	N/A
C1794	BARD ISO 103 PAL PD3S111L/PD3S111P	No pre-authorization is required for all providers.	N/A
C1795	BARD BRACHYSRC 125 IO-1251L 1251C	No pre-authorization is required for all providers.	N/A
C1796	TECH MEDICAL I-125 SEED-STM 1251	No pre-authorization is required for all providers.	N/A
C1797	DRAXIMAGE I-125 SEED LS-1	No pre-authorization is required for all providers.	N/A
C1798	SYNCOR I-125 PHARMASEED BT-125-1	No pre-authorization is required for all providers.	N/A
C1799	I-PLANT IODINE 125 MODEL 3500	No pre-authorization is required for all providers.	N/A
C1800	MENTOR PDGOLD PD-103	No pre-authorization is required for all providers.	N/A
C1801	Mjr multi trauma w brain or SCI M >=67.50,comorb in tier 2	No pre-authorization is required for all providers.	N/A
C1802	Mjr multi trauma w brain or SCI M >=55.50 and M <67.50,comorb in tier 2	No pre-authorization is required for all providers.	N/A
C1803	Mjr multi trauma w brain or SCI M >=45.50 and M <55.50,comorb in tier 2	No pre-authorization is required for all providers.	N/A
C1804	Mjr multi trauma w brain or SCI M >=40.50 and M <45.50,comorb in tier 2	No pre-authorization is required for all providers.	N/A
C1805	Mjr multi trauma w brain or SCI M >=30.50 and M <40.50,comorb in tier 2	No pre-authorization is required for all providers.	N/A
C1806	Mjr multi trauma w brain or SCI M <30.50,comorb in tier 2	No pre-authorization is required for all providers.	N/A
C1810	D114S OVER-WR BALL DILAT CATH	No pre-authorization is required for all providers.	N/A
C1811	SURG DYN ANCHRS + 2.0/3.0MM	No pre-authorization is required for all providers.	N/A
C1812	ANCHORS OBL 2.0MM/2.8MM HS/+	No pre-authorization is required for all providers.	N/A
C1813	PROSTHESIS, PENILE, INFLATABLE	This service is not covered by Superior HealthPlan.	N/A
C1814	RETINAL TAMPONADE DEVICE, SILICONE OIL	This service is not covered by Superior HealthPlan.	N/A
C1815	PROSTHESIS, URINARY SPHINCTER (IMPLANTABLE)	This service is not covered by Superior HealthPlan.	N/A
C1816	RECEIVER AND/OR TRANSMITTER, NEUROSTIMULATOR (IMPLANTABLE)	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
C1817	SEPTAL DEFECT IMPLANT SYSTEM, INTRACARDIAC	This service is not covered by Superior HealthPlan.	N/A
C1818	INTEGRATED KERATOPROSTHESIS	This service is not covered by Superior HealthPlan.	N/A
C1819	TISSUE LOCALIZATION EXCISION	This service is not covered by Superior HealthPlan.	N/A
C1820	GEN NEUROSTIM RECHRG BATT&CHARG SYS	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
C1821	INTERSPINOUS PROCESS DISTRACTION DEVICE (IMPLANTABLE)	This service is not covered by Superior HealthPlan.	N/A
C1822	GEN NEUROSTIM HI FREQ RECHARG BATT	This service is not covered by Superior HealthPlan.	N/A
C1823	GENERATR NEUROSTIM NON-RECHRGABL TV S AND STIM LEADS	This service is not covered by Superior HealthPlan.	N/A
C1824	GENERATOR CARDIAC CONTRACTILITY MODULATION	This service is not covered by Superior HealthPlan.	N/A
C1830	POWER BONE MARROW BX NEEDLE	This service is not covered by Superior HealthPlan.	N/A
C1839	IRIS PROSTHESIS	No pre-authorization is required for all providers.	N/A
C1840	TELESCOPIC INTRAOCULAR LENS	No pre-authorization is required for all providers.	N/A
C1842	RETINAL PROSTH, ADD-ON	This service is not covered by Superior HealthPlan.	N/A
C1849	SKIN SUBSTITUTE SYNTHETIC RESORBABLE PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
C1850	REPLIFORM TIS REG MAT P/14/21 SQ CM	No pre-authorization is required for all providers.	N/A
C1851	REPLIFORM TIS REG MAT P/24/28 SQ CM	No pre-authorization is required for all providers.	N/A
C1852	TRANSCYTE P/247 SQUARE CENTIMETERS	No pre-authorization is required for all providers.	N/A
C1853	SUSPEND TPFL P/8/14 SQ CM	No pre-authorization is required for all providers.	N/A
C1854	SUSPEND TPFL P/24/28 SCM	No pre-authorization is required for all providers.	N/A
C1855	SUSPEND TPFL P/36 SQ CM	No pre-authorization is required for all providers.	N/A
C1856	SUSPEND TPFL P/48 SQ CM	No pre-authorization is required for all providers.	N/A
C1857	SUSPEND TPFL P/84 SQ CM	No pre-authorization is required for all providers.	N/A
C1858	DURADERM ACE ALLOGRFT P/8/14 SQ CM	No pre-authorization is required for all providers.	N/A
C1859	DURADERM ACE ALO P/21 24 / 28 SQ CM	No pre-authorization is required for all providers.	N/A
C1860	DURADERM ACE ALLO P/48 SQ CM	No pre-authorization is required for all providers.	N/A
C1861	DURADERM ACE ALLO P/36 SQ CM	No pre-authorization is required for all providers.	N/A
C1862	DURADERM ACE ALLO P/72 SQ CM	No pre-authorization is required for all providers.	N/A
C1863	DURADERM ACE ALLO P/84 SQ CM	No pre-authorization is required for all providers.	N/A
C1864	BARD SPERMA TEX MSH P/13.44 SQ CM	No pre-authorization is required for all providers.	N/A
C1865	BARD FASLATA ALLO TISS P/8/14 SQ CM	No pre-authorization is required for all providers.	N/A
C1866	BARD FAS ALLO TISS P/24/28 SQ CM	No pre-authorization is required for all providers.	N/A
C1867	BARD FAS ALLO TISS P/36/48 SQ CM	No pre-authorization is required for all providers.	N/A
C1868	FASLATA ALLOGFT TISS P/96 SQ CM	No pre-authorization is required for all providers.	N/A
C1869	GORE THYROPLASTY DEVICE	No pre-authorization is required for all providers.	N/A
C1870	DERMMATRIX SURG MESH P/16 SQ CM	No pre-authorization is required for all providers.	N/A
C1871	DERMMATRIX SURG MESH P/32/64 SQ CM	No pre-authorization is required for all providers.	N/A
C1872	DERMAGFT P/37.5 SQ CM	No pre-authorization is required for all providers.	N/A
C1873	BARD 3DMAX MESH MED/LG SIZE	No pre-authorization is required for all providers.	N/A
C1874	STENT, COATED/COVERED, WITH DELIVERY SYSTEM	This service is not covered by Superior HealthPlan.	N/A
C1875	STENT, COATED/COVERED, WITHOUT DELIVERY SYSTEM	This service is not covered by Superior HealthPlan.	N/A
C1876	STENT, NON-COATED/NON-COVERED, WITH DELIVERY SYSTEM	This service is not covered by Superior HealthPlan.	N/A
C1877	STENT, NON-COATED/NON-COVERED, WITHOUT DELIVERY SYSTEM	This service is not covered by Superior HealthPlan.	N/A
C1878	MATERIAL FOR VOCAL CORD MEDIALIZATION, SYNTHETIC (IMPLANTABLE)	This service is not covered by Superior HealthPlan.	N/A
C1879	TISSUE MARKER (IMPLANTABLE)	This is no longer a valid code.	N/A
C1880	VENA CAVA FILTER	This service is not covered by Superior HealthPlan.	N/A
C1881	DIALYSIS ACCESS SYSTEM (IMPLANTABLE)	This service is not covered by Superior HealthPlan.	N/A
C1882	CARDIOVERTER DEFIBRILATOR IMPLANTABLE	This service is not covered by Superior HealthPlan.	N/A
C1883	ADAPTOR/EXTENSION, PACING LEAD OR NEUROSTIMULATOR LEAD (IMPLANTABLE)	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
C1884	EMBOLIZATION PROTECTIVE SYSTEM	This service is not covered by Superior HealthPlan.	N/A
C1885	CATHETER, TRANSLUMINAL ANGIOPLASTY, LASER	This service is not covered by Superior HealthPlan.	N/A
C1886	CATHETER, ABLATION	This service is not covered by Superior HealthPlan.	N/A
C1887	CATHETER, GUIDING (MAY INCLUDE INFUSION/PERFUSION CAPABILITY)	This service is not covered by Superior HealthPlan.	N/A
C1888	CATH ABLATION NON-CARDIAC ENDOVASC	This service is not covered by Superior HealthPlan.	N/A
C1889	IMPLANTABLE/INSERTABLE DEVICE NOT OTRW CLASS	This service is not covered by Superior HealthPlan.	N/A
C1890	NO IMPLANT/INSERTABLE DEVC USED W/DEVC-INT PROC	No authorization required. Code is for informational purposes only.	N/A
C1891	INFUSION PUMP, NON-PROGRAMMABLE, PERMANENT (IMPLANTABLE)	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
C1892	INTRODUCER/SHEATH, GUIDING INTRACARDIAC FIXED CURVE PEEL AWAY	This service is not covered by Superior HealthPlan.	N/A
C1893	INTRODUCER/SHEATH, OTHER THAN PEEL AWAY	This service is not covered by Superior HealthPlan.	N/A
C1894	INTINTRODUCER/SHEATH, NON LASER	This service is not covered by Superior HealthPlan.	N/A
C1895	LEAD, CARDIOVERTER-DEFIBRILLATOR, ENDOCARDIAL DUAL COIL (IMPLANTABLE)	This service is not covered by Superior HealthPlan.	N/A
C1896	LEAD CARDIOVERTER-DEFIBRILATOR	This service is not covered by Superior HealthPlan.	N/A
C1897	LEAD, NEUROSTIMULATOR TEST KIT (IMPLANTABLE)	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
C1898	LEAD, PACEMAKER, OTHER THAN TRANSVENOUS VDD SINGLE PASS	This service is not covered by Superior HealthPlan.	N/A
C1899	LEAD, PACEMAKER/CARDIOVERTER-DEFIBRILLATOR COMBINATION (IMPLANTABLE)	This service is not covered by Superior HealthPlan.	N/A
C1900	LEAD LT VENTRICULAR CORON VENUS SYS	This service is not covered by Superior HealthPlan.	N/A
C1929	MAVERICK MONORAIL/OVER-WR PTCA CATH	No pre-authorization is required for all providers.	N/A
C1930	COYOTE DIL PTCA CATH 20/30/40MM	No pre-authorization is required for all providers.	N/A
C1931	CATH TALON BALL DILAT CATH	No pre-authorization is required for all providers.	N/A
C1932	COR BALL DIL INFUS CATH/20MM	No pre-authorization is required for all providers.	N/A
C1933	CATH OPTI-PLAST CENTURION/XL CATHS	No pre-authorization is required for all providers.	N/A
C1934	ULTRAVERSE 3.5F BALL DILATATN CATH	No pre-authorization is required for all providers.	N/A
C1935	WORKHORSE PTA BALLOON CATH	No pre-authorization is required for all providers.	N/A
C1936	ULTRA HI PRESS BALL DIL CATH W/HYD+	No pre-authorization is required for all providers.	N/A
C1937	SYNERGY BALL DIL CATH EXPLORR ST 6F	No pre-authorization is required for all providers.	N/A
C1938	BARD UROFORCE BALL DILATATN CATH	No pre-authorization is required for all providers.	N/A
C1939	SYNERGY BALL/PTCA DILATATN CATHS	No pre-authorization is required for all providers.	N/A
C1940	CATH POWERFLEX EXTREM PTA BALL +	No pre-authorization is required for all providers.	N/A

C1941	CATH JUPITER PTA BALL DILATATN CATH	No pre-authorization is required for all providers.	N/A
C1942	CATH CORDIS MAXI LD PTA BALL CATH	No pre-authorization is required for all providers.	N/A
C1943	COR DILATATN CATHS-RX CROSSSAIL/OTW	No pre-authorization is required for all providers.	N/A
C1944	CATH RAPID EXC SU BIL BALL DIL CATH	No pre-authorization is required for all providers.	N/A
C1945	CATH CORDIS SAVVY PTA DILATATN CATH	No pre-authorization is required for all providers.	N/A
C1946	R1S RAPID EXC PRE-DILAT BALL CATH	No pre-authorization is required for all providers.	N/A
C1947	CATH GAZELLE BALLOON DILATATN CATH	No pre-authorization is required for all providers.	N/A
C1948	CATH PURSUIT BALL ANGIOPLASTY CATH	No pre-authorization is required for all providers.	N/A
C1949	ORACLE MEGASONICS 5-64F/X PTCA CATH	No pre-authorization is required for all providers.	N/A
C1979	INTRAVAS US IMAGING CATHS	No pre-authorization is required for all providers.	N/A
C1980	CATH ATLANTIS SR COR IMG CATH	No pre-authorization is required for all providers.	N/A
C1981	COR ANGIOPLASTY BALLOON CATHS	No pre-authorization is required for all providers.	N/A
C1982	CATHETER PRES GENERAT 1-WAY VALV INTERMIT OCCL	This service is not covered by Superior HealthPlan.	N/A
C2000	ORBITER ST STEERABLE ELECTRODE CATH	No pre-authorization is required for all providers.	N/A
C2001	Miscellaneous M >=66.50.,comorbidity in tier 2	No pre-authorization is required for all providers.	N/A
C2002	Miscellaneous M >=55.50 and M <66.50.,comorbidity in tier 2	No pre-authorization is required for all providers.	N/A
C2003	Miscellaneous M >=46.50 and M <55.50.,comorbidity in tier 2	No pre-authorization is required for all providers.	N/A
C2004	Miscellaneous M <46.50 and A >=77.50.,comorbidity in tier 2	No pre-authorization is required for all providers.	N/A
C2005	Miscellaneous M <46.50 and A <77.50.,comorbidity in tier 2	No pre-authorization is required for all providers.	N/A
C2006	EP DFLCT TIP CATH-DECAPOLAR SM ANAT	No pre-authorization is required for all providers.	N/A
C2007	IRVINE LUMA 6F FIXED CURVE EP CATH	No pre-authorization is required for all providers.	N/A
C2008	LUMA-CATH 7F STERABL EP CATH-81910/	No pre-authorization is required for all providers.	N/A
C2009	LUMA-CATH 7F STERABL EP CATH-81920	No pre-authorization is required for all providers.	N/A
C2010	EP CORDIS FIXED CURVE CATH	No pre-authorization is required for all providers.	N/A
C2011	EP DEFLECTABLE TIP CATH	No pre-authorization is required for all providers.	N/A
C2012	CELSIUS BRAID TIP ABLATION CATH	No pre-authorization is required for all providers.	N/A
C2013	CELSIUS LG DOME ABLATION CATH	No pre-authorization is required for all providers.	N/A
C2014	CELSIUS II ASYMETRC ABLATION CATH	No pre-authorization is required for all providers.	N/A
C2015	CELSIUS II SYMETRC ABLATION CATH	No pre-authorization is required for all providers.	N/A
C2016	ABLATION CATH-NAVI-STAR DS/THERMO +	No pre-authorization is required for all providers.	N/A
C2017	ABLATION DEFLECTABLE TIP CATH	No pre-authorization is required for all providers.	N/A
C2018	CATH ABLATION POLARIS T ABLATN CATH	No pre-authorization is required for all providers.	N/A
C2019	CATH EP MEDSYS DEFLECTABLE EP CATH	No pre-authorization is required for all providers.	N/A
C2020	BLAZER II XP/6F/HI TORQUE ABL CATHS	No pre-authorization is required for all providers.	N/A
C2021	SILVERFLEX EP CATH NON-DEFLECTABLE	No pre-authorization is required for all providers.	N/A
C2022	CP AB CA 41422/42 45422/42 43422/42	No pre-authorization is required for all providers.	N/A
C2023	CP COOL AB CATH-STD 3005/LG3006	No pre-authorization is required for all providers.	N/A
C2100	CATH EP CARD PATHWAYS CS REF CATH	No pre-authorization is required for all providers.	N/A
C2101	Burns M >=52.50.,comorbidity in tier 2	No pre-authorization is required for all providers.	N/A
C2102	Burns M <52.50.,comorbidity in tier 2	No pre-authorization is required for all providers.	N/A
C2103	EP 7F RADII CATH W/TRACKNG	No pre-authorization is required for all providers.	N/A
C2104	EP LASSO DEFLECT CIRC TIP MAPNG CATH	No pre-authorization is required for all providers.	N/A
C2151	CATH VERIPATH PERIPHERL GUIDNG CATH	No pre-authorization is required for all providers.	N/A
C2152	CORDIS VISTA BRITE TIP GIDNG CATH	No pre-authorization is required for all providers.	N/A
C2153	EP BARD VKG FIX CURV CATH BI/QD/ASP	No pre-authorization is required for all providers.	N/A
C2200	CATH ARROW-TREROTOLA PTD CATH	No pre-authorization is required for all providers.	N/A
C2300	CATH VARISOURCE STANDARD CATH	No pre-authorization is required for all providers.	N/A
C2596	PROBE IMAGE GUIDED ROBOTIC WATERJET ABLATION	No authorization required. Code is for informational purposes only.	N/A
C2597	CLINICATH PICC SGL/DUAL 16G/18G/+	No pre-authorization is required for all providers.	N/A
C2598	CLINICATH PICC SGL 18G/20G/24G	No pre-authorization is required for all providers.	N/A
C2599	CLINICATH PICC DUAL 16G/18G	No pre-authorization is required for all providers.	N/A
C2600	GOLD PROBE S/U ELECTROHEMO CATH	No pre-authorization is required for all providers.	N/A
C2601	BARD 10F DUAL LUMEN URETERAL CATH	No pre-authorization is required for all providers.	N/A
C2602	1.4/1.7MM VITESSE COS CON LSR CATH	No pre-authorization is required for all providers.	N/A
C2603	2.0MM VITESSE COS CON LSR CATH	No pre-authorization is required for all providers.	N/A
C2604	2.0MM VITESSE E ECC LASER CATH	No pre-authorization is required for all providers.	N/A
C2605	SPECTRANETICS EXTREM LASER CATH	No pre-authorization is required for all providers.	N/A
C2606	ORATEC SPINECATH XL INTRADISCL CATH	No pre-authorization is required for all providers.	N/A
C2607	ORATEC SPINECATH INTRADISCL CATH	No pre-authorization is required for all providers.	N/A
C2608	CATH SCIMED 6F WISEGUID GUID CATH	No pre-authorization is required for all providers.	N/A
C2609	FLEXIMA BILIARY DRAIN CATHS +	No pre-authorization is required for all providers.	N/A
C2610	ARROW FLEX TIP + INTRASPNL CATH KIT	No pre-authorization is required for all providers.	N/A
C2611	MEDT PS MED ALGO SPIN CATH 81102/92	No pre-authorization is required for all providers.	N/A
C2612	CATH INDURA INTRASPINAL CATH	No pre-authorization is required for all providers.	N/A
C2613	LUNG BX PLUG W/DEL SYS	This service is not covered by Superior HealthPlan.	N/A
C2614	PROBE PERCUT LUMBAR DISCECTOMY	This service is not covered by Superior HealthPlan.	N/A
C2615	SEALANT, PULMONARY, LIQUID	This service is not covered by Superior HealthPlan.	N/A
C2616	BRACHYTHERAPY SOURCE, YTTRIUM-90	This service is not covered by Superior HealthPlan.	N/A
C2617	STENT, NON-CORONARY, TEMPORARY, WITHOUT DELIVERY SYSTEM	This service is not covered by Superior HealthPlan.	N/A
C2618	PROBE, CRYOABLATION	This service is not covered by Superior HealthPlan.	N/A
C2619	PACEMAKER, DUAL CHAMBER, NON RATE-RESPONSIVE (IMPLANTABLE)	This service is not covered by Superior HealthPlan.	N/A
C2620	PACEMAKER, SINGLE CHAMBER, NON RATE-RESPONSIVE (IMPLANTABLE)	This service is not covered by Superior HealthPlan.	N/A
C2621	PACEMAKER, OTHER THAN SINGLE OR DUAL CHAMBER (IMPLANTABLE)	This service is not covered by Superior HealthPlan.	N/A
C2622	PROSTHESIS, PENILE, NON-INFLATABLE	This service is not covered by Superior HealthPlan.	N/A
C2623	CATHETER TA DRUG-COATED NON-LASER	Authorization is required for all non-participating providers. Authorization is required for participating providers if billed amount is greater than or equal to \$500.	Prior to 09/01/2019
C2624	WIRELESS PRESSURE SENSOR	This service is not covered by Superior HealthPlan.	N/A
C2625	STENT, NON-CORONARY, TEMPORARY, WITH DELIVERY SYSTEM	This service is not covered by Superior HealthPlan.	N/A
C2626	INFUSION PUMP, NON-PROGRAMMABLE, TEMPORARY (IMPLANTABLE)	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
C2627	CATHETER, SUPRAPUBIC/CYSTOSCOPIC	This service is not covered by Superior HealthPlan.	N/A
C2628	CATHETER, OCCLUSION	This service is not covered by Superior HealthPlan.	N/A
C2629	INTRODUCER/SHEATH, LASER	This service is not covered by Superior HealthPlan.	N/A
C2630	CATHETER	This service is not covered by Superior HealthPlan.	N/A
C2631	REPAIR DEVICE, URINARY, INCONTINENCE, WITHOUT SLING GRAFT	This service is not covered by Superior HealthPlan.	N/A
C2632	BRACHYTX SOL IODINE-125 PER MCI	This service is not covered by Superior HealthPlan.	N/A
C2633	BRACHYTHERAPY SOURCE CESIUM131 PER SOURCE	This is no longer a valid code.	N/A
C2634	BRACHYTX SOURCE HA I-125	This service is not covered by Superior HealthPlan.	N/A
C2635	BBRACHYTX SOURCE HA P-103	This service is not covered by Superior HealthPlan.	N/A
C2636	BRACHYTX LINEAR SOURCE P-10	This service is not covered by Superior HealthPlan.	N/A
C2637	BRACHYTHERAPY SOURCE YTTERBIUM-169 /SOURCE	This service is not covered by Superior HealthPlan.	N/A
C2638	BRACHYTX SSTRANDED I-125	This service is not covered by Superior HealthPlan.	N/A
C2639	BRACHYTX NON-STRANDED I-125	This service is not covered by Superior HealthPlan.	N/A
C2640	BRACHYTX STRANDED P-103	This service is not covered by Superior HealthPlan.	N/A
C2641	BRACHYTX NON-STRANDED P-103	This service is not covered by Superior HealthPlan.	N/A
C2642	BRACHYTX STRANDED C-131	This service is not covered by Superior HealthPlan.	N/A
C2643	BRACHYTX NON-STRANDED C-131	This service is not covered by Superior HealthPlan.	N/A
C2644	BRACHYTX CESIUM-131 CHLORIDE	This service is not covered by Superior HealthPlan.	N/A
C2645	BRT PLANAR SOURCE PD-103 PER SQ ML	This service is not covered by Superior HealthPlan.	N/A
C2676	CATH RESPONSE CV CATH	No pre-authorization is required for all providers.	N/A
C2698	BRACHYTX STRANDED NOS	This service is not covered by Superior HealthPlan.	N/A
C2699	BRACHYTX NON-STRANDED NOS	This service is not covered by Superior HealthPlan.	N/A
C2700	DEFIB SC IMPLNT MYCROPHYLAX PLUS	No pre-authorization is required for all providers.	N/A
C2701	DEFIB SGL CHMBR IMPLNT PHYLAX XM	No pre-authorization is required for all providers.	N/A
C2702	DEFIB SC IMP VENTAK PRIZM 2 VR 1860	No pre-authorization is required for all providers.	N/A
C2703	DF SC IMP VENTAK PRIZM VR HE1857/58	No pre-authorization is required for all providers.	N/A
C2704	DEFIB SC IMPLNT VENTAK MINI IV+	No pre-authorization is required for all providers.	N/A
C2801	DEFIB DC IMP ELA MED DFNDR IVDR 612	No pre-authorization is required for all providers.	N/A
C2802	DEFIB DUAL CHMBR IMPLNT PHYLAX AV	No pre-authorization is required for all providers.	N/A
C2803	DF DC IMP VENTAK PRIZM DR HE1852/53	No pre-authorization is required for all providers.	N/A
C2804	DEFIB DC IMP VENTAK PRIZM 2 DR 1861	No pre-authorization is required for all providers.	N/A
C2805	DEFIB DC IMPLNT JEWEL AF 7250	No pre-authorization is required for all providers.	N/A
C2806	DEFIB IMPLNT GEM VR 7227	No pre-authorization is required for all providers.	N/A

C2807	DEFIB IMPLNT CONTAK CD 1823	No pre-authorization is required for all providers.	N/A
C2808	DEFIB IMPLNT CONTAK TR 1241	No pre-authorization is required for all providers.	N/A
C3001	LEAD DEFIB IMP KAINOX SL KAINOX RV	No pre-authorization is required for all providers.	N/A
C3002	LEAD DEFIB IMP ESYTRAK	No pre-authorization is required for all providers.	N/A
C3003	LEAD DEFIB IMP ENDOTAK SQ ARRAY XP	No pre-authorization is required for all providers.	N/A
C3004	LEAD DEFIB IMP INTERVENE 497-23/24	No pre-authorization is required for all providers.	N/A
C3400	PROS BRST MENTOR SAL-FILLD CONTR +	No pre-authorization is required for all providers.	N/A
C3401	PROS BRST MENTOR SAL-FILLD SPECTRUM	No pre-authorization is required for all providers.	N/A
C3500	ALPHA I INFLATABLE PENILE PROSTH	No pre-authorization is required for all providers.	N/A
C3510	AMS SPHINCTER 800 URIN PROSTH	No pre-authorization is required for all providers.	N/A
C3551	GUID WR PERCUT TRANSLMNL COR ANGIOP	No pre-authorization is required for all providers.	N/A
C3552	GUID WIRE COR HI-TORQUE WHISPER	No pre-authorization is required for all providers.	N/A
C3553	STABILIZER MRKR WR STEERABLE GUIDWR	No pre-authorization is required for all providers.	N/A
C3554	JINDO TAPERED PERIPHERAL GUIDWIRE	No pre-authorization is required for all providers.	N/A
C3555	WHOLEY HI-TORQUE + GUID WR SYS	No pre-authorization is required for all providers.	N/A
C3556	ENDOSNCS CARD WW PRESS/FLOWR DOP GW	No pre-authorization is required for all providers.	N/A
C3557	GUIDWIRE HYTEK GUIDWIRE	No pre-authorization is required for all providers.	N/A
C3800	IMP PROGRM SYNCHROMED INFUS PUMP	No pre-authorization is required for all providers.	N/A
C3801	INFUS PUMP ARROW/MICROJECT PCA SYS	No pre-authorization is required for all providers.	N/A
C3851	ELASTC UV-ABSRBG SIL PST CHMBR IO +	No pre-authorization is required for all providers.	N/A
C4000	PMKR SC ELA MED OPUS G-4621 4624	No pre-authorization is required for all providers.	N/A
C4001	PMKR SC ELA MED OPUS S-4121 4124	No pre-authorization is required for all providers.	N/A
C4002	PMKR SC ELA MED TALENT MODEL 113	No pre-authorization is required for all providers.	N/A
C4003	PMKR SGL CHMBR KAIROS SR	No pre-authorization is required for all providers.	N/A
C4004	PMKR SC ACTROS SR+ ACTROS SR-B+	No pre-authorization is required for all providers.	N/A
C4005	PMKR SC PHILOS SR PHILOS SR-B	No pre-authorization is required for all providers.	N/A
C4006	PMKR SC PULSAR MAX II SR 1180 1181	No pre-authorization is required for all providers.	N/A
C4007	PMKR SNGL CHMBR MARATHON SR	No pre-authorization is required for all providers.	N/A
C4008	PMKR SGL CHMBR DISCOVERY II SSI 481	No pre-authorization is required for all providers.	N/A
C4009	PMKR SC DISCOVERY II SR 1184-1187	No pre-authorization is required for all providers.	N/A
C4300	PMKR DC INTEGRITY AFX DR MODEL 5342	No pre-authorization is required for all providers.	N/A
C4301	PMKR DC INTEGRITY AFX DR MODEL 5346	No pre-authorization is required for all providers.	N/A
C4302	PMKR DUAL CHMBR AFFINITY VDR 5430	No pre-authorization is required for all providers.	N/A
C4303	PMKR DC ELA BRIO MDL 112 PMKR SYST	No pre-authorization is required for all providers.	N/A
C4304	PMKR DC MED BRIO212 TALENT213/223	No pre-authorization is required for all providers.	N/A
C4305	PMKR DC ELA MED BRIO MODEL 222	No pre-authorization is required for all providers.	N/A
C4306	PMKR DC ELA MED BRIO MODEL 220	No pre-authorization is required for all providers.	N/A
C4307	PMKR DUAL CHMBR KAIROS DR	No pre-authorization is required for all providers.	N/A
C4308	PMKR DUAL CHMBR INOS 2 INOS 2+	No pre-authorization is required for all providers.	N/A
C4309	PMKR DC ACTROS DR+/D-/DR-A+/SLR+	No pre-authorization is required for all providers.	N/A
C4310	PMKR DUAL CHMBR ACTROS DR-B+	No pre-authorization is required for all providers.	N/A
C4311	PMKR DC PHILOS DR/DR-B/SLR	No pre-authorization is required for all providers.	N/A
C4312	PMKR DC PULSAR MAX II DR 1280	No pre-authorization is required for all providers.	N/A
C4313	PMKR DC MARATHON DR 293-09 294-09+	No pre-authorization is required for all providers.	N/A
C4314	PMKR DUAL CHMBR MOMENTUM DR 294-23	No pre-authorization is required for all providers.	N/A
C4315	PMKR DC SELECT AFM 902 SLC 902C	No pre-authorization is required for all providers.	N/A
C4316	PMKR DC DISCOVERY II DR 1283 1284+	No pre-authorization is required for all providers.	N/A
C4317	PMKR DC DISCOVERY II DDD 981	No pre-authorization is required for all providers.	N/A
C4600	LEAD PMKR SYNOX POLYROX ELOX +	No pre-authorization is required for all providers.	N/A
C4601	LEAD PMKR AESCULA LV 1055K	No pre-authorization is required for all providers.	N/A
C4602	LEAD PMKR TENDRIL SDX1488K/46/52/58	No pre-authorization is required for all providers.	N/A
C4603	LEAD PMKR OSCOR/FLEX 4015-4018	No pre-authorization is required for all providers.	N/A
C4604	LD PMKR CRYST ACTFIX NOV 5076	No pre-authorization is required for all providers.	N/A
C4605	LEAD PMKR CAPSURE EPI 4968	No pre-authorization is required for all providers.	N/A
C4606	LEAD PMKR FLEXTEND 4080 4081 4082	No pre-authorization is required for all providers.	N/A
C4607	LD PMKR-FINELINE/THINLINE II/II EZ	No pre-authorization is required for all providers.	N/A
C5000	BX VEL W/HEPACOAT RAPTOR ST 28/33ML	No pre-authorization is required for all providers.	N/A
C5001	BARD MEMOTHM-FLEX BILI STNT SM/MED	No pre-authorization is required for all providers.	N/A
C5002	BARD MEMTHERM-FLX BILI STNT LG DIAM	No pre-authorization is required for all providers.	N/A
C5003	BARD MEMOTHM-FLX BILI STNT X-LG	No pre-authorization is required for all providers.	N/A
C5004	CORDIS PC IQ TRANSHEPATIC BILI STNT	No pre-authorization is required for all providers.	N/A
C5005	CP IQ TRANSHEP BILI STNT & DEL SYS	No pre-authorization is required for all providers.	N/A
C5006	C MED PALM TRANSHEPTC BIL STNT & DS	No pre-authorization is required for all providers.	N/A
C5007	PALMAZ XL TRANSHEPTC BILI STNT 40MM	No pre-authorization is required for all providers.	N/A
C5008	PALMAZ XL TRANSHEPTC BILI STNT 50MM	No pre-authorization is required for all providers.	N/A
C5009	BILIARY VISTAFLEX STENT	No pre-authorization is required for all providers.	N/A
C5010	RAPID EXCHG SNGL-USE BILI STNT SYST	No pre-authorization is required for all providers.	N/A
C5011	STENT BILI INTRASTENT INTRASTENT LP	No pre-authorization is required for all providers.	N/A
C5012	STNT BILI INTRASTENT DOUBLESTRUT LD	No pre-authorization is required for all providers.	N/A
C5013	STNT BILI INTRASTENT DOUBLESTRUT/XS	No pre-authorization is required for all providers.	N/A
C5014	MTRNIC BRIDG BILI ST SYS 10/17/28MM	No pre-authorization is required for all providers.	N/A
C5015	AVE BRIDG BILI STNT 40-60/80-100MM+	No pre-authorization is required for all providers.	N/A
C5016	SU CVRD BILI STNT ENDO W/UNISTEP+DS	No pre-authorization is required for all providers.	N/A
C5017	BILI ENDO W/UNI+DS 20/40/42/60/68MM	No pre-authorization is required for all providers.	N/A
C5018	BILI ENDOPROS W/UNISTP+DS 80/94MM	No pre-authorization is required for all providers.	N/A
C5019	FLEXIMA SGL USE BILI STENT SYST	No pre-authorization is required for all providers.	N/A
C5020	C SMART NITINOL STNT TRANSHEP 20MM	No pre-authorization is required for all providers.	N/A
C5021	SMART NITINOL STNT TRANSHEP 40/60MM	No pre-authorization is required for all providers.	N/A
C5022	SMART NITINOL STNT TRANSHEP 80MM	No pre-authorization is required for all providers.	N/A
C5023	BX VEL TRNHEP BILI STNT & DS 8/13MM	No pre-authorization is required for all providers.	N/A
C5024	BX VEL TRNHEP BILI STNT & DS 18MM	No pre-authorization is required for all providers.	N/A
C5025	BX VEL TRNHEP BILI STNT & DS 23MM	No pre-authorization is required for all providers.	N/A
C5026	BX VEL TRNHEP BIL STNT & DS 28/33MM	No pre-authorization is required for all providers.	N/A
C5027	BX VEL W/HEPACOAT RAPTR STNT-8/13MM	No pre-authorization is required for all providers.	N/A
C5028	BX VEL W/HEPACOAT RAPTOR STNT-18MM	No pre-authorization is required for all providers.	N/A
C5029	BX VEL W/HEPACOAT RAPTOR STNT-23MM	No pre-authorization is required for all providers.	N/A
C5030	S660 OVER-WR COR STNT SYS 9/12MM	No pre-authorization is required for all providers.	N/A
C5031	S660 OVER-WR COR STNT SYS 15/18MM	No pre-authorization is required for all providers.	N/A
C5032	S660 OVER-WR COR STNT SYS 24/30MM	No pre-authorization is required for all providers.	N/A
C5033	NIROYAL ADV PREMT COR STNT SYS-9MM	No pre-authorization is required for all providers.	N/A
C5034	NIROYAL ADV PREMT COR STNT-12/15MM	No pre-authorization is required for all providers.	N/A
C5035	NIROYAL ADV PREMT COR STNT SYS-18MM	No pre-authorization is required for all providers.	N/A
C5036	NIROYAL ADV PREMT COR STNT SYS-25MM	No pre-authorization is required for all providers.	N/A
C5037	NIROYAL ADV PREMT COR STNT SYS-31MM	No pre-authorization is required for all providers.	N/A
C5038	BX VEL BALL-EXP COR STNT W/RAPTR DS	No pre-authorization is required for all providers.	N/A
C5039	INTRACOIL PRPHRL STNT/40MM	No pre-authorization is required for all providers.	N/A
C5040	INTRACOIL PRPHRL STNT/60MM	No pre-authorization is required for all providers.	N/A
C5041	MDTRON BESTENT 2 OVR-WR C S 24/30MM	No pre-authorization is required for all providers.	N/A
C5042	BESTENT 2 OVER-WR COR STNT SYS-18MM	No pre-authorization is required for all providers.	N/A
C5043	BESTENT 2 OVER-WR COR STNT SYS-15MM	No pre-authorization is required for all providers.	N/A
C5044	BESTENT 2 OVR-WR COR STNT 9/12MM	No pre-authorization is required for all providers.	N/A
C5045	MULTILINK TETRA COR STNT SYST	No pre-authorization is required for all providers.	N/A
C5046	RAD 20MM SF EX COR STNT W/OVR-WR DS	No pre-authorization is required for all providers.	N/A
C5047	NIROYAL EL PREMT C STNT-15/25/31MM	No pre-authorization is required for all providers.	N/A
C5048	STENT COR GR II COR STENT	No pre-authorization is required for all providers.	N/A
C5130	WILSON-COOK COLONIC Z-STENT	No pre-authorization is required for all providers.	N/A
C5131	BARD MEMO COLORECTAL STNT-S30R060	No pre-authorization is required for all providers.	N/A
C5132	BARD MEMO COLORECTAL STNT-S30R080	No pre-authorization is required for all providers.	N/A
C5133	BARD MEMO COLORECTAL STNT-S30R100	No pre-authorization is required for all providers.	N/A
C5134	WS ENTERAL ENDOPROS & UNIST DS-90MM	No pre-authorization is required for all providers.	N/A
C5271	LOW COST SKIN SUBSTITUTE APP	This service is not covered by Superior HealthPlan.	N/A

C5272	LOW COST SKIN SUBSTITUTE APP	This service is not covered by Superior HealthPlan.	N/A
C5273	LOW COST SKIN SUBSTITUTE APP	This service is not covered by Superior HealthPlan.	N/A
C5274	LOW COST SKIN SUBSTITUTE APP	This service is not covered by Superior HealthPlan.	N/A
C5275	LOW COST SKIN SUBSTITUTE APP	This service is not covered by Superior HealthPlan.	N/A
C5276	LOW COST SKIN SUBSTITUTE APP	This service is not covered by Superior HealthPlan.	N/A
C5277	LOW COST SKIN SUBSTITUTE APP	This service is not covered by Superior HealthPlan.	N/A
C5278	LOW COST SKIN SUBSTITUTE APP	This service is not covered by Superior HealthPlan.	N/A
C5279	BS CONT SFT PERCUFLX URETERAL STNT	No pre-authorization is required for all providers.	N/A
C5280	BARD INLAY DBL PIGTAIL URETERAL STN	No pre-authorization is required for all providers.	N/A
C5281	TRACHEOBR ENDOPRS STNT W/UNIST-70MM	No pre-authorization is required for all providers.	N/A
C5282	TRACHEOBR ENDOPRS STNT 20/30/50MM	No pre-authorization is required for all providers.	N/A
C5283	TRANSJUG INTRAHEP PROTOSYST SHNT +	No pre-authorization is required for all providers.	N/A
C5284	STNT ULTRAFLEX TRACHBR ENDOPROSTH	No pre-authorization is required for all providers.	N/A
C5600	VASCULAR CLO DEV VASOSEAL ES DEV	No pre-authorization is required for all providers.	N/A
C5601	VAS CLO DEV DUETT SEALNG DEV 1000	No pre-authorization is required for all providers.	N/A
C6001	MESH HERN COMPOSIX MSH P/8/18 IN	No pre-authorization is required for all providers.	N/A
C6002	MESH HERN COMPOSIX MESH P/32 IN	No pre-authorization is required for all providers.	N/A
C6003	MESH HERN COMPOSIX MESH P/48 IN	No pre-authorization is required for all providers.	N/A
C6004	MESH HERN COMPOSIX MESH P/80 IN	No pre-authorization is required for all providers.	N/A
C6005	MESH HERN COMPOSIX MESH P/140 IN	No pre-authorization is required for all providers.	N/A
C6006	MESH HERN COMPOSIX MESH P/144 IN	No pre-authorization is required for all providers.	N/A
C6012	PELV ACELULR COL MTRX P/8/14 SQ CM	No pre-authorization is required for all providers.	N/A
C6013	PELV ACELU COL MAT P/21/24/28 SQCM	No pre-authorization is required for all providers.	N/A
C6014	PELV ACELULR COLLGN MTRX P/40 SQ CM	No pre-authorization is required for all providers.	N/A
C6015	PELV ACELULR COLLGN MTRX P/48 SQ CM	No pre-authorization is required for all providers.	N/A
C6016	PELV ACELULR COLLGN MTRX P/96 SQ CM	No pre-authorization is required for all providers.	N/A
C6017	GORE-TEX DUALMSH BIOMAT 75/96 SQ CM	No pre-authorization is required for all providers.	N/A
C6018	GORE-TEX DUALMSH BIOMAT 150SQCM OVL	No pre-authorization is required for all providers.	N/A
C6019	GORE-TEX DUALMSH BIOMAT P/285 SQ CM	No pre-authorization is required for all providers.	N/A
C6020	GORE-TEX DUALMSH BIOMAT P/432 SQ CM	No pre-authorization is required for all providers.	N/A
C6021	GORE-TEX DUALMSH BIOMAT P/600 SQ CM	No pre-authorization is required for all providers.	N/A
C6022	GORE-TEX DUALMSH BIOMAT 884 SQ CM	No pre-authorization is required for all providers.	N/A
C6023	GORE-TEX DUMSH+BIOMAT P/75/96 SQ CM	No pre-authorization is required for all providers.	N/A
C6024	GORE-TEX DUALMSH+BIOMAT P/150 SQ CM	No pre-authorization is required for all providers.	N/A
C6025	GORE-TEX DUALMSH+BIOMAT P/285 SQ CM	No pre-authorization is required for all providers.	N/A
C6026	GORE-TEX DUALMSH+BIOMAT P/432 SQ CM	No pre-authorization is required for all providers.	N/A
C6027	GORE-TEX DUALMSH+BIOMAT P/600 SQ CM	No pre-authorization is required for all providers.	N/A
C6028	GORE-TEX DUALMSH+BIOMAT P/884 SQ CM	No pre-authorization is required for all providers.	N/A
C6029	GORE-TEX DUALMSH+BIOMAT P/150 SQ CM	No pre-authorization is required for all providers.	N/A
C6030	GORE-TEX DUALMSH+BIOMAT P/285 SQ CM	No pre-authorization is required for all providers.	N/A
C6031	GORE-TEX DUALMSH+BIOMAT P/432 SQ CM	No pre-authorization is required for all providers.	N/A
C6032	GORE-TEX DUALMSH+BIOMAT P/600 SQ CM	No pre-authorization is required for all providers.	N/A
C6033	GORE-TEX DUALMSH+BIOMAT P/884 SQ CM	No pre-authorization is required for all providers.	N/A
C6034	BARD EPTFE RECON PTCH 150 SQ CM-2MM	No pre-authorization is required for all providers.	N/A
C6035	EPTFE RECN PTCH 150/75 SQ CM-1-2MM	No pre-authorization is required for all providers.	N/A
C6036	EPTFE RECN PTCH 50/75/50SQ CM/1-2MM	No pre-authorization is required for all providers.	N/A
C6037	BARD EPTFE RECN PTCH 300SQ CM/1MM	No pre-authorization is required for all providers.	N/A
C6038	EPTFE RECN PTCH 600/300SQ CM 1-2MM	No pre-authorization is required for all providers.	N/A
C6039	EPTFE RECN PTCH 884 SQ CM OVAL/1MM	No pre-authorization is required for all providers.	N/A
C6040	EPTFE RECON PTCH 600SQ CM/2MM	No pre-authorization is required for all providers.	N/A
C6041	EPTFE RECN PTCH 884 SQ CM OVAL/2MM	No pre-authorization is required for all providers.	N/A
C6050	FE SLNG FIX SYS W/WO SLING MAT	No pre-authorization is required for all providers.	N/A
C6051	STRATASIS URETHRAL SLING 20/40 CM	No pre-authorization is required for all providers.	N/A
C6052	STRATASIS URETHRAL SLING 60 CM	No pre-authorization is required for all providers.	N/A
C6053	SURGISIS SFT TIS GFT P/70/105/140CM	No pre-authorization is required for all providers.	N/A
C6054	SRG E/ST SFT TIS GFT-4.2/20/28/40CM	No pre-authorization is required for all providers.	N/A
C6055	SRG E/ST SFT TIS GFT-52.5/60/70 CM	No pre-authorization is required for all providers.	N/A
C6056	SURG ENH STRG SFT TIS GFT-105/140CM	No pre-authorization is required for all providers.	N/A
C6057	SURGISIS HERNIA GRAFT PER 195 CM	No pre-authorization is required for all providers.	N/A
C6058	SUGIPRO HERNIA MATE PLUG MED/LG	No pre-authorization is required for all providers.	N/A
C6080	MA SLG FIX SYS W/WO SLING MAT	No pre-authorization is required for all providers.	N/A
C6200	VAS GFT EXXCEL SFT EPTFE VAS GRFT	No pre-authorization is required for all providers.	N/A
C6201	IMPRA VENAFLO VAS GFT W/CAR 10/20CM	No pre-authorization is required for all providers.	N/A
C6202	IMPRA VENAFLO VAS GFT W/CAR 30/40CM	No pre-authorization is required for all providers.	N/A
C6203	IM VFL V GFT W/C 50CM/CNRFLX 45CM	No pre-authorization is required for all providers.	N/A
C6204	IMPRA VENAFLO VAS STPD GFT W/CAR	No pre-authorization is required for all providers.	N/A
C6205	IMPRA CARBOFLO VAS GFT STR GFT 10CM	No pre-authorization is required for all providers.	N/A
C6206	IMPRA CARBOFLO VAS GFT ST GFT 20CM	No pre-authorization is required for all providers.	N/A
C6207	IMPRA CARBFLO VAS GFT SG 30/35/40CM	No pre-authorization is required for all providers.	N/A
C6208	IMPRA CARBOFLO VAS GFT-STR ACT STP	No pre-authorization is required for all providers.	N/A
C6209	IMPRA CF VAS GFT-CFLX STR/STEP	No pre-authorization is required for all providers.	N/A
C6210	EXXCEL EPTFE VAS GRFT <6MM DIA	No pre-authorization is required for all providers.	N/A
C6300	VANGUARD III ENDOVAS AORTIC GFT	No pre-authorization is required for all providers.	N/A
C6500	PREFACE BRAIDED GUIDING SHEATH	No pre-authorization is required for all providers.	N/A
C6501	SHEATH SOFT-TIP SHEATHS	No pre-authorization is required for all providers.	N/A
C6525	SPECTRANETICS LSR SHEATH 12/14/16 F	No pre-authorization is required for all providers.	N/A
C6600	MICRO SWISS F/G LITHOCLAST FLX PRBS	No pre-authorization is required for all providers.	N/A
C6650	FAST-CATH 2-PIECE GUIDING INTRODUCR	No pre-authorization is required for all providers.	N/A
C6651	SEAL-AWAY CS GUIDING INTRODUCER	No pre-authorization is required for all providers.	N/A
C6652	BARD SAFETY EXCALIBUR INTRODUCER	No pre-authorization is required for all providers.	N/A
C6700	SYN ABSORBABL SEALANT FOCAL SEAL-L	No pre-authorization is required for all providers.	N/A
C8099	SPECTRANETICS LEAD LOCKING DEVICE	No pre-authorization is required for all providers.	N/A
C8100	ADHESION BARRIER ADCON-L	No pre-authorization is required for all providers.	N/A
C8102	SURGI-VISION ESOPH STYLET INT COIL	No pre-authorization is required for all providers.	N/A
C8103	CAPIO SUT CAPTRNG DEV STD/OP ACCESS	No pre-authorization is required for all providers.	N/A
C8500	ATHEROCATH-GTO ATHERECTMY CATH	No pre-authorization is required for all providers.	N/A
C8501	PACEMAKER SGL CHMBR VIGOR SSI	No pre-authorization is required for all providers.	N/A
C8502	CATH DX EP LIVEWR STEERABLE EP CATH	No pre-authorization is required for all providers.	N/A
C8503	SYNCHROMED VASCULAR CATH MODEL 8702	No pre-authorization is required for all providers.	N/A
C8504	CLO DEV VASOSEAL VAS HEMOSTASIS DEV	No pre-authorization is required for all providers.	N/A
C8505	IMP PROGRAM SYNCHROMED INFUS PUMP	No pre-authorization is required for all providers.	N/A
C8506	LEAD PMKR 4057M 4058/4557/4558-M	No pre-authorization is required for all providers.	N/A
C8507	PMKR-6721L/M/S/6939-OVL PTCH LEAD	No pre-authorization is required for all providers.	N/A
C8508	LEAD DEFIBRILLATOR CAPSURE 4965	No pre-authorization is required for all providers.	N/A
C8509	LEAD DEFIB TRANSVENE 6933/6937	No pre-authorization is required for all providers.	N/A
C8510	LEAD DEFIBRILLATOR DP-3238	No pre-authorization is required for all providers.	N/A
C8511	LEAD DEFIBRILLATOR ENDOTAK DSP	No pre-authorization is required for all providers.	N/A
C8512	LEAD NEUROSTM ONPNT/PISCES/RESUME	No pre-authorization is required for all providers.	N/A
C8513	LEAD NEUROSTM-PISCES-QUAD/RESUMEII	No pre-authorization is required for all providers.	N/A
C8514	DURA II PENILE PROSTH	No pre-authorization is required for all providers.	N/A
C8516	ACU-FORM MALLEABLE PENILE PROSTH	No pre-authorization is required for all providers.	N/A
C8518	PMKR DUAL CHMBR VIGOR DDD	No pre-authorization is required for all providers.	N/A
C8519	PMKR DUAL CHMBR VISTA DDD	No pre-authorization is required for all providers.	N/A
C8520	PMKR SGL CHMBR LEGACY II S	No pre-authorization is required for all providers.	N/A
C8521	RECEIVR/TRANSMITR NEUROSTM MATTRX	No pre-authorization is required for all providers.	N/A
C8522	STENT BILIARY PALMAZ BALL EXP STENT	No pre-authorization is required for all providers.	N/A
C8523	STNT BILI TRNSHEPATIC BIL ENDOPROS	No pre-authorization is required for all providers.	N/A
C8524	WALLSTENT ESOPH PROSTH	No pre-authorization is required for all providers.	N/A
C8525	WALLSTENT ESOPH PROSTH (DOUBLE)	No pre-authorization is required for all providers.	N/A
C8526	OPTIPLAST XT 5F PTA CATH	No pre-authorization is required for all providers.	N/A
C8528	MS CLASSIQUE BALL DILAT CATH	No pre-authorization is required for all providers.	N/A

C8529	CRISTA CATH II DEFLECT 20-POLE CATH	No pre-authorization is required for all providers.	N/A
C8530	GEL-FILLED/SMOOTH-SURFACE MAMM PROS	No pre-authorization is required for all providers.	N/A
C8531	ESOPH Z METAL EXP STENT	No pre-authorization is required for all providers.	N/A
C8532	ULTRAFLEX ESOPH STENT SYS	No pre-authorization is required for all providers.	N/A
C8533	SYNCHROMED VAS CATH MDL 8700A/8700V	No pre-authorization is required for all providers.	N/A
C8534	AMS MALLEABLE 650 PENILE PROSTH	No pre-authorization is required for all providers.	N/A
C8535	SPIRAL Z/ZA BILIARY METAL EXP STENT	No pre-authorization is required for all providers.	N/A
C8536	ESOPH Z METAL EXP STNT W/DUA +	No pre-authorization is required for all providers.	N/A
C8539	WILSON-COOK QUANTUM DILAT BALL	No pre-authorization is required for all providers.	N/A
C8540	FLX-EZ ESOPH BALL DILAT 3302/3304/	No pre-authorization is required for all providers.	N/A
C8541	CARSON/PASSPORT BALL WR DIL CATH	No pre-authorization is required for all providers.	N/A
C8542	HI PRESS URETHL BALL DIL CATH/KIT	No pre-authorization is required for all providers.	N/A
C8543	AMPLATZ RENAL DILATOR SET	No pre-authorization is required for all providers.	N/A
C8550	LIVEWIRE EP/5F DECAPOLAR/7FCSM CATH	No pre-authorization is required for all providers.	N/A
C8551	LIVEWIRE EP/7F DUO-DECAPOLAR CATH	No pre-authorization is required for all providers.	N/A
C8552	CATH SANTURO FIXED CURVE CATH	No pre-authorization is required for all providers.	N/A
C8597	CORDIS WISDOM ST STEERABLE GUIDWR	No pre-authorization is required for all providers.	N/A
C8598	CORDIS SV GUIDWR 5/8/14CM DISTAL +	No pre-authorization is required for all providers.	N/A
C8599	CORDIS STABILIZR XS STERABL GUIDWR	No pre-authorization is required for all providers.	N/A
C8600	CORDIS SHINOBI + STERABL GUIDWR	No pre-authorization is required for all providers.	N/A
C8650	COOK EXTRA LG CHECK-FLO INTRODUCER	No pre-authorization is required for all providers.	N/A
C8724	LEAD NEUROSTIM OCTAD LEAD 3898-33/	No pre-authorization is required for all providers.	N/A
C8725	LEAD NEUROSTIM SYMMIX LEAD 3982	No pre-authorization is required for all providers.	N/A
C8748	LEAD DEFIB ENDOTAK SQ PTCH 0047/	No pre-authorization is required for all providers.	N/A
C8749	LEAD DEFIB ENDOTAK SQ ARRAY 0048/	No pre-authorization is required for all providers.	N/A
C8750	PMKR DUAL CHMBR UNITY VDDR 292-07	No pre-authorization is required for all providers.	N/A
C8775	LEAD PMKR 2188 COR SINUS LEAD	No pre-authorization is required for all providers.	N/A
C8776	INNOMEDICA SUTLES MYOCARD PMKR LEAD	No pre-authorization is required for all providers.	N/A
C8777	LEAD PMKR UNIPASS 425-02/04/06	No pre-authorization is required for all providers.	N/A
C8800	LG PALMAZ BALL EXP BILI STNT W/DS	No pre-authorization is required for all providers.	N/A
C8801	COOK Z STNT GIANTURCO-ROSCHE BIL DSN	No pre-authorization is required for all providers.	N/A
C8802	COOK OASIS 1 ACTION BIL STNT INTRO	No pre-authorization is required for all providers.	N/A
C8830	COOK GIANTURCO-ROUBIN COR FLX-STNT	No pre-authorization is required for all providers.	N/A
C8900	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, ABDOMEN	This service is not covered by Superior HealthPlan.	N/A
C8901	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, ABDOMEN	This service is not covered by Superior HealthPlan.	N/A
C8902	MAGNETIC RESONANCE ANGIOGRAPHY W/WITHOUT CONTRAST ABDOMEN	This service is not covered by Superior HealthPlan.	N/A
C8903	MAGNETIC RESONANCE IMAGING WITH CONTRAST, BREAST	This service is not covered by Superior HealthPlan.	N/A
C8904	MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST, BREAST	This is no longer a valid code.	N/A
C8905	MAGNETIC RESONANCE IMAGING, BRASST	This service is not covered by Superior HealthPlan.	N/A
C8906	MAGNETIC RESONANCE IMAGING WITH CONTRAST, BREAST	This service is not covered by Superior HealthPlan.	N/A
C8907	MAGNETIC RESONANCE IMAGING WITHOUT CONTRAST, BREAST	This is no longer a valid code.	N/A
C8908	MAGNETIC RESONANCE IMAGING W/OUT CONTRAST	This service is not covered by Superior HealthPlan.	N/A
C8909	MAGNETIC RESONANCE ANGIOGRAPHY	This service is not covered by Superior HealthPlan.	N/A
C8910	MAGNETIC RESONANCE ANGIOGRAPHY W/OUT CONTRAST	This service is not covered by Superior HealthPlan.	N/A
C8911	MAGNETIC RESONANCE ANGIOGRAPHY	This service is not covered by Superior HealthPlan.	N/A
C8912	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, LOWER EXTREMITY	This service is not covered by Superior HealthPlan.	N/A
C8913	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, LOWER EXTREMITY	This service is not covered by Superior HealthPlan.	N/A
C8914	MAGNETIC RESONANCE ANGIOGRAPHY W/OUT CONTRAST FLLWD BY W CONT.	This service is not covered by Superior HealthPlan.	N/A
C8918	MAGNETIC RESONANCE ANGIOGRAPHY WITH CONTRAST, PELVIS	This service is not covered by Superior HealthPlan.	N/A
C8919	MAGNETIC RESONANCE ANGIOGRAPHY WITHOUT CONTRAST, PELVIS	This service is not covered by Superior HealthPlan.	N/A
C8920	MGNTC RESNNCE ANGIOGRPHY W/OUT CNTRST FLLWD BY W CNTRST, PELVIS	This service is not covered by Superior HealthPlan.	N/A
C8921	COMP TRANSTHO ECHO W/CONTR	This service is not covered by Superior HealthPlan.	N/A
C8922	LIMIT TRANSTHO ECHO W/CONTR	This service is not covered by Superior HealthPlan.	N/A
C8923	2D COM TRANSTHO ECHO W/CONTR	This service is not covered by Superior HealthPlan.	N/A
C8924	2D LIM TRANSTHO ECHO W/CONTR	This service is not covered by Superior HealthPlan.	N/A
C8925	2D TEE W/CONTRAST INT/REPT	This service is not covered by Superior HealthPlan.	N/A
C8926	CONG TEE W/CONTR INT/REPT	This service is not covered by Superior HealthPlan.	N/A
C8927	TEE W/CONTRAST MONITOR	This service is not covered by Superior HealthPlan.	N/A
C8928	2D TRANSTHO W/CONTR STRESS	This service is not covered by Superior HealthPlan.	N/A
C8929	TTE W OR WO FOL WCON DOPPLER	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
C8930	TTE W OR W O CONTR CONT ECG	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
C8931	MRA, W/DYE, SPINAL CANAL	This service is not covered by Superior HealthPlan.	N/A
C8932	MRA, W/O DYE, SPINAL CANAL	This service is not covered by Superior HealthPlan.	N/A
C8933	MRA, W/O&W/DYE, SPINAL CANAL	This service is not covered by Superior HealthPlan.	N/A
C8934	MRA, W/DYE, UPPER EXTREMITY	This service is not covered by Superior HealthPlan.	N/A
C8935	MRA, W/O DYE, UPPER EXTR	This service is not covered by Superior HealthPlan.	N/A
C8936	MRA, W/O&W/DYE, UPPER EXTR	This service is not covered by Superior HealthPlan.	N/A
C8937	CMP-AID DETN INCL CMP ALG ANALYS BR MRI IMG DATA	This service is not covered by Superior HealthPlan.	N/A
C8950	IV INFUSION FOR THERAPY/ DX UP TO 1 HOUR	No pre-authorization is required for all providers.	N/A
C8953	CHEMOTHERAPY ADMINISTRATION IV PUSH TECHNIQUE	No pre-authorization is required for all providers.	N/A
C8954	CHEMOTHERAPY ADMINISTRATION IV INFUSION TECHNIQUE UP TO 1 HOUR	No pre-authorization is required for all providers.	N/A
C8956	REFILLING & MAINT OF PORTABLE OR IMPLANT PUMP OR RESEVOIR FOR RX DELIVER	This is no longer a valid code.	N/A
C8957	PROLONGED IV INFUSION, REQUIRING PUMP	This service is not covered by Superior HealthPlan.	N/A
C9000	INJ SODIUM CHROMATE CR51 P/0.25 MCI	No pre-authorization is required for all providers.	N/A
C9003	PALIVIZUMAB-RSV-IGM P/50 MG	This is no longer a valid code.	N/A
C9007	BACLOFEN INTRATHECAL SCRNG KIT/1AMP	No pre-authorization is required for all providers.	N/A
C9008	BACLOFEN INTRATHECAL REFILL 500MCG	No pre-authorization is required for all providers.	N/A
C9009	BACLOFEN INTRATHECAL REFILL KIT, PER 2000 MCG	No pre-authorization is required for all providers.	N/A
C9013	SUPPLY OF CO 57 COBALTOUS CHLORIDE	No pre-authorization is required for all providers.	N/A
C9014	INJECTION CERLIPONASE ALFA 1 MG	This is no longer a valid code.	N/A
C9015	INJ C-1 ESA INHIBITOR HAEGARDA 10 U	This is no longer a valid code.	N/A
C9016	INJ TRIPTORELIN EXTEND REL 3.75 MG	This is no longer a valid code.	N/A
C9021	INJECTION OBINUTUZUMAB 10 MG	This is no longer a valid code.	N/A
C9022	INJECTION, ELOSULFASE ALFA	This is no longer a valid code.	N/A
C9023	INJ TESTOSTERONE UNDECANOATE 1 M	This is no longer a valid code.	N/A
C9024	INJ LIP 1 MG DNR & 2.27 MG CY	This is no longer a valid code.	N/A
C9025	INJECTION RAMUCIRUMAB 5 M	This is no longer a valid code.	N/A
C9026	INJECTION VEDOLIZUMAB 1 M	This is no longer a valid code.	N/A
C9027	INJECTION, PEMBROLIZUMAB	This is no longer a valid code.	N/A
C9028	INJ INOTUZUMAB OZOGAMICIN	This is no longer a valid code.	N/A
C9029	INJECTION GUSELKUMAB 1 MG	This is no longer a valid code.	N/A
C9030	INJECTION COPANLISIB 1 MG	This is no longer a valid code.	N/A
C9031	LUTETIUM LU 177 DOTATATE THER 1 MCI	This is no longer a valid code.	N/A
C9032	INJ VORETIGN NEPARVOVC-RZYL 1 B V G	This is no longer a valid code.	N/A
C9033	INJ FSNTPTNT 235 MG AND PLNSTRN 0.25 MG	This is no longer a valid code.	N/A
C9034	INJ DEXAMETHASONE 9 PERCENT IOL 1 MCG	This service is not covered by Superior HealthPlan.	N/A
C9035	INJECTION ARIPIPRAZOLE LAUROXIL 1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
C9036	INJECTION PATISIRAN 0.1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
C9037	INJECTION RISPERIDONE 0.5 MG	This service is not covered by Superior HealthPlan.	N/A
C9038	INJECTION MOGAMULIZUMAB-KPKC 1 MG	This service is not covered by Superior HealthPlan.	N/A
C9039	INJECTION PLAZOMICIN 5 MG	No pre-authorization is required for all providers.	N/A
C9040	INJECTION FREMANEZUMAB-VFRM 1 MG	No authorization required. Code is for informational purposes only.	N/A
C9041	INJECTION COAGULATION FACTR XA INACTIVATED 10 MG	This is no longer a valid code.	N/A
C9042	INJECTION BENDAMUSTINE HCL 1 MG	This is no longer a valid code.	N/A
C9043	INJECTION LEVOLEUCOVORIN 1 MG	This is no longer a valid code.	N/A
C9044	INJECTION CEMPLIMAB-RWLC 1 MG	This is no longer a valid code.	N/A
C9045	INJECTION MOXETUMOMAB PASUDOTOX-TDFK 0.01 MG	This is no longer a valid code.	N/A
C9046	COCAINE HYDROCHLORIDE NASAL SOL TOP ADMN 1 MG	No authorization required. Code is for informational purposes only.	N/A
C9047	INJECTION, CAPLACIZUMAB-YHDP, 1 MG	No pre-authorization is required for all providers.	N/A
C9048	DEXAMETHASONE, LACRIMAL OPTHALMIC INSERT, 0.1 MG	No pre-authorization is required for all providers.	N/A
C9049	INJECTION, TAGRAXOFUSP-ERZS, 10 MCG	Pre-authorization required for all providers.	Prior to 09/01/2019

C9050	INJECTION, EMAPALUMAB-LZSG, 1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
C9051	INJECTION, OMADACYCLINE, 1 MG	No pre-authorization is required for all providers.	N/A
C9052	INJECTION, RAVULIZUMAB-CWVZ, 10 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
C9053	INJECTION CRIZANLIZUMAB-TMCA 1 MG	This is no longer a valid code.	N/A
C9054	INJECTION LEFAMULIN XENLETA 1 MG	This is no longer a valid code.	N/A
C9055	INJECTION BREXANOLONE 1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
C9056	INJECTION GIVOSIRAN 0.5 MG	This is no longer a valid code.	N/A
C9057	INJECTION CETIRIZINE HCL 1 MG	This is no longer a valid code.	N/A
C9058	INJECTION PEGFILGRASTIM-BMEZ BIOSIMILAR 0.5 MG	This is no longer a valid code.	N/A
C9059	INJECTION MELOXICAM 1 MG	This service is not covered by Superior HealthPlan.	N/A
C9061	INJECTION TEPROTUMUMAB-TRBW 10 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
C9063	INJECTION EPTINEZUMAB-JJMR 1 MG	This service is not covered by Superior HealthPlan.	N/A
C9100	SUP RDIA IODINATED I-131 ALB	No pre-authorization is required for all providers.	N/A
C9102	SUP RDIA 51 NA CHROMATE 50 MCI	No pre-authorization is required for all providers.	N/A
C9103	SUP RD NA IOTHALAMATE I-125 10 UCI	No pre-authorization is required for all providers.	N/A
C9105	INJ HEPATITIS B IMMUNE GLOB 1ML	No pre-authorization is required for all providers.	N/A
C9112	INJECTION, PERFLUTREN LIPID MICROSPHERE, PER 2 ML VIAL	No pre-authorization is required for all providers.	N/A
C9113	INJECTION, PANTOPRAZOLE SODIUM, PER VIAL	This service is not covered by Superior HealthPlan.	N/A
C9121	INJECTION ARGATROBAN PER 5 MG	This is no longer a valid code.	N/A
C9122	MOMETASONE FUROATE SINUS IMPLANT 10 MCG SINUVA	This service is not covered by Superior HealthPlan.	N/A
C9123	TRANSCYTE, PER 247 SQUARE CENTIMETERS	No pre-authorization is required for all providers.	N/A
C9126	INJECTION NATALIZUMAB /5 MG	This is no longer a valid code.	N/A
C9128	INJECTION PEGAPTANIB SODIUM /0.3 MG	No pre-authorization is required for all providers.	N/A
C9129	INJECTION CLOFARABINE /1 MG	No pre-authorization is required for all providers.	N/A
C9130	INJ IMMUNE GLOBULIN BIVIGAM 500 MG	This is no longer a valid code.	N/A
C9131	IN ADO-TRASTUZUMAB EMTANSINE	This is no longer a valid code.	N/A
C9132	KCENTRA, PER I.U.	Pre-authorization required for all providers.	Prior to 09/01/2019
C9133	FACTOR IX RECOMBINANT	This is no longer a valid code.	N/A
C9134	FACTOR XIII A-SUBUNIT RECOMB	This is no longer a valid code.	N/A
C9135	FACTOR IX ALPROLIX PER 10 I.U.	This is no longer a valid code.	N/A
C9136	FACTOR VIII (ELOCATE)	Pre-authorization required for all providers.	Prior to 09/01/2019
C9137	ADYNOVATE FACTOR VIII RECOMB	This is no longer a valid code.	N/A
C9138	NUWIQ FACTOR VIII RECOMB	This is no longer a valid code.	N/A
C9139	IDELVION 1 IU	This is no longer a valid code.	N/A
C9140	AFSTYLA FACTOR VIII RECOMB	This is no longer a valid code.	N/A
C9141	INJECTION FACTOR VIII PEGYLATED-AUCL 1 IU	This is no longer a valid code.	N/A
C9200	ORCEL, PER 36 SQUARE CENTIMETERS	No pre-authorization is required for all providers.	N/A
C9201	DERMAGRAFT, PER 37.5 SQUARE CENTIMETERS	No pre-authorization is required for all providers.	N/A
C9202	INJ/SPNSN/MICROSPHERES/HUMAN SERUM ALBUMIN/OCTAFLUOROPROPANE/3 ML	No pre-authorization is required for all providers.	N/A
C9203	INJECTION, PERFLEXANE LIPID MICROSPHERES, PER 10 ML VIAL	No pre-authorization is required for all providers.	N/A
C9205	OXALIPLATIN INJECTION OXALIPLATIN PER 5 MG	No pre-authorization is required for all providers.	N/A
C9206	INTEGRA PER CM 2	No pre-authorization is required for all providers.	N/A
C9211	ALEFACEPT, IV, PER 7.5 MG	No pre-authorization is required for all providers.	N/A
C9212	ALEFACEPT, IM, PER 7.5 MG	No pre-authorization is required for all providers.	N/A
C9218	INJECTION AZACITIDINE PER 1 MG	No pre-authorization is required for all providers.	N/A
C9220	SODIUM HYALURONATE	No pre-authorization is required for all providers.	N/A
C9221	GRAFTJACKET REG MATRIX	No pre-authorization is required for all providers.	N/A
C9222	GRAFTJACKET SOFT TISS	No pre-authorization is required for all providers.	N/A
C9223	INJECTION ADENOSINE FOR THERAPEUTIC OR DIAGNOSTIC USE 6 MG	No pre-authorization is required for all providers.	N/A
C9224	INJECTION GALSULFASE /5 MG	No pre-authorization is required for all providers.	N/A
C9225	INJECTION FLUOCINOLONE ACETONIDE INTRAVITREAL IMPLANT /0.59 MG	No pre-authorization is required for all providers.	N/A
C9226	INJECTION ZICONOTIDE FOR INTRATHECAL INFUSION /5 MCG	No pre-authorization is required for all providers.	N/A
C9239	INJ TEMSIROLIMUS	This service is not covered by Superior HealthPlan.	N/A
C9248	INJ CLEVIDIPINE BUTYRATE	This service is not covered by Superior HealthPlan.	N/A
C9250	ARTISS FIBRIN SEALANT	No pre-authorization is required for all providers.	N/A
C9252	INJECTION, PLERIXAFOR	This service is not covered by Superior HealthPlan.	N/A
C9254	INJECTION, LACOSAMIDE	No pre-authorization is required for all providers.	N/A
C9255	PALIPERIDONE PALMITATE INJ	This is no longer a valid code.	N/A
C9256	DEXAMETHASONE INTRAVITREAL	This is no longer a valid code.	N/A
C9257	BEVACIZUMAB INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
C9262	FLUDARABINE PHOSPHATE, ORAL, 1 MG	This is no longer a valid code.	N/A
C9265	INJECTION, ROMIDEPSIN, 1MG	This is no longer a valid code.	N/A
C9266	INJECTION, COLLAGENASE CLOSTRIDIUM HISTOLYTICUM, 1MG	This is no longer a valid code.	N/A
C9268	CAPSAICIN PATCH, 10CM	This is no longer a valid code.	N/A
C9275	HEXAMINOLEVULINATE HCL	This is no longer a valid code.	N/A
C9276	CABAZITAXEL INJECTION	This is no longer a valid code.	N/A
C9280	INJECTION, ERIBULIN MESYLATE	This is no longer a valid code.	N/A
C9285	PATCH, LIDOCAINE/TETRACAINE	This service is not covered by Superior HealthPlan.	N/A
C9286	INJECTION, BELATACEPT	This is no longer a valid code.	N/A
C9287	INJ, BRENTUXIMAB VEDOTIN	This is no longer a valid code.	N/A
C9290	INJ BUPIVACAINE LIPOSOME	This service is not covered by Superior HealthPlan.	N/A
C9292	INJECTION, PERTUZUMAB	This is no longer a valid code.	N/A
C9293	INJECTION, GLUCARPIDASE	This service is not covered by Superior HealthPlan.	N/A
C9294	INJ, TALIGLUCERASE ALFA	This is no longer a valid code.	N/A
C9295	INJECTION, CARFILZOMIB	This is no longer a valid code.	N/A
C9296	INJECTION, ZIV-AFLIBERCEPT	This is no longer a valid code.	N/A
C9297	INJ OMACETAZN MEPEUSUCCINATE 0.01 MG	This is no longer a valid code.	N/A
C9298	INJECTION OCRIPLASMIN 0.125 MG	This is no longer a valid code.	N/A
C9349	PURAPLY PURAPLY ANTIMIC	This is no longer a valid code.	N/A
C9352	NEURAGEN NERVE GUIDE PER CM	This service is not covered by Superior HealthPlan.	N/A
C9353	NEURAWRAP NERVE PROTECTOR CM	This service is not covered by Superior HealthPlan.	N/A
C9354	VERITAS COLLAGEN MATRIX CM2	This service is not covered by Superior HealthPlan.	N/A
C9355	NEUROMATRIX NERVE CUFF CM	This service is not covered by Superior HealthPlan.	N/A
C9356	TENDON, POROUS MATRIX OF CROSS-LINKED COLLAGEN PER SQUARE CM	This service is not covered by Superior HealthPlan.	N/A
C9357	DERMAL SUBSTITUTE, FLOWABLE WOUND MATRIX, 1CC	No pre-authorization is required for all providers.	N/A
C9358	SURGIMEND, FETAL	This service is not covered by Superior HealthPlan.	N/A
C9359	IMPLNT, BON VOID FILLER-PUTTY	Pre-authorization is required for all providers.	Prior to 09/01/2019
C9360	SURGIMEND, NEONATAL	Pre-authorization is required for all providers.	Prior to 09/01/2019
C9361	NEUROMEND NERVE WRAP	Pre-authorization is required for all providers.	Prior to 09/01/2019
C9362	IMPLNT, BON VOID FILLER-STRIP	Pre-authorization is required for all providers.	Prior to 09/01/2019
C9363	INTEGRA MESHED BIL WOUND MAT	This service is not covered by Superior HealthPlan.	N/A
C9364	PORCINE IMPLANT, PERMACOL	This service is not covered by Superior HealthPlan.	N/A
C9367	SKIN SUBSTITUTE, ENDOFORM DERMAL TEMPLATE, SQUARE CNTMTR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
C9399	UNCLASSIFIED DRUGS OR BIOLOGICALS	Authorization is required for all non-participating providers. Authorization is required for participating providers if billed amount is greater than or equal to \$500.	Prior to 09/01/2019
C9400	SPL RADOPHRM DX THALLOUS CHLORD TL 201 MCI BRAND	No pre-authorization is required for all providers.	N/A
C9401	SPL TX RADOPHRM STRONTIUM-89 CHLORID BRAND-MCI	No pre-authorization is required for all providers.	N/A
C9402	SPL RADOPHRM TX I-131 SODIM IODIDE CAP MCI BRAND	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
C9403	SPL RADOPHRM DX I-131 SODIM IODIDE CAP MCI BRAND	No pre-authorization is required for all providers.	N/A
C9405	SPL RADOPHRM TX I-131 SODIM IODIDE SOL MCI BRAND	No pre-authorization is required for all providers.	N/A
C9407	IODINE I-131 IOBENGUANE DIAGNOSTIC 1 MCI	No pre-authorization is required for all providers.	N/A
C9408	IODINE I-131 IOBENGUANE THERAPEUTIC 1 MCI	This service is not covered by Superior HealthPlan.	N/A
C9410	INJ DEXRAZOXANE HYDROCHLORIDE PER 250 MG BRAND	No pre-authorization is required for all providers.	N/A
C9411	INJECTION PAMIDRONATE DISODIUM PER 30 MG BRAND	No pre-authorization is required for all providers.	N/A
C9413	SODIM HYALURONATE 20-25 MG IA INJ BRAND NAME	No pre-authorization is required for all providers.	N/A
C9414	ETOPOSIDE ORAL 50 MG BRAND NAME	No pre-authorization is required for all providers.	N/A
C9415	DOXORUBICIN HCL 10 MG BRAND NAME	No pre-authorization is required for all providers.	N/A
C9417	BLEOMYCIN SULFATE 15 UNITS BRAND NAME	No pre-authorization is required for all providers.	N/A
C9418	CISPLATIN POWDER/SOLUTION PER 10 MG BRAND NAME	No pre-authorization is required for all providers.	N/A
C9419	INJECTION CLADRIBINE PER 1 MG BRAND NAME	No pre-authorization is required for all providers.	N/A
C9420	CYCLOPHOSPHAMIDE 100 MG BRAND NAME	No pre-authorization is required for all providers.	N/A
C9421	CYCLOPHOSPHAMIDE LYOPHILIZED 100 MG BRAND NAME	No pre-authorization is required for all providers.	N/A

C9422	CYTARABINE 100 MG BRAND NAME	No pre-authorization is required for all providers.	N/A
C9423	DACARBAZINE 100 MG BRAND NAME	No pre-authorization is required for all providers.	N/A
C9424	DAUNORUBICIN HCL 10 MG BRAND NAME	No pre-authorization is required for all providers.	N/A
C9425	ETOPOSIDE 10 MG BRAND NAME	No pre-authorization is required for all providers.	N/A
C9426	FLOXURIDINE 500 MG BRAND NAME	No pre-authorization is required for all providers.	N/A
C9427	IFOSFAMIDE 1 GM BRAND NAME	No pre-authorization is required for all providers.	N/A
C9428	MESNA 200 MG BRAND NAME	No pre-authorization is required for all providers.	N/A
C9429	IDARUBICIN HCL 5 MG BRAND NAME	No pre-authorization is required for all providers.	N/A
C9430	LEUPROLIDE ACETATE PER 1 MG BRAND NAME	No pre-authorization is required for all providers.	N/A
C9431	PACLITAXEL 30 MG BRAND NAME	No pre-authorization is required for all providers.	N/A
C9432	MITOMYCIN 5 MG BRAND NAME	No pre-authorization is required for all providers.	N/A
C9433	THIOTEPA 15 MG BRAND NAME	No pre-authorization is required for all providers.	N/A
C9435	GONADORELIN BYDROCH BRAND	This is no longer a valid code.	N/A
C9436	AZATHIOPRINE PARENTERAL BRAND	No pre-authorization is required for all providers.	N/A
C9437	CARMUS BISCHL NITRO INJ	This is no longer a valid code.	N/A
C9438	CYCLOSPORINE ORAL 100 MG BRAND NAME	This is no longer a valid code.	N/A
C9439	DIETHYLSTILBESTROL INJECTION	No pre-authorization is required for all providers.	N/A
C9440	SUPPLY OF RADIOPHARMACEUTICAL DIAGN IMAGING AGENT THALLOUS CHLORIDE TL	No pre-authorization is required for all providers.	N/A
C9442	INJECTION, BELINOSTAT	This is no longer a valid code.	N/A
C9443	INJECTION, DALBAVANCIN	This is no longer a valid code.	N/A
C9444	INJECTION, ORITAVANCIN	This is no longer a valid code.	N/A
C9445	INJ C-1 ESTRASE INHIB RUCONEST 10 U	This is no longer a valid code.	N/A
C9446	INJ, TEDIZOLID PHOSPHATE	This is no longer a valid code.	N/A
C9447	INJ, PHENYLEPHRINE KETOROLAC	This service is not covered by Superior HealthPlan.	N/A
C9448	NETUPITNT 300MG&PALONOSTRN 0.5 MG O	This is no longer a valid code.	N/A
C9449	INJECTION BLINATUMOMAB 1 MCG	This is no longer a valid code.	N/A
C9450	INJ FA INTRAVITREAL IMPLANT 0.01 MG	This is no longer a valid code.	N/A
C9451	INJECTION PERAMIVIR 1 MG	This is no longer a valid code.	N/A
C9452	INJECTION TOL 50 MG AND TAZ 25 MG	This is no longer a valid code.	N/A
C9453	INJECTION NIVOLUMAB 1 MG	This is no longer a valid code.	N/A
C9454	INJECTION PASIREOTIDE LONG ACTING 1 MG	This is no longer a valid code.	N/A
C9455	INJECTION SILTUXIMAB 10 MG	This is no longer a valid code.	N/A
C9456	INJ, ISAVUCONAZONIUM SULFATE	This is no longer a valid code.	N/A
C9457	LUMASON CONTRAST AGENT	This is no longer a valid code.	N/A
C9458	FLORBETABEN F18 DIAGN TO 8.1 MCI	This is no longer a valid code.	N/A
C9459	FLUTEMETAMOL F18 DIAGNOSTC TO 5 MCI	This is no longer a valid code.	N/A
C9460	INJECTION CANGRELOR 1 MG	No pre-authorization is required for all providers.	N/A
C9461	CHOLINE C 11, DIAGNOSTIC	This is no longer a valid code.	N/A
C9462	INJECTION, DELAFLOXACIN	This is no longer a valid code.	N/A
C9463	INJECTION, APREPITANT	This is no longer a valid code.	N/A
C9464	INJECTION, ROLAPITANT	This is no longer a valid code.	N/A
C9465	INJECTION, DUROLANE	This is no longer a valid code.	N/A
C9466	INJECTION, BENRALIZUMAB	This is no longer a valid code.	N/A
C9467	INJ RITUXIMAB HYALURONIDASE	This is no longer a valid code.	N/A
C9468	INJ, FACTOR IX, REBINYN	This is no longer a valid code.	N/A
C9469	INJ TRIAMCINOLONE ACETONIDE	This is no longer a valid code.	N/A
C9470	ARIPIRAZOLE LAUROXIL IM	This is no longer a valid code.	N/A
C9471	HYMOVIS, 1 MG	This is no longer a valid code.	N/A
C9472	INJ TALIMOGENE LAHERPAREPVEC	This is no longer a valid code.	N/A
C9473	INJECTION, MEPOLIZUMAB	This is no longer a valid code.	N/A
C9474	INJ, IRINOTECAN LIPOSOME	This is no longer a valid code.	N/A
C9475	INJECTION, NECITUMUMAB	This is no longer a valid code.	N/A
C9476	INJECTION, DARATUMUMAB, 10 MG	This is no longer a valid code.	N/A
C9477	INJECTION, ELOTUZUMAB, 1 MG	This is no longer a valid code.	N/A
C9478	INJECTION, SEBELIPASE ALFA, 1 MG	This is no longer a valid code.	N/A
C9479	INSTILL, CIPROFLOXACIN OTIC SUSP, 6 MG	This is no longer a valid code.	N/A
C9480	INJECTION, TRABECTEDIN, 0.1 MG	This is no longer a valid code.	N/A
C9481	INJECTION RESLIZUMAB	This is no longer a valid code.	N/A
C9483	INJECTION ATEZOLIZUMAB	This is no longer a valid code.	N/A
C9484	INJECTION ETEPLIRSEN 10 MG	This is no longer a valid code.	N/A
C9485	INJECTION OLARATUMAB 10 MG	This is no longer a valid code.	N/A
C9486	INJ GRANISETRON EXTENDED RLS 0.1 MG	This is no longer a valid code.	N/A
C9487	USTEKINUMAB INTRAVENOUS INJ 1 MG	This is no longer a valid code.	N/A
C9488	INJ CONIVAPTAN HYDROCHLORIDE 1 MG	This service is not covered by Superior HealthPlan.	N/A
C9489	INJECTION, NUSINERSEN	This is no longer a valid code.	N/A
C9490	INJECTION, BEZLOTOXUMAB	This is no longer a valid code.	N/A
C9491	INJECTION, AVELUMAB, 10 MG	This is no longer a valid code.	N/A
C9492	INJECTION, DURVALUMAB, 10 MG	This is no longer a valid code.	N/A
C9493	INJECTION, EDARAVONE, 1 MG	This is no longer a valid code.	N/A
C9494	INJECTION, OCRELIZUMAB, 1 MG	This is no longer a valid code.	N/A
C9497	LOXAPINE, INHALATION POWDER	This is no longer a valid code.	N/A
C9500	PLATELETS IRRADIATED EA UNT	No pre-authorization is required for all providers.	N/A
C9501	PLATELETS PHERESIS EA UNT	No pre-authorization is required for all providers.	N/A
C9502	PLATELETS PHERESIS IRRADIATED EA	No pre-authorization is required for all providers.	N/A
C9504	RB CELLS DEGLYCEROLIZED EA UNIT	No pre-authorization is required for all providers.	N/A
C9505	RED BLD CELLS IRRADIATED EA UNT	No pre-authorization is required for all providers.	N/A
C9600	PERC DRUG-EL COR STENT SING	No pre-authorization is required for all providers.	N/A
C9601	PERC DRUG-EL COR STENT BRAN	No pre-authorization is required for all providers.	N/A
C9602	PERC D-E COR STENT ATHER S	No pre-authorization is required for all providers.	N/A
C9603	PERC D-E COR STENT ATHER BR	No pre-authorization is required for all providers.	N/A
C9604	PERC D-E COR REVASC T CABG S	No pre-authorization is required for all providers.	N/A
C9605	PERC D-E COR REVASC T CABG B	No pre-authorization is required for all providers.	N/A
C9606	PERC D-E COR REVASC W AMI S	No pre-authorization is required for all providers.	N/A
C9607	PERC D-E COR REVASC CHRO SIN	No pre-authorization is required for all providers.	N/A
C9608	PERC D-E COR REVASC CHRO ADD	No pre-authorization is required for all providers.	N/A
C9702	CHECKMATE INTRAVAS BRACHYTHERY SYS	No pre-authorization is required for all providers.	N/A
C9704	INJ/INSERT INERT SBSTNC UP GI TRACT UND FLUORO	No pre-authorization is required for all providers.	N/A
C9711	H.E.L.P. APHERESIS SYSTEM	This is no longer a valid code.	N/A
C9713	NON-CONTACT LASER VAPORIZATION PROSTATE	No pre-authorization is required for all providers.	N/A
C9718	KYPHOPLASTY FIRST VERTEBRA	No pre-authorization is required for all providers.	N/A
C9719	KYPHOPLASTY EACH ADD	No pre-authorization is required for all providers.	N/A
C9720	HE ESW TX TENNIS ELBOW	No pre-authorization is required for all providers.	N/A
C9721	HE ESW TX PLANTAR FASCIITIS	No pre-authorization is required for all providers.	N/A
C9722	KV IMAGING W/IR TRACKING	No pre-authorization is required for all providers.	N/A
C9724	EPS STOMACH PLIC	This is no longer a valid code.	N/A
C9725	PLACEMENT OF ENDORECTAL INTRACAVITARY APPLICATOR FOR HIGH INTENSITY	This service is not covered by Superior HealthPlan.	N/A
C9726	PLACEMENT ENDORECTAL INTERCAVITARY APPLICATOR	This service is not covered by Superior HealthPlan.	N/A
C9728	PLACE DEVICE/MARKER, NON PRO	This service is not covered by Superior HealthPlan.	N/A
C9733	NON-OPHTHALMIC FVA	This service is not covered by Superior HealthPlan.	N/A
C9734	FOCUSED U/S ABL/TX INT OTH THAN UL	No pre-authorization is required for all providers.	N/A
C9735	ANOSCOPY; DIR SM INJ ANY SUBSTANCE	This is no longer a valid code.	N/A
C9736	LAP ABLATE UTERI FIBROID RF	This is no longer a valid code.	N/A
C9737	LAP ESOPH AUGMENTATION	This service is not covered by Superior HealthPlan.	N/A
C9738	ADJUNCT BLUE LT CYSTO FLUO IMAG AGT	No pre-authorization is required for all providers.	N/A
C9741	IMPL PRESSURE SENSOR W/ANGIO	This is no longer a valid code.	N/A
C9742	LARYNGOSCOPY WITH INJECTION	This is no longer a valid code.	N/A
C9743	BULKING/SPACER MATERIAL IMPL	This is no longer a valid code.	N/A
C9744	ABD US W/CONTRAST	This is no longer a valid code.	N/A
C9745	NASAL ENDO EUSTACHIAN TUBE	This service is not covered by Superior HealthPlan.	N/A
C9746	TRANS IMP BALLOON CONT	This is no longer a valid code.	N/A
C9747	ABLATION, HIFU, PROSTATE	This service is not covered by Superior HealthPlan.	N/A

C9748	TRANSURETHRAL DESTRUC PROS TISS - BY	This is no longer a valid code.	N/A
C9749	REPAIR NASAL STENOSIS W/IMP	No pre-authorization is required for all providers.	N/A
C9750	INS/REM-REPLACE COMPL IIMS	This is no longer a valid code.	N/A
C9751	BRONCHOSCOPY RIGID/FLEXIBLE TRANSBRON ABL LESION	No pre-authorization is required for all providers.	N/A
C9752	DESTRUC IO BASIVERTEB NERV 1ST 2 VERT B LUMB/SAC	No pre-authorization is required for all providers.	N/A
C9753	DESTRUC IO BASIVERTEB NERV EA ADD VERT BODY L/S	No pre-authorization is required for all providers.	N/A
C9754	CREATION AV FISTULA PERCUTANEOUS DIRCT ANY SITE	This is no longer a valid code.	N/A
C9755	CREATION OF ARTERIOVENOUS FISTULA PERCUTANEOUS	This is no longer a valid code.	N/A
C9756	FLUORESCENCE LYMPH MAP W/ICG	No pre-authorization is required for all providers.	N/A
C9757	LAMINOTOMY DECOMP NERVE ROOT 1 INTERSPACE LUMB	This service is not covered by Superior HealthPlan.	N/A
C9758	BI PROC NYHA CL III/IV HF TRNSCATH IMPL IAS/PC	This service is not covered by Superior HealthPlan.	N/A
C9759	TRANSCATHETER IO BLOOD VESSEL MICROINFUSION TX	This service is not covered by Superior HealthPlan.	N/A
C9760	NONRAND NONBL PRO NYHA CL II III IV HEART FAIL	This service is not covered by Superior HealthPlan.	N/A
C9762	CMRI MORPHOL AND FUNC QUAN SEG DYSFUNC STRAIN IMAG	This service is not covered by Superior HealthPlan.	N/A
C9763	CMRI MORPHOL AND FUNC QUAN SEG DYSFUNC STRESS IMAG	This service is not covered by Superior HealthPlan.	N/A
C9764	REV EVAR OPEN/PERQ ANY VESSEL IV LITHOTRIPSY	This service is not covered by Superior HealthPlan.	N/A
C9765	REV EVAR ANY VES IV LITHOTRIPSY AND TL STENT PLCMT	This service is not covered by Superior HealthPlan.	N/A
C9766	REV EVAR ANY VES) IV LITHOTRIPSY AND ATHERECTOMY	This service is not covered by Superior HealthPlan.	N/A
C9767	REV EVAR ANY VES IV LITHO AND TL STNT PLCMT AND ATHERECT	This service is not covered by Superior HealthPlan.	N/A
C9800	DERMAL FILLER INJ PX/SUPP	This is no longer a valid code.	N/A
C9898	INPNT STAY RADIOLABELED ITEM	This service is not covered by Superior HealthPlan.	N/A
C9899	INPT IMPLANT PROS DEV NO COV	This service is not covered by Superior HealthPlan.	N/A
D0120	PERIODIC ORAL EVALUATION, EST PATIENT	Dental services are administered by DentaQuest.	N/A
D0140	LIMITED ORAL EVALUATION-PROBLEM FOCUSED	Dental services are administered by DentaQuest.	N/A
D0145	ORAL EVAL FOR PATIENT UNDER 3 YRS AGE & COUNSEL W PRIM CAREGIVER	Dental services are administered by DentaQuest.	N/A
D0150	COMP ORAL EVALUATION - NEW/EST PT	Dental services are administered by DentaQuest.	N/A
D0160	DETAIL & EXTEN ORAL EVAL-PROB FOCUSED, BR	Dental services are administered by DentaQuest.	N/A
D0170	RE-EVAL LTD-PROB FOCUSED (ESTAB PT)	Dental services are administered by DentaQuest.	N/A
D0171	RE-EVALUATION-POST-OP OFFICE VISIT	Dental services are administered by DentaQuest.	N/A
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	Dental services are administered by DentaQuest.	N/A
D0190	SCREENING OF A PATIENT	Dental services are administered by DentaQuest.	N/A
D0191	ASSESSMENT OF A PATIENT	Dental services are administered by DentaQuest.	N/A
D0210	INTRAORAL-CMPL SER RADIOGRAPH IMAGS	Dental services are administered by DentaQuest.	N/A
D0220	IO-PERIALPICAL 1ST RADIOGRAPHIC IMAGE	Dental services are administered by DentaQuest.	N/A
D0230	IO-PERIALPICAL EA ADD RADIOGRPH IMAG	Dental services are administered by DentaQuest.	N/A
D0240	INTRAORAL-OCCLUSAL RADIOGRAPH IMAGE	Dental services are administered by DentaQuest.	N/A
D0250	EXTRA-ORAL - 2D PROJECTION X-RAY	Dental services are administered by DentaQuest.	N/A
D0260	EXTRAORAL-EA ADD RADIOGRAPHIC IMAGE	Dental services are administered by DentaQuest.	N/A
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	Dental services are administered by DentaQuest.	N/A
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	Dental services are administered by DentaQuest.	N/A
D0273	BITEWINGS-THREE RADIOGRAPHIC IMAGES	Dental services are administered by DentaQuest.	N/A
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	Dental services are administered by DentaQuest.	N/A
D0277	VERT BITEWINGS - 7-8 RADIOGRAPH IMAG	Dental services are administered by DentaQuest.	N/A
D0290	POST-ANT/LAT SKULL&FACE BONE FILM	Dental services are administered by DentaQuest.	N/A
D0310	SIALOGRAPHY	Dental services are administered by DentaQuest.	N/A
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM INCLUDING INJ	Dental services are administered by DentaQuest.	N/A
D0321	OTH TMJ FILMS BY REPORT	Dental services are administered by DentaQuest.	N/A
D0322	TOMOGRAPHIC SURVEY	Dental services are administered by DentaQuest.	N/A
D0330	PANORAMIC RADIOGRAPHIC IMAGE	Dental services are administered by DentaQuest.	N/A
D0340	2D CEPHALOMET X-RAY-ACQN MSR&ANALY	Dental services are administered by DentaQuest.	N/A
D0350	ORAL/FACIAL PHOTOGRAPH IMAGES IO/EO	Dental services are administered by DentaQuest.	N/A
D0351	3D PHOTOGRAPHIC IMAGE	Dental services are administered by DentaQuest.	N/A
D0363	CONE BEAM 3 DIMENSION IMAGE RECONSTR USING EXIST DATA INCL MULT IMAGE	This is no longer a valid code.	N/A
D0364	CONE BM CT CAP&INT LTD FD VW<1 W JW	Dental services are administered by DentaQuest.	N/A
D0365	CONE BEAM CT 1 FULL DENT ARCH-MAND	Dental services are administered by DentaQuest.	N/A
D0366	CONE BEAM CT 1 FULL DENT ARCH-MAX	Dental services are administered by DentaQuest.	N/A
D0367	CONE BEAM CT CAP&INT FD VW BOTH JWS	Dental services are administered by DentaQuest.	N/A
D0368	CONE BM CT CAP&INT TMJ SER2/>EXPOS	Dental services are administered by DentaQuest.	N/A
D0369	MAXILLOFACIAL MRI CAP & INTERPRET	Dental services are administered by DentaQuest.	N/A
D0370	MAXILLOFACIAL U/S CAP & INTERPRET	Dental services are administered by DentaQuest.	N/A
D0371	SIALOENDOSCOPY CAP & INTERPRETATION	Dental services are administered by DentaQuest.	N/A
D0380	CONE BEAM CT IMAG LTD FD VW<1 W JAW	Dental services are administered by DentaQuest.	N/A
D0381	CONE BEAM CT 1 FULL DENT ARCH-MAND	Dental services are administered by DentaQuest.	N/A
D0382	CONE BEAM CT 1 FULL DENT ARCH-MAX	Dental services are administered by DentaQuest.	N/A
D0383	CONE BEAM CT CAP FD VIEW BOTH JAWS	Dental services are administered by DentaQuest.	N/A
D0384	CONE BM CT IMAG CAP TMJ SER2/>EXPOS	Dental services are administered by DentaQuest.	N/A
D0385	MAXILLOFACIAL MRI IMAGE CAPTURE	Dental services are administered by DentaQuest.	N/A
D0386	MAXILLOFACIAL ULTRASOUND IMAGE CAP	Dental services are administered by DentaQuest.	N/A
D0391	INT DX IMAG P NOT ASSO CAP IMAG RPT	Dental services are administered by DentaQuest.	N/A
D0393	TX SIMULATION 3D IMAGE VOLUME	Dental services are administered by DentaQuest.	N/A
D0394	DIGTL SUBTR 2/> IMAGES/VOL SAME MOD	Dental services are administered by DentaQuest.	N/A
D0395	FUSION 2/> 3D IMAG VOL 1/> MODAL	Dental services are administered by DentaQuest.	N/A
D0415	BACTERIOLOGIC STUDIES DETERMINE PATHOLOGIC AGENT	Dental services are administered by DentaQuest.	N/A
D0416	VIRAL CULTURE	Dental services are administered by DentaQuest.	N/A
D0417	COLLECT & PREP SALIVA SAMPLE	Dental services are administered by DentaQuest.	N/A
D0418	ANALYSIS OF SALIVA SAMPLE	Dental services are administered by DentaQuest.	N/A
D0421	GENETIC TEST FOR SUSCEPTIBILITY TO ORAL DISEASES	Dental services are administered by DentaQuest.	N/A
D0425	CARIES SUSCEPTIBILITY TESTS	Dental services are administered by DentaQuest.	N/A
D0431	ADJUNCTIVE PREDX TST NOT INCL CYTOLOGY/BX PROC	Dental services are administered by DentaQuest.	N/A
D0460	PULP VITALITY TESTS	Dental services are administered by DentaQuest.	N/A
D0470	DIAGNOSTIC CASTS	Dental services are administered by DentaQuest.	N/A
D0471	DIAGNOSTIC PHOTOGRAPHS	This is no longer a valid code.	N/A
D0472	ACCESS TISS-GROSS EXAM-PREP & REPRT	Dental services are administered by DentaQuest.	N/A
D0473	ACCESS TISS-GROSS/MICRO-PREP/REPRT	Dental services are administered by DentaQuest.	N/A
D0474	ACCESS TISS/SURG MARGINS-PREP/REPRT	Dental services are administered by DentaQuest.	N/A
D0475	DECALCIFICATION PROCEDURE	Dental services are administered by DentaQuest.	N/A
D0476	SPECIAL STAINS FOR MICROORGANISMS	Dental services are administered by DentaQuest.	N/A
D0477	SPECIAL STAINS NOT FOR MICROORGANISMS	Dental services are administered by DentaQuest.	N/A
D0478	IMMUNOHISTOCHEMICAL STAINS	Dental services are administered by DentaQuest.	N/A
D0479	TISSUE INSITU HYBRIDIZATION INCL INTERPRETATION	Dental services are administered by DentaQuest.	N/A
D0480	ACCESSION OF EXFOLIATIVE CYTOLOGIC SMEARS, MICROSCOPIC EXAM, PREP & TRA	Dental services are administered by DentaQuest.	N/A
D0481	ELECTRON MICROSCOPY DIAGNOSTIC	Dental services are administered by DentaQuest.	N/A
D0482	DIRECT IMMUNOFLUORESCENCE	Dental services are administered by DentaQuest.	N/A
D0483	INDIRECT IMMUNOFLUORESCENCE	Dental services are administered by DentaQuest.	N/A
D0484	CONSULTATION ON SLIDES PREPARED ELSEWHERE	Dental services are administered by DentaQuest.	N/A
D0485	CONSULT INCL PREP SLIDES BX MATL SPL REF SRC	Dental services are administered by DentaQuest.	N/A
D0486	LAB ACCSS TRNSEPI CYTL SMP MICRO EX	Dental services are administered by DentaQuest.	N/A
D0502	OTHER ORAL PATHOLOGYH PROCEDURES BY REPORT	Dental services are administered by DentaQuest.	N/A
D0999	UNSPECIFIED DIAGNOSTIC PROCEDURE BY REPORT	Dental services are administered by DentaQuest.	N/A
D1110	PROPHYLAXIS ADULT	Dental services are administered by DentaQuest.	N/A
D1120	PROPHYLAXIS CHILD	Dental services are administered by DentaQuest.	N/A
D1201	Osteoarthritis M >=61.50...comorbidity in tier 3	Dental services are administered by DentaQuest.	N/A
D1205	TOPICAL FLUORIDE (INC PROPHYLAXIS) ADULT	This is no longer a valid code.	N/A
D1206	TOPICAL APPLICATN FLUORIDE VARNISH	Dental services are administered by DentaQuest.	N/A
D1208	TOPICAL APPLICATION OF FLUORIDE	Dental services are administered by DentaQuest.	N/A
D1310	NUTRITION COUNSEL CONTROL OF DENTAL DISEASE	Dental services are administered by DentaQuest.	N/A
D1320	TOBACCO COUNSEL-CONTRL & PREVENT ORAL DIS	Dental services are administered by DentaQuest.	N/A
D1330	ORAL HYGIENE INSTRUCTION	Dental services are administered by DentaQuest.	N/A
D1351	SEALANT PER TOOTH	Dental services are administered by DentaQuest.	N/A
D1352	PRVNT RSN RESTOR PMNT TOOTH	Dental services are administered by DentaQuest.	N/A
D1353	SEALANT REPAIR - PER TOOTH	Dental services are administered by DentaQuest.	N/A

D1510	SPACE MAINTAINER - FIXED UNILATERAL - PER QUAD	Dental services are administered by DentaQuest.	N/A
D1515	SPACE MAINTAINER FIXED BILATERAL	Dental services are administered by DentaQuest.	N/A
D1520	SPACE MAINTAINER - REMOVABLE UNI - PER QUADRANT	Dental services are administered by DentaQuest.	N/A
D1525	SPACE MAINTAINER REMOVABLE BILATERAL	Dental services are administered by DentaQuest.	N/A
D1550	RECEMENTATION OF SPACE MAINTAINER	Dental services are administered by DentaQuest.	N/A
D1555	REMOVAL OF FIXED SPACE MAINTAINER	Dental services are administered by DentaQuest.	N/A
D1999	UNSPECIFIED PREVENTIVE PROCEDURE BY REPORT	Dental services are administered by DentaQuest.	N/A
D2131	AMALGAM FOUR/MORE SURFACES PRIMARY	Dental services are administered by DentaQuest.	N/A
D2140	AMALGAM-ONE SURFACE PRIMARY/PERM	Dental services are administered by DentaQuest.	N/A
D2150	AMALGAM-TWO SURFACES PRIMARY/PERM	Dental services are administered by DentaQuest.	N/A
D2160	AMALGAM-3 SURFACES PRIMARY/PERM	Dental services are administered by DentaQuest.	N/A
D2161	AMALGAM-FOUR/MORE SURF PRIM/PERM	Dental services are administered by DentaQuest.	N/A
D2210	SILICATE CEMENT PER RESTORATION	Dental services are administered by DentaQuest.	N/A
D2330	RESIN ONE SURFACE ANTERIOR	Dental services are administered by DentaQuest.	N/A
D2331	RESIN TWO SURFACES ANTERIOR	Dental services are administered by DentaQuest.	N/A
D2332	RESIN THREE SURFACES ANTERIOR	Dental services are administered by DentaQuest.	N/A
D2335	RESIN FOUR/MORE SURFACES/INCISAL ANGLE ANT	Dental services are administered by DentaQuest.	N/A
D2380	RESIN ONE SURFACE POSTERIOR PRIMARY	Dental services are administered by DentaQuest.	N/A
D2385	RESIN ONE SURFACE POSTERIOR PERMANENT	Dental services are administered by DentaQuest.	N/A
D2390	RESIN COMPOS CROWN ANTERIOR	Dental services are administered by DentaQuest.	N/A
D2391	RESIN COMPOS - 1 SURFACE POSTERIOR	Dental services are administered by DentaQuest.	N/A
D2392	RESIN COMPOS - 2 SURFACES POSTERIOR	Dental services are administered by DentaQuest.	N/A
D2393	RESIN COMPOS - 3 SURFACES POSTERIOR	Dental services are administered by DentaQuest.	N/A
D2394	RESIN COMPOS - 4/MORE SURFACES POST	Dental services are administered by DentaQuest.	N/A
D2410	GOLD FOIL ONE SURFACE	Dental services are administered by DentaQuest.	N/A
D2420	GOLD FOIL TWO SURFACES	Dental services are administered by DentaQuest.	N/A
D2430	GOLD FOIL THREE SURFACES	Dental services are administered by DentaQuest.	N/A
D2510	INLAY METALLIC ONE SURFACE	Dental services are administered by DentaQuest.	N/A
D2520	INLAY-METALLIC TWO-SURFACES	Dental services are administered by DentaQuest.	N/A
D2530	INLAY-METALLIC-THREE OR MORE SURFACES	Dental services are administered by DentaQuest.	N/A
D2542	ONLAY-METALLIC-2 SURFACES	Dental services are administered by DentaQuest.	N/A
D2543	ONLAY-METALLIC-THREE SURFACES	Dental services are administered by DentaQuest.	N/A
D2544	ONLAY-METALLIC-FOUR OR MORE SURFACES	Dental services are administered by DentaQuest.	N/A
D2610	INLAY PORCELAIN/CERAMIC ONE SURFACE	Dental services are administered by DentaQuest.	N/A
D2620	INLAY PORCELAIN/CERAMIC TWO SURFACES	Dental services are administered by DentaQuest.	N/A
D2630	INLAY-PORCELAIN/CERAMIC-THREE OR MORE SURFACES	Dental services are administered by DentaQuest.	N/A
D2642	ONLAY-PORCELAIN/CERAMIC-TWO SURFACES	Dental services are administered by DentaQuest.	N/A
D2643	ONLAY-PORCELAIN/CERAMIC-THREE SURFACES	Dental services are administered by DentaQuest.	N/A
D2644	ONLAY-PORCELAIN/CERAMIC-FOUR OR MORE SURFACES	Dental services are administered by DentaQuest.	N/A
D2650	INLAY COMPOSIT RESIN ONE SURFACE (LAB PROC)	Dental services are administered by DentaQuest.	N/A
D2651	INLAY COMPOSIT RESIN TWO SURFACE (LAB PROC)	Dental services are administered by DentaQuest.	N/A
D2652	INLAY-COMPOSITE/RESIN->3 SURF (LAB PROCESS)	Dental services are administered by DentaQuest.	N/A
D2662	ONLAY-COMPOSITE/RESIN-TWO SURFACES	Dental services are administered by DentaQuest.	N/A
D2663	ONLAY-COMPOSITE/RESIN-THREE SURFACES	Dental services are administered by DentaQuest.	N/A
D2664	ONLAY-COMPOSITE/RESIN-FOUR OR MORE SURFACES	Dental services are administered by DentaQuest.	N/A
D2710	CROWN - RESIN-BASED COMPOSITE	Dental services are administered by DentaQuest.	N/A
D2712	CROWN 3/4 RESINBASED COMPOSITE INDIRECT	Dental services are administered by DentaQuest.	N/A
D2720	CROWN RESIN WITH HIGH NOBLE METAL	Dental services are administered by DentaQuest.	N/A
D2721	CROWN RESIN WITH PREDOMINANTLY BASE METAL	Dental services are administered by DentaQuest.	N/A
D2722	CROWN RESIN WITH NOBLE METAL	Dental services are administered by DentaQuest.	N/A
D2740	CROWN - PORCELAIN/CERAMIC	Dental services are administered by DentaQuest.	N/A
D2750	CROWN PORCELAIN FUSED TO HIGH NOBLE METAL	Dental services are administered by DentaQuest.	N/A
D2751	CROWN PORCELAIN FUSED TO PREDOMINATE BASE METAL	Dental services are administered by DentaQuest.	N/A
D2752	CROWN PORCELAIN FUSED TO NOBLE METAL	Dental services are administered by DentaQuest.	N/A
D2780	CROWN-3/4 CAST HIGH NOBLE METAL	Dental services are administered by DentaQuest.	N/A
D2781	CROWN-3/4 CAST PREDOM BASE METAL	Dental services are administered by DentaQuest.	N/A
D2782	CROWN - 3/4 CAST NOBLE METAL	Dental services are administered by DentaQuest.	N/A
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	Dental services are administered by DentaQuest.	N/A
D2790	CROWN FULL CAST HIGH NOBLE METAL	Dental services are administered by DentaQuest.	N/A
D2791	CROWN FULL CAST PREDOMINANTLY BASE METAL	Dental services are administered by DentaQuest.	N/A
D2792	CROWN FULL CAST NOBLE METAL	Dental services are administered by DentaQuest.	N/A
D2794	CROWN - TITANIUM AND TITANIUM ALLOYS	Dental services are administered by DentaQuest.	N/A
D2799	PROV CROWN-TX/CMPL DX B4 FINAL IMP	Dental services are administered by DentaQuest.	N/A
D2810	CROWN 3/4 CAST METALLIC	This is no longer a valid code.	N/A
D2910	RECEMENT INLAY ONLAY/PART COV REST	Dental services are administered by DentaQuest.	N/A
D2915	RECEMENT CAST/PREFAB POST & CORE	Dental services are administered by DentaQuest.	N/A
D2920	RECEMENT CROWN	Dental services are administered by DentaQuest.	N/A
D2921	REATTCH TOOTH FRAG INCISL EDGE/CUSP	Dental services are administered by DentaQuest.	N/A
D2929	PREFAB PORC/CERAMC CROWN-PRIM TOOTH	Dental services are administered by DentaQuest.	N/A
D2930	PREFABRICATED STAINLESS STEEL CROWN PRIMRY TOOTH	Dental services are administered by DentaQuest.	N/A
D2931	PREFABRICATED STAINLESS STEEL CROWN PERM TOOTH	Dental services are administered by DentaQuest.	N/A
D2932	PREFABRICATED RESIN CROWN	Dental services are administered by DentaQuest.	N/A
D2933	PREFABRICATED STAINLESS STEEL CROWN RESIN WINDOW	Dental services are administered by DentaQuest.	N/A
D2934	PREFAB ESTHETIC COAT STNLESS STEEL CROWN PRIM	Dental services are administered by DentaQuest.	N/A
D2940	PROTECTIVE RESTORATION	Dental services are administered by DentaQuest.	N/A
D2941	INTRIM TX RESTORATION-PRIM DENTITN	Dental services are administered by DentaQuest.	N/A
D2949	RESTORATIV FOUNDATN INDIR RESTORATN	Dental services are administered by DentaQuest.	N/A
D2950	CORE BUILDUP INCL PINS WHEN REQUIRE	Dental services are administered by DentaQuest.	N/A
D2951	PIN RETENTION PER TOOTH IN ADD TO RESTORATION	Dental services are administered by DentaQuest.	N/A
D2952	POST & CODE IN ADDITION TO CROWN, INDIRECTLY FABRICATED	Dental services are administered by DentaQuest.	N/A
D2953	EACH ADDITIONAL INDIRECTLY FABRICATED POST, SAME TOOTCH	Dental services are administered by DentaQuest.	N/A
D2954	PREFABRICATED POST & CORE IN ADD TO CROWN	Dental services are administered by DentaQuest.	N/A
D2955	POST REMOVAL	Dental services are administered by DentaQuest.	N/A
D2957	EA ADD PREFAB POST-SAME TOOTH	Dental services are administered by DentaQuest.	N/A
D2960	LABIAL VENEER (LAMINATE) CHAIRSIDE	Dental services are administered by DentaQuest.	N/A
D2961	LABIAL VENEER (RESIN LAMINATE) LABORATORY	Dental services are administered by DentaQuest.	N/A
D2962	LABIAL VENEER (PORCELAIN LAMINATE) LABORATORY	Dental services are administered by DentaQuest.	N/A
D2970	TEMPORARY (FRACTURED TOOTH)	Dental services are administered by DentaQuest.	N/A
D2971	ADD PROC NEW CRWN UND XSTING PART DENTUR FRMEWRK	Dental services are administered by DentaQuest.	N/A
D2975	COPING	Dental services are administered by DentaQuest.	N/A
D2980	CROWN REPR NEC RESTORATV MATL FAIL	Dental services are administered by DentaQuest.	N/A
D2981	INLAY REPR NEC RESTORATV MATL FAIL	Dental services are administered by DentaQuest.	N/A
D2982	ONLAY REPR NEC RESTORATV MATL FAIL	Dental services are administered by DentaQuest.	N/A
D2983	VENEER REPR NEC RESTORATV MATL FAIL	Dental services are administered by DentaQuest.	N/A
D2990	RESIN INFIL INCIPIENT SMTH SURF LES	Dental services are administered by DentaQuest.	N/A
D2999	UNSPECIFIED RESTORATIVE PROCEDURE BY REPORT	Dental services are administered by DentaQuest.	N/A
D3110	PULP CAP DIRECT (EXCLUDING FINAL RESTORATION)	Dental services are administered by DentaQuest.	N/A
D3120	PULP CAP INDIRECT (EXCLUDING FINAL RESTORATION)	Dental services are administered by DentaQuest.	N/A
D3220	THERAPEUTIC PULPOTOMY (EXC FINAL RESTORATION)	Dental services are administered by DentaQuest.	N/A
D3221	PULPAL DEBRID PRIMARY&PERM TEETH	Dental services are administered by DentaQuest.	N/A
D3222	PART PULP FOR APEXOGENESIS	Dental services are administered by DentaQuest.	N/A
D3230	PULPAL THERAP-ANT PRIM TTH (EXCLD FINAL RESTOR)	Dental services are administered by DentaQuest.	N/A
D3240	PULPAL THERAP-POST PRIM TTH (EXCLD FINAL RESTOR)	Dental services are administered by DentaQuest.	N/A
D3310	END THXPY, ANTERIOR TOOTH	Dental services are administered by DentaQuest.	N/A
D3320	ENDODONTIC THERAPY PREMOLAR TOOTH	Dental services are administered by DentaQuest.	N/A
D3330	ENDODONTIC THERAPY MOLAR TOOTH	Dental services are administered by DentaQuest.	N/A
D3331	TX ROOT CANAL OBSTRUC NON-SURG	Dental services are administered by DentaQuest.	N/A
D3332	INCOMPLT ENDO THERAP-INOP/FX TOOTH	Dental services are administered by DentaQuest.	N/A
D3333	INT ROOT REPR-PERFORATION DEFECTS	Dental services are administered by DentaQuest.	N/A
D3346	RETREATMENT PREVIOUS ROOT CANAL THERAPY-ANT	Dental services are administered by DentaQuest.	N/A
D3347	RETREATMENT PREVIOUS RC TX-PREMOLAR	Dental services are administered by DentaQuest.	N/A

D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-MOLA	Dental services are administered by DentaQuest.	N/A
D3351	APEX/RECALCIFICATION INITIAL VISIT	Dental services are administered by DentaQuest.	N/A
D3352	APEX/RECALCIFICATN INTRM MED REPLAC	Dental services are administered by DentaQuest.	N/A
D3353	APEXIFICATION/RECALCIFICATION FINAL VISIT	Dental services are administered by DentaQuest.	N/A
D3354	ENDO PUPAL REGEN IM PER TOOT	This is no longer a valid code.	N/A
D3355	PULPAL REGENERATION - INITIAL VISIT	Dental services are administered by DentaQuest.	N/A
D3356	PULPAL REGENERATION - MED REPLACMNT	Dental services are administered by DentaQuest.	N/A
D3357	PULPAL REGENERATION - COMPLETION TX	Dental services are administered by DentaQuest.	N/A
D3410	APICOECTOMY - ANTERIOR	Dental services are administered by DentaQuest.	N/A
D3421	APICOECTOMY - PREMOLAR	Dental services are administered by DentaQuest.	N/A
D3425	APICOECTOMY - MOLAR FIRST ROOT	Dental services are administered by DentaQuest.	N/A
D3426	APICOECTOMY	Dental services are administered by DentaQuest.	N/A
D3427	PERIRADICULAR SURG W/O APICOECTOMY	Dental services are administered by DentaQuest.	N/A
D3428	BONE GRAFT PERIRADICULR SURG 1 SITE	Dental services are administered by DentaQuest.	N/A
D3429	BONE GRAFT PERIRADICULR SURG EA ADD	Dental services are administered by DentaQuest.	N/A
D3430	RETROGRADE FILLING PER ROOT	Dental services are administered by DentaQuest.	N/A
D3431	BIOL MATL TSS REGEN PERIRADICLR SRG	Dental services are administered by DentaQuest.	N/A
D3432	GUIDE TISS REGEN PERIRADICULAR SURG	Dental services are administered by DentaQuest.	N/A
D3450	ROOT AMPUTATION PER ROOT	Dental services are administered by DentaQuest.	N/A
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	Dental services are administered by DentaQuest.	N/A
D3470	INTENTIONAL REPLANTATION (INC NECESSARY SPLINT)	Dental services are administered by DentaQuest.	N/A
D3910	SURGICAL PROC ISOLATE TOOTH W/RUBBER DAM	Dental services are administered by DentaQuest.	N/A
D3920	HEMISECTION (INC ROOT REMOVAL) WO ROOT CANAL	Dental services are administered by DentaQuest.	N/A
D3950	CANAL PREP & FITTING PREFORMED DOWEL/POST	Dental services are administered by DentaQuest.	N/A
D3960	BLEACHING DISCOLORED TOOTH	This is no longer a valid code.	N/A
D3999	UNSPECIFIED ENDODONTIC PROCEDURE BY REPORT	Dental services are administered by DentaQuest.	N/A
D4210	GINGIVECTOMY/PLASTY PER QUAD	Dental services are administered by DentaQuest.	N/A
D4211	GINGIVECTOMY/PLASTY PER TOOT	Dental services are administered by DentaQuest.	N/A
D4212	GING/GINGIVOPLASTY RES PROC-TOOTH	Dental services are administered by DentaQuest.	N/A
D4230	ANAT CROWN EXP-4/>CONT TEETH/BND TT SPACES QUAD	Dental services are administered by DentaQuest.	N/A
D4231	ANAT CROWN EXP 1-3 TEETH/BND TOOTH SP PER QUAD	Dental services are administered by DentaQuest.	N/A
D4240	GINGIVAL FLAP PROC W/ PLANIN	Dental services are administered by DentaQuest.	N/A
D4241	GNGVL FLAP W ROOTPLAN 1-3 TH	Dental services are administered by DentaQuest.	N/A
D4245	APICALLY POSITIONED FLAP	Dental services are administered by DentaQuest.	N/A
D4249	CLIN CROWN LEN - HARD TISSUE	Dental services are administered by DentaQuest.	N/A
D4250	MUCOGINGIVAL SURGERY PER QUADRANT	Dental services are administered by DentaQuest.	N/A
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	Dental services are administered by DentaQuest.	N/A
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	Dental services are administered by DentaQuest.	N/A
D4263	BONE REPL GRAFT - RET NAT TOOTH - 1ST SITE QUAD	Dental services are administered by DentaQuest.	N/A
D4264	BONE REPL GR - RET NAT TOOTH - EA ADD SITE QUAD	Dental services are administered by DentaQuest.	N/A
D4265	BIO MATL AID SFT&OSSEOUS TISS REGEN	Dental services are administered by DentaQuest.	N/A
D4266	GUID TISS REGEN-RESORB BARRIER/SITE/TOOTH	Dental services are administered by DentaQuest.	N/A
D4267	GUID TISS REGEN-NONRESORB BARR/SITE/TOOTH	Dental services are administered by DentaQuest.	N/A
D4268	SURG REVISION PROC/TOOTH	Dental services are administered by DentaQuest.	N/A
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	Dental services are administered by DentaQuest.	N/A
D4273	AUTOGEN CONNECTIVE TISS GRAFT PROC	Dental services are administered by DentaQuest.	N/A
D4274	MESIAL/DISTAL WEDGE PROCEDURE SINGLE TOOTH	Dental services are administered by DentaQuest.	N/A
D4275	NON-AUTOGENOUS CONNECTIVE TISS GRFT	Dental services are administered by DentaQuest.	N/A
D4276	COMB CNCTV TISSUE&DBL PEDICLE GRAFT	Dental services are administered by DentaQuest.	N/A
D4277	FREE SFT TSS GFT 1ST T/EDNTULOUS T	Dental services are administered by DentaQuest.	N/A
D4278	FREE ST GFT EA CNTG T/EDNT T SAME S	Dental services are administered by DentaQuest.	N/A
D4320	PROVISIONAL SPLINTING-INTRACORONAL	Dental services are administered by DentaQuest.	N/A
D4321	PROVISIONAL SPLINTING EXTRACORONAL	Dental services are administered by DentaQuest.	N/A
D4341	PRDONTAL SCAL 4/> CONT TEETH-QUAD	Dental services are administered by DentaQuest.	N/A
D4342	PRDONTAL SCAL&ROOT PLAN 1-3 TEETH	Dental services are administered by DentaQuest.	N/A
D4355	FM DEBR ENBL COMP OR E&DX SUBQ VST	Dental services are administered by DentaQuest.	N/A
D4381	LOC DEL ANTIM DZ CRVICUL TISS-TOOTH	Dental services are administered by DentaQuest.	N/A
D4910	PERIODONTAL MAINTENANCE	Dental services are administered by DentaQuest.	N/A
D4920	UNSCHEDULED DRESSING CHANGE	Dental services are administered by DentaQuest.	N/A
D4921	GINGIVAL IRRIGATION - PER QUADRANT	Dental services are administered by DentaQuest.	N/A
D4999	UNSPECIFIED PERIODONTAL PROCEDURE BY REPORT	Dental services are administered by DentaQuest.	N/A
D5110	COMPLETE DENTURE MAXILLARY	Dental services are administered by DentaQuest.	N/A
D5120	COMPLETE DENTURE MANDIBULAR	Dental services are administered by DentaQuest.	N/A
D5130	IMMEDIATE DENTURE MAXILLARY	Dental services are administered by DentaQuest.	N/A
D5140	IMMEDIATE DENTURE MANDIBULAR	Dental services are administered by DentaQuest.	N/A
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	Dental services are administered by DentaQuest.	N/A
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	Dental services are administered by DentaQuest.	N/A
D5213	MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK	Dental services are administered by DentaQuest.	N/A
D5214	MANDIBULAR PRTL DENTURE - CAST METAL FRAMEWORK	Dental services are administered by DentaQuest.	N/A
D5225	MAXILLARY PARTIAL DENTURE FLEXIBLE BASE	Dental services are administered by DentaQuest.	N/A
D5226	MANDIBULAR PARTIAL DENTURE FLEXIBLE BASE	Dental services are administered by DentaQuest.	N/A
D5281	REMOV UNILAT PART DENT-ONE PIECE CAST METAL	Dental services are administered by DentaQuest.	N/A
D5410	ADJUST COMPLETE DENTURE-MAXILLARY	Dental services are administered by DentaQuest.	N/A
D5411	ADJUST COMPLETE DENTURE-MANDIBULAR	Dental services are administered by DentaQuest.	N/A
D5421	ADJUST PARTIAL DENTURE-MAXILLARY	Dental services are administered by DentaQuest.	N/A
D5422	ADJUST PARTIAL DENTURE-MANDIBULAR	Dental services are administered by DentaQuest.	N/A
D5510	REPAIR BROKEN COMPLETE DENTURE BASE	Dental services are administered by DentaQuest.	N/A
D5520	REPLACE MISS/BROKE TEETH COMP DENTURE EA TOOTH	Dental services are administered by DentaQuest.	N/A
D5610	REPAIR RESIN DENTURE BASE	Dental services are administered by DentaQuest.	N/A
D5620	REPAIR CAST FRAMEWORK	Dental services are administered by DentaQuest.	N/A
D5630	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	Dental services are administered by DentaQuest.	N/A
D5640	REPLACE BROKEN TEETH PER TOOTH	Dental services are administered by DentaQuest.	N/A
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	Dental services are administered by DentaQuest.	N/A
D5660	ADD CLASP XST PRT DENTURE-PER TOOTH	Dental services are administered by DentaQuest.	N/A
D5670	REPL ALL TEETH&ACRYLC FRMEWRK MAX	Dental services are administered by DentaQuest.	N/A
D5671	REPL ALL TEETH&ACRYLC FRMEWRK MAND	Dental services are administered by DentaQuest.	N/A
D5710	REBASE COMPLETE MAXILLARY DENTURE	Dental services are administered by DentaQuest.	N/A
D5711	REBASE COMPLETE MANDIBULAR DENTURE	Dental services are administered by DentaQuest.	N/A
D5720	REBASE MAXILLARY PARTIAL DENTURE	Dental services are administered by DentaQuest.	N/A
D5721	REBASE MANDIBULAR PARTIAL DENTURE	Dental services are administered by DentaQuest.	N/A
D5730	RELIN MAXILLARY COMPLETE DENTURE (CHAIRSIDE)	Dental services are administered by DentaQuest.	N/A
D5731	RELIN MANDIBULAR COMPLETE DENTURE (CHAIRSIDE)	Dental services are administered by DentaQuest.	N/A
D5740	RELIN MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	Dental services are administered by DentaQuest.	N/A
D5741	RELIN MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	Dental services are administered by DentaQuest.	N/A
D5750	RELIN MAXILLARY COMPLETE DENTURE (LABORATORY)	Dental services are administered by DentaQuest.	N/A
D5751	RELIN COMPLETE MANDIBULAR DENTURE (LABORATORY)	Dental services are administered by DentaQuest.	N/A
D5760	RELIN MAXILLARY PARTIAL DENTURE (LABORATORY)	Dental services are administered by DentaQuest.	N/A
D5761	RELIN MANDIBULAR PARTIAL DENTURE (LABORATORY)	Dental services are administered by DentaQuest.	N/A
D5810	INTERIM COMPLETE DENTURE (MAXILLARY)	Dental services are administered by DentaQuest.	N/A
D5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	Dental services are administered by DentaQuest.	N/A
D5820	INTERIM PARTIAL DENTURE (MAXILLARY)	Dental services are administered by DentaQuest.	N/A
D5821	INTERIM PARTIAL DENTURE (MANDIBULAR)	Dental services are administered by DentaQuest.	N/A
D5850	TISSUE CONDITIONING, MAXILLARY	Dental services are administered by DentaQuest.	N/A
D5851	TISSUE CONDITIONING, MANDIBULAR	Dental services are administered by DentaQuest.	N/A
D5860	OVERDENTURE COMPLETE BY REPORT	This is no longer a valid code.	N/A
D5861	OVERDENTURE PARTIAL BY REPORT	This is no longer a valid code.	N/A
D5862	PRECISION ATTACHMENT BY REPORT	Dental services are administered by DentaQuest.	N/A
D5867	REPLAC PART SEMI-PRECISSN ATTACHMNT	Dental services are administered by DentaQuest.	N/A
D5875	MODIFI REMOV PROSTH POST IMPLNT	Dental services are administered by DentaQuest.	N/A
D5899	UNS REMOVABLE PROSTHODONTIC PROCEDURE REPORT	Dental services are administered by DentaQuest.	N/A
D5911	FACIAL MOULAGE (SECTIONAL)	Dental services are administered by DentaQuest.	N/A

D5912	FACIAL MOULAGE (COMPLETE)	Dental services are administered by DentaQuest.	N/A
D5913	NASAL PROSTHESIS	Dental services are administered by DentaQuest.	N/A
D5914	AURICULAR PROSTHESIS	Dental services are administered by DentaQuest.	N/A
D5915	ORBITAL PROSTHESIS	Dental services are administered by DentaQuest.	N/A
D5916	OCULAR PROSTHESIS	Dental services are administered by DentaQuest.	N/A
D5919	FACIAL PROSTHESIS	Dental services are administered by DentaQuest.	N/A
D5922	NASAL SEPTAL PROSTHESIS	Dental services are administered by DentaQuest.	N/A
D5923	OCULAR PROSTHESIS INTERIM	Dental services are administered by DentaQuest.	N/A
D5924	CRANIAL PROSTHESIS	Dental services are administered by DentaQuest.	N/A
D5925	FACIAL AUGMENTATION IMPLANT PROSTHESIS	Dental services are administered by DentaQuest.	N/A
D5926	NASAL PROSTHESIS REPLACEMENT	Dental services are administered by DentaQuest.	N/A
D5927	AURICULAR PROSTHESIS REPLACEMENT	Dental services are administered by DentaQuest.	N/A
D5928	ORBITAL PROSTHESIS REPLACEMENT	Dental services are administered by DentaQuest.	N/A
D5929	FACIAL PROSTHESIS REPLACEMENT	Dental services are administered by DentaQuest.	N/A
D5931	OBTURATOR PROSTHESIS SURGICAL	Dental services are administered by DentaQuest.	N/A
D5932	OBTURATOR PROSTHESIS DEFINITIVE	Dental services are administered by DentaQuest.	N/A
D5933	OBTURATOR PROSTHESIS MODIFICATION	Dental services are administered by DentaQuest.	N/A
D5934	MANDIBULAR RESECTION PROSTHESIS W/GUIDE FLANGE	Dental services are administered by DentaQuest.	N/A
D5935	MANDIBULAR RESECTION PROSTHESIS WO GUIDE FLANGE	Dental services are administered by DentaQuest.	N/A
D5936	OBTURATOR/PROSTHESIS INTERIM	Dental services are administered by DentaQuest.	N/A
D5937	TRISMUS APPLIANCE (NOT TM TREATMENT)	Dental services are administered by DentaQuest.	N/A
D5951	FEEDING AID	Dental services are administered by DentaQuest.	N/A
D5952	SPEECH AID PROSTHESIS PEDIATRIC	Dental services are administered by DentaQuest.	N/A
D5953	SPEECH AID PROSTHESIS ADULT	Dental services are administered by DentaQuest.	N/A
D5954	PALATAL AUGMENTATION PROSTHESIS	Dental services are administered by DentaQuest.	N/A
D5955	PALATAL LIFE PROSTHESIS DEFINITIVE	Dental services are administered by DentaQuest.	N/A
D5958	PALATAL LIFT PROSTHESIS INTERIM	Dental services are administered by DentaQuest.	N/A
D5959	PALATAL LIFT PROSTHESIS MODIFICATION	Dental services are administered by DentaQuest.	N/A
D5960	SPEECH AID PROSTHESIS MODIFICATION	Dental services are administered by DentaQuest.	N/A
D5982	SURGICAL STENT	Dental services are administered by DentaQuest.	N/A
D5983	RADIATION CARRIER	Dental services are administered by DentaQuest.	N/A
D5984	RADIATION SHIELD	Dental services are administered by DentaQuest.	N/A
D5985	RADIATION CONE LOCATOR	Dental services are administered by DentaQuest.	N/A
D5986	FLUORIDE GEL CARRIER	Dental services are administered by DentaQuest.	N/A
D5987	COMMISSURE SPLINT	Dental services are administered by DentaQuest.	N/A
D5988	SURGICAL SPLINT	Dental services are administered by DentaQuest.	N/A
D5991	VESICULOBULLOUS DZ MEDICAMENT CARR	Dental services are administered by DentaQuest.	N/A
D5992	MAXFAC PROSTHETIC ADJ, BY RPT	Dental services are administered by DentaQuest.	N/A
D5993	MAINT CLEAN MFP OTH THAN REQ ADJ	Dental services are administered by DentaQuest.	N/A
D5994	PERIODONTAL MED CARRIER LAB PROCESS	Dental services are administered by DentaQuest.	N/A
D5999	UNSPECIFIED MAXILLOFACIAL PROSTHESIS BY REPORT	Dental services are administered by DentaQuest.	N/A
D6010	SURG PLACMT IMPL BODY: ENDOSTEAL	Dental services are administered by DentaQuest.	N/A
D6011	SECOND STAGE IMPLANT SURGERY	Dental services are administered by DentaQuest.	N/A
D6012	SURG PLACE INTERIM IMPLANT BODY FOR TRANS PROSTH EMDOSTEAL IMPLANT	Dental services are administered by DentaQuest.	N/A
D6013	SURGICAL PLACEMENT OF MINI IMPLANT	Dental services are administered by DentaQuest.	N/A
D6020	ABUTMENT PLACE/SUB: ENDOSTEAL IMPLANT	Dental services are administered by DentaQuest.	N/A
D6040	SURGICAL PLACEMENT: EPOSTEAL IMPLANT	Dental services are administered by DentaQuest.	N/A
D6050	SURGICAL PLACEMENT: TRANSOSTEAL IMPLANT	Dental services are administered by DentaQuest.	N/A
D6051	INTERIM ABUTMENT	Dental services are administered by DentaQuest.	N/A
D6052	SEMI-PRECISION ATTACHMENT ABUTMENT	Dental services are administered by DentaQuest.	N/A
D6053	IMPL/ABUT DENTUR Cmpl EDNTULS ARCH	This is no longer a valid code.	N/A
D6054	IMPL/ABUT DENTUR PART EDNTULS ARCH	This is no longer a valid code.	N/A
D6055	DENTAL IMPLANT SUPPORTED CONNECTING BAR	Dental services are administered by DentaQuest.	N/A
D6056	PREFAB ABUTMENT-INCL MOD & PLCMNT	Dental services are administered by DentaQuest.	N/A
D6057	CUSTOM FAB ABUTMENT-INCL PLACEMENT	Dental services are administered by DentaQuest.	N/A
D6058	ABUT SUPP PORCELN/CERAMIC CROWN	Dental services are administered by DentaQuest.	N/A
D6059	ABUT PORCLN TO MTL CRWN HI NOBL MTL	Dental services are administered by DentaQuest.	N/A
D6060	ABUT PORCLN TO METL CROWN BASE METL	Dental services are administered by DentaQuest.	N/A
D6061	ABUT PORCELAIN-FUSE TO METAL CROWN	Dental services are administered by DentaQuest.	N/A
D6062	ABUT SUPPRT CAST METAL CROWN	Dental services are administered by DentaQuest.	N/A
D6063	ABUT SUPPRT CAST METAL CROWN	Dental services are administered by DentaQuest.	N/A
D6064	ABUT SUPPRT CAST METAL CROWN	Dental services are administered by DentaQuest.	N/A
D6065	IMPLNT SUPPRT PORCELAIN/CERAM CROWN	Dental services are administered by DentaQuest.	N/A
D6066	IMPLANT SUPP CROWN - PORCELAIN FUSED HI NBL ALY	Dental services are administered by DentaQuest.	N/A
D6067	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	Dental services are administered by DentaQuest.	N/A
D6068	ABUT RETAINER-PORCELN/CERAM FPD	Dental services are administered by DentaQuest.	N/A
D6069	ABUT RETAINER-PORCELN TO METAL FPD	Dental services are administered by DentaQuest.	N/A
D6070	ABUT RETAINER-PORCELN TO METAL FPD	Dental services are administered by DentaQuest.	N/A
D6071	ABUT RETAINER-PORCELN TO METAL FPD	Dental services are administered by DentaQuest.	N/A
D6072	ABUT RETAINER FOR CAST METAL FPD	Dental services are administered by DentaQuest.	N/A
D6073	ABUT SUPPRT RETAINER-CAST METAL FPD	Dental services are administered by DentaQuest.	N/A
D6074	ABUT SUPPRT RETAINER-CAST METAL FPD	Dental services are administered by DentaQuest.	N/A
D6075	IMPLNT SUPPRT RETAINER-CERAMIC FPD	Dental services are administered by DentaQuest.	N/A
D6076	IMPLANT SUPP RET FPD - PORCELN FUSED HI NBL ALY	Dental services are administered by DentaQuest.	N/A
D6077	IMPLANT SUPP RET METAL FPD - HIGH NOBLE ALLOYS	Dental services are administered by DentaQuest.	N/A
D6078	IMPLNT/ABUT DENTURE-COMPLT EDENT	This is no longer a valid code.	N/A
D6079	IMPLNT/ABUT DENTURE-PART EDENTULOUS	This is no longer a valid code.	N/A
D6080	IMPL MAINT PROC REMV REINSRT CLEAN	Dental services are administered by DentaQuest.	N/A
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	Dental services are administered by DentaQuest.	N/A
D6091	REPLACE SEMI-PRECISION OR PREC ATTACH OF IMPLANT/ABUT SUPP PROSTH	Dental services are administered by DentaQuest.	N/A
D6092	RECEMENT IMPL/ABUT SUPPORTED CROWN	Dental services are administered by DentaQuest.	N/A
D6093	RECEMENT IMPL/ABUT FIX PART DENTURE	Dental services are administered by DentaQuest.	N/A
D6094	ABUTMENT SUPP CROWN - TITANIUM AND TITANIUM ALLOYS	Dental services are administered by DentaQuest.	N/A
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	Dental services are administered by DentaQuest.	N/A
D6100	IMPLANT REMOVAL BY REPORT	Dental services are administered by DentaQuest.	N/A
D6101	DEBR PRIIMPL DEF CLN EXPSD IMPL FLP	Dental services are administered by DentaQuest.	N/A
D6102	DEBR&OSS CNTR PRIIMPL DEF;CLN SURF	Dental services are administered by DentaQuest.	N/A
D6103	BONE GRAFT REPAIR PERI-IMPL DEFECT	Dental services are administered by DentaQuest.	N/A
D6104	BONE GRAFT TIME IMPLANT PLACEMENT	Dental services are administered by DentaQuest.	N/A
D6110	IMPL/ABUT SUPP RMV D EDENT ARCH-MAX	Dental services are administered by DentaQuest.	N/A
D6111	IMPL/ABUT SUPP RMV D EDENT ARCH-MND	Dental services are administered by DentaQuest.	N/A
D6112	IMPL/ABUT SUP RMV D PR EDNT ARCH-MX	Dental services are administered by DentaQuest.	N/A
D6113	IMPL/ABUT SP RMV D PR EDNT ARCH-MND	Dental services are administered by DentaQuest.	N/A
D6114	IMPL/ABUT SP FIXED D EDENT ARCH-MAX	Dental services are administered by DentaQuest.	N/A
D6115	IMPL/ABUT SUP FIXD D EDENT ARCH-MND	Dental services are administered by DentaQuest.	N/A
D6116	IMPL/ABUT SUP F D PR EDENT ARCH-MAX	Dental services are administered by DentaQuest.	N/A
D6117	IMPL/ABUT SP FIXD D PR EDENT ARCH-M	Dental services are administered by DentaQuest.	N/A
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX BY REPORT	Dental services are administered by DentaQuest.	N/A
D6194	ABUTMENT SUPP RETAIN CROWN FPD - TIT AND TIT ALY	Dental services are administered by DentaQuest.	N/A
D6199	UNSPECIFIED IMPLANT PROCEDURE BY REPORT	Dental services are administered by DentaQuest.	N/A
D6205	PONTIC INDIRECT RESIN BASED COMPOSITE	Dental services are administered by DentaQuest.	N/A
D6210	PONTIC CAST HIGH NOBLE METAL	Dental services are administered by DentaQuest.	N/A
D6211	PONTIC CAST PREDOMINANTLY BASE METAL	Dental services are administered by DentaQuest.	N/A
D6212	PONTIC CAST NOBLE METAL	Dental services are administered by DentaQuest.	N/A
D6214	PONTIC - TITANIUM AND TITANIUM ALLOYS	Dental services are administered by DentaQuest.	N/A
D6240	PONTIC PORCELAIN FUSED TO HIGH NOBLE METAL	Dental services are administered by DentaQuest.	N/A
D6241	PONTIC PORCELAIN FUSED PREDOMINANTLY BASE METAL	Dental services are administered by DentaQuest.	N/A
D6242	PONTIC PORCELAIN FUSED TO NOBLE METAL	Dental services are administered by DentaQuest.	N/A
D6245	PONTIC - PORCELAIN/CERAMIC	Dental services are administered by DentaQuest.	N/A
D6250	PONTIC RESIN W/HIGH NOBLE METAL	Dental services are administered by DentaQuest.	N/A
D6251	PONTIC RESIN W/PREDOMINANTLY BASE METAL	Dental services are administered by DentaQuest.	N/A

D6252	PONTIC RESIN W/NOBLE METAL	Dental services are administered by DentaQuest.	N/A
D6253	PRVS PONTIC-TX/CMPL DX NEC B4 F IMP	Dental services are administered by DentaQuest.	N/A
D6530	INLAY METALLIC THREE/MORE SURFACES	Dental services are administered by DentaQuest.	N/A
D6545	RETAIN-CAST METAL FOR RESIN BONDED FIXED PROSTH	Dental services are administered by DentaQuest.	N/A
D6548	RETAINER-PORCELN/CERAM-FIXED PROSTH	Dental services are administered by DentaQuest.	N/A
D6549	RETAINER - FOR RESIN BONDED FIXED PROSTHESIS	Dental services are administered by DentaQuest.	N/A
D6600	RETAINER INLAY-PORCELN/CERAM 2 SURF	Dental services are administered by DentaQuest.	N/A
D6601	RETAINER INLAY-PORC/CERAM 3/MOR SRF	Dental services are administered by DentaQuest.	N/A
D6602	RET INLAY-CAST HI NOBLE METL 2 SURF	Dental services are administered by DentaQuest.	N/A
D6603	RET INLA-CST HI NOBL MTL 3/MORE SRF	Dental services are administered by DentaQuest.	N/A
D6604	RET INLAY-CAST PDMT BASE METL 2 SRF	Dental services are administered by DentaQuest.	N/A
D6605	RET INLA-CST PDMT BSE MTL 3/MOR SRF	Dental services are administered by DentaQuest.	N/A
D6606	RETAIN INLAY-CAST NOBLE METL 2 SURF	Dental services are administered by DentaQuest.	N/A
D6607	RET INLAY-CAST NOBLE METL 3/MRE SRF	Dental services are administered by DentaQuest.	N/A
D6608	RETAINER ONLAY-PORCELN/CERAM 2 SURF	Dental services are administered by DentaQuest.	N/A
D6609	RETAINR ONLAY-PORC/CERAM 3/MORE SRF	Dental services are administered by DentaQuest.	N/A
D6610	RET ONLAY-CAST HI NOBLE METL 2 SURF	Dental services are administered by DentaQuest.	N/A
D6611	RET ON-CST HI NOBLE METL 3/MORE SRF	Dental services are administered by DentaQuest.	N/A
D6612	ONLAY-CAST PREDOM BASE METL 2 SURF	Dental services are administered by DentaQuest.	N/A
D6613	RET ON-CST PDMT BSE METL 3/MORE SRF	Dental services are administered by DentaQuest.	N/A
D6614	RET ONLAY-CAST NOBLE METAL 2 SURF	Dental services are administered by DentaQuest.	N/A
D6615	RET ONLAY-CST NOBLE METL 3/MORE SRF	Dental services are administered by DentaQuest.	N/A
D6624	RETAINER INLAY - TITANIUM	Dental services are administered by DentaQuest.	N/A
D6634	RETAINER ONLAY - TITANIUM	Dental services are administered by DentaQuest.	N/A
D6710	RET CROWN-INDIR RESIN BASED COMPOS	Dental services are administered by DentaQuest.	N/A
D6720	RETAINER CROWN-RESIN HI NOBLE METAL	Dental services are administered by DentaQuest.	N/A
D6721	RETAINER CROWN-RESIN PDMT BASE METL	Dental services are administered by DentaQuest.	N/A
D6722	RETAINER CROWN-RESIN W/NOBLE METAL	Dental services are administered by DentaQuest.	N/A
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	Dental services are administered by DentaQuest.	N/A
D6750	RET CROWN-PORC FUSED HI NOBLE METL	Dental services are administered by DentaQuest.	N/A
D6751	RET CROWN-PORC FUSED PDMT BASE METL	Dental services are administered by DentaQuest.	N/A
D6752	RETNR CRWN-PORCELN FUSD NOBLE METAL	Dental services are administered by DentaQuest.	N/A
D6780	RETNER CROWN-3/4 CAST HI NOBLE METL	Dental services are administered by DentaQuest.	N/A
D6781	RETNR CRWN-3/4 CAST PDMT BASE METAL	Dental services are administered by DentaQuest.	N/A
D6782	RETAINER CROWN-3/4 CAST NOBLE METAL	Dental services are administered by DentaQuest.	N/A
D6783	RETAINER CROWN-3/4 PORCELAIN/CERAMC	Dental services are administered by DentaQuest.	N/A
D6793	PRVS RET CRWN-TX/CMPL DX B4 FNL IMP	Dental services are administered by DentaQuest.	N/A
D6794	RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS	Dental services are administered by DentaQuest.	N/A
D6920	CONNECTOR BAR	Dental services are administered by DentaQuest.	N/A
D6985	PEDIATRIC PARTIAL DENTURE, FIXED	Dental services are administered by DentaQuest.	N/A
D7111	EXTRACT CORONAL RMNNTS-PRIM TOOTH	Dental services are administered by DentaQuest.	N/A
D7130	ROOT REMOVAL EXPOSED ROOTS	Dental services are administered by DentaQuest.	N/A
D7140	EXTRAC ERUPTD TOOTH/EXPOSED ROOT	Dental services are administered by DentaQuest.	N/A
D7210	EXTRACTION ERU TOOTH RQR REMV BONE &/SECTN TOOTH	Dental services are administered by DentaQuest.	N/A
D7220	REMOVAL IMPACTED TOOTH SOFT TISSUE	Dental services are administered by DentaQuest.	N/A
D7230	REMOVAL IMPACTED TOOTH PARTIALLY BONY	Dental services are administered by DentaQuest.	N/A
D7240	REMOVAL IMPACTED TOOTH COMPLETELY BONY	Dental services are administered by DentaQuest.	N/A
D7251	SURG EXTRACT, PARTL TOOTH	Dental services are administered by DentaQuest.	N/A
D7261	PRIMARY CLOSURE SINUS PERFORATION	Dental services are administered by DentaQuest.	N/A
D7270	TOOTH REIMPL&/STBL ACC DISPLCD	Dental services are administered by DentaQuest.	N/A
D7280	EXPOSURE OF AN UNERUPTED TOOTH	Dental services are administered by DentaQuest.	N/A
D7282	MOBILZ ERUPT/MALPSTN TOOTH AID ERUP	Dental services are administered by DentaQuest.	N/A
D7283	PLCMT DEVICE FACILITATE ERUPTION IMPACTED TOOTH	Dental services are administered by DentaQuest.	N/A
D7287	CYTOLOGY SAMPLE COLLECTION	Dental services are administered by DentaQuest.	N/A
D7288	BRUSH BIOPSY TRANSEPIHELIAL SAMPLE COLLECTION	Dental services are administered by DentaQuest.	N/A
D7291	TRNSSEPTL/SUPRA CRESTAL FIBEROT RPT	Dental services are administered by DentaQuest.	N/A
D7292	PLCMT TEMP ANC DEVC SCREW RETN PLATE RQR FLAP;	Dental services are administered by DentaQuest.	N/A
D7293	PLACEMENT TEMP ANC DEVC RQR FLAP; INC DEVC REMV	Dental services are administered by DentaQuest.	N/A
D7294	PLACEMENT TEMP ANC DEVC W/O FLAP; INC DEVC REMV	Dental services are administered by DentaQuest.	N/A
D7295	OTHER SURGICAL PROCEDURES	Dental services are administered by DentaQuest.	N/A
D7311	ALVEOLOPLSTY CONJNC XTRACT 1-3 TEETH/SPACES QUAD	Dental services are administered by DentaQuest.	N/A
D7321	ALVEOLOPLSTY NOT CNJNC XTRCT 1-3 TEETH/SPCE QUAD	Dental services are administered by DentaQuest.	N/A
D7410	EXCISION BENIGN LESION UP TO 1.25 CM	Dental services are administered by DentaQuest.	N/A
D7411	EXCISION OF BENIGN LESION > 1.25 CM	Dental services are administered by DentaQuest.	N/A
D7412	EXCISION BENIGN LESION COMPLICATED	Dental services are administered by DentaQuest.	N/A
D7413	EXCISION MALIG LESION UP 1.25 CM	Dental services are administered by DentaQuest.	N/A
D7414	EXCISION MALIGNANT LESION > 1.25 CM	Dental services are administered by DentaQuest.	N/A
D7415	EXCISION MALIG LESION COMPLICATED	Dental services are administered by DentaQuest.	N/A
D7450	REMV BEN ODONTOGNIC TUMR-TO 1.25 CM	Dental services are administered by DentaQuest.	N/A
D7451	REMV BEN ODONTOGNIC TUMR >1.25 CM	Dental services are administered by DentaQuest.	N/A
D7460	REMV BEN NONODONTGN TUMR-TO 1.25 CM	Dental services are administered by DentaQuest.	N/A
D7461	REMV BEN NONODONTGNIC TUMR >125 CM	Dental services are administered by DentaQuest.	N/A
D7465	DESTRUCTION LESION(S) PHYSICAL/CHEMICAL BR	Dental services are administered by DentaQuest.	N/A
D7471	REMOVAL OF LATERAL EXOSTOSIS	Dental services are administered by DentaQuest.	N/A
D7472	REMOVAL OF TORUS PALATINUS	Dental services are administered by DentaQuest.	N/A
D7473	REMOVAL OF TORUS MANDIBULARIS	Dental services are administered by DentaQuest.	N/A
D7480	PARTIAL OSTECTOMY (GUTTERING/SAUCERIZATION)	Dental services are administered by DentaQuest.	N/A
D7485	REDUCTION OF OSSEOUS TUBEROSITY	Dental services are administered by DentaQuest.	N/A
D7490	RADICAL RESECTION MANDIBLE W/BONE GRAFT	Dental services are administered by DentaQuest.	N/A
D7510	INCISION & DRAINAGE ABSCESS INTRAORAL SOFT TISS	Dental services are administered by DentaQuest.	N/A
D7511	I & D ABSCESS INTRAORAL SOFT TISSUE COMPLICATED	Dental services are administered by DentaQuest.	N/A
D7520	INCISION & DRAINAGE ABSCESS EXTRAORAL SOFT TISS	Dental services are administered by DentaQuest.	N/A
D7521	I & D ABSCESS EXTRAORAL SOFT TISSUE COMPLICATED	Dental services are administered by DentaQuest.	N/A
D7530	REMV FB MUCOS SKN/SUBQ ALVEOL TISS	Dental services are administered by DentaQuest.	N/A
D7540	REMOVAL REACT PROD FOREIGN BODIES MUSCULOSKEL	Dental services are administered by DentaQuest.	N/A
D7550	PART OSTEC/SEQECT REMV NON-VITAL BN	Dental services are administered by DentaQuest.	N/A
D7560	MAXILLARY SINUSOTOMY REMOVE TOOTH FRAG/BODY	Dental services are administered by DentaQuest.	N/A
D7610	MAXILLA-OPEN REDUCTION	Dental services are administered by DentaQuest.	N/A
D7620	MAXILLA CLOSE REDUCT (TEETH IMMOBIL IF PRESENT)	Dental services are administered by DentaQuest.	N/A
D7630	MANDIBLE-OPEN REDUCTION	Dental services are administered by DentaQuest.	N/A
D7640	MANDIBLE CLOSE REDUCT (TEETH IMMOBIL IF PRESENT)	Dental services are administered by DentaQuest.	N/A
D7650	MALAR &/OR ZYGOMATIC ARCH OPEN REDUCTION	Dental services are administered by DentaQuest.	N/A
D7660	MALAR &/OR ZYGOMATIC ARCH CLOSED REDUCTION	Dental services are administered by DentaQuest.	N/A
D7670	ALVEOL - CLO RDUC MAY W/STBL TEETH	Dental services are administered by DentaQuest.	N/A
D7671	ALVEOL - OPN RDUC MAY W/STBL TEETH	Dental services are administered by DentaQuest.	N/A
D7680	FACIAL BONES COMP REDUCT W/FIX & MULT APPROACHES	Dental services are administered by DentaQuest.	N/A
D7710	MAXILLA-OPEN REDUCTION	Dental services are administered by DentaQuest.	N/A
D7720	MAXILLA CLOSED REDUCTION	Dental services are administered by DentaQuest.	N/A
D7730	MANDIBLE-OPEN REDUCTION	Dental services are administered by DentaQuest.	N/A
D7740	MANDIBLE CLOSED REDUCTION	Dental services are administered by DentaQuest.	N/A
D7750	MALAR AND/OR ZYGOMATIC ARCH-OPEN REDUCTION	Dental services are administered by DentaQuest.	N/A
D7760	MALAR &/OR ZYGOMATIC ARCH CLOSED REDUCTION	Dental services are administered by DentaQuest.	N/A
D7770	ALVEOLUS - OPEN REDUCTION STABILIZATION OF TEETH	Dental services are administered by DentaQuest.	N/A
D7771	ALVEOL CLOS RDUC STBL TEETH	Dental services are administered by DentaQuest.	N/A
D7780	FACIAL BONES-COMP RDUC FIX & MX SURG APPROACHES	Dental services are administered by DentaQuest.	N/A
D7810	OPEN REDUCTION OF DISLOCATION	Dental services are administered by DentaQuest.	N/A
D7820	CLOSED REDUCTION OF DISLOCATION	Dental services are administered by DentaQuest.	N/A
D7830	MANIPULATION UNDER ANESTHESIA	Dental services are administered by DentaQuest.	N/A
D7840	CONDYLECTOMY	Dental services are administered by DentaQuest.	N/A
D7850	SURGICAL DISCECTOMY W/WO IMPLANT	Dental services are administered by DentaQuest.	N/A
D7852	DISC REPAIR	Dental services are administered by DentaQuest.	N/A

D7854	SYNOVECTOMY	Dental services are administered by DentaQuest.	N/A
D7856	MYOTOMY	Dental services are administered by DentaQuest.	N/A
D7858	JOINT RECONSTRUCTION	Dental services are administered by DentaQuest.	N/A
D7860	ARTHROTOMY	Dental services are administered by DentaQuest.	N/A
D7865	ARTHROPLASTY	Dental services are administered by DentaQuest.	N/A
D7870	ARTHROCENTESIS	Dental services are administered by DentaQuest.	N/A
D7871	NON-ARTHROSCOPIC LYSIS & LAVAGE	Dental services are administered by DentaQuest.	N/A
D7872	ARTHROSCOPY DIAGNOSIS W/O BIOPSY	Dental services are administered by DentaQuest.	N/A
D7873	ARTHROSCOPY: LAVAGE AND LYSIS OF ADHESIONS	Dental services are administered by DentaQuest.	N/A
D7874	ARTHROSCOPY: DISC REPOSITIONING & STABILIZATION	Dental services are administered by DentaQuest.	N/A
D7875	ARTHROSCOPY: SYNOVECTOMY	Dental services are administered by DentaQuest.	N/A
D7876	ARTHROSCOPY: DISCECTOMY	Dental services are administered by DentaQuest.	N/A
D7877	ARTHROSCOPY: DEBRIDEMENT	Dental services are administered by DentaQuest.	N/A
D7880	OCCLUSAL ORTHOTIC APPLIANCE	Dental services are administered by DentaQuest.	N/A
D7899	UNSPECIFIED TMD THERAPY BY REPORT	Dental services are administered by DentaQuest.	N/A
D7910	SUTURE RECENT SMALL WOUNDS TO 5 CM	Dental services are administered by DentaQuest.	N/A
D7911	COMPLICATED SUTURE UP TO 5CM	Dental services are administered by DentaQuest.	N/A
D7912	COMPLICATED SUTURE GREATER THAN 5 CM	Dental services are administered by DentaQuest.	N/A
D7920	SKIN GRAFTS (IDENT DEFECT LOCATION & TYPE)	Dental services are administered by DentaQuest.	N/A
D7921	COLLECT&APPLIC AUTO BLOOD CONC PROD	Dental services are administered by DentaQuest.	N/A
D7940	OSTEOPLASTY ORTHOGNATHIC DEFORMITIES	Dental services are administered by DentaQuest.	N/A
D7941	OSTEOTOMY RAMUS CLOSED	Dental services are administered by DentaQuest.	N/A
D7943	OSTEOTOMY RAMUS OPEN W/BONE GRAFT	Dental services are administered by DentaQuest.	N/A
D7944	OSTEOTOMY SEGMENTED OR SUBAPICAL	Dental services are administered by DentaQuest.	N/A
D7945	OSTEOTOMY-BODY OF MANDIBLE	Dental services are administered by DentaQuest.	N/A
D7946	LEFORT I MAXILLA TOTAL	Dental services are administered by DentaQuest.	N/A
D7947	LEFORT I MAXILLA SEGMENTED	Dental services are administered by DentaQuest.	N/A
D7948	LEFORT II/LEFORT III - W/O BONE GRAFT	Dental services are administered by DentaQuest.	N/A
D7949	LEFORT II/LEFORT III W/BONE GRAFT	Dental services are administered by DentaQuest.	N/A
D7950	OSS OSTEOPERIOSTL CART GFT MAND/MAX	Dental services are administered by DentaQuest.	N/A
D7951	SINUS AUG BONE/BONE SUBST LAT OPN	Dental services are administered by DentaQuest.	N/A
D7952	SINUS AUGMENTATION VERTICAL APPR	Dental services are administered by DentaQuest.	N/A
D7953	BONE REPLCMT GRAFT RIDGE PRES -SITE	Dental services are administered by DentaQuest.	N/A
D7955	REPR MAXLOFACL SOFT&/HARD TISS DFCT	Dental services are administered by DentaQuest.	N/A
D7960	FRENULECTOMY SEP PROC NOT INCIDENTL ANOTHER PROC	Dental services are administered by DentaQuest.	N/A
D7963	FRENULOPLASTY	Dental services are administered by DentaQuest.	N/A
D7970	EXCISION HYPERPLASTIC TISSUE PER ARCH	Dental services are administered by DentaQuest.	N/A
D7971	EXCISION OF PERICORONAL GINGIVA	Dental services are administered by DentaQuest.	N/A
D7972	SURGICAL RDUCE FIBROUS TUBEROSITY	Dental services are administered by DentaQuest.	N/A
D7980	SURGICAL SIALOLITHOTOMY	Dental services are administered by DentaQuest.	N/A
D7981	EXCISION OF SALIVARY GLAND, BY REPORT	Dental services are administered by DentaQuest.	N/A
D7982	SIALODOCHOPLASTY	Dental services are administered by DentaQuest.	N/A
D7983	CLOSURE OF SALIVARY FISTULA	Dental services are administered by DentaQuest.	N/A
D7990	EMERGENCY TRACHEOTOMY	Dental services are administered by DentaQuest.	N/A
D7991	CORONOIDECTOMY	Dental services are administered by DentaQuest.	N/A
D7995	SYNTHETIC GRAFT-MANDIBLE OR FACIAL BONES, BR	Dental services are administered by DentaQuest.	N/A
D7996	IMPLANT-MANDIBLE FOR AUGMENTATION PURPOSES, BR	Dental services are administered by DentaQuest.	N/A
D7997	APPLIANCE REMOV INCLU REMOV ARCHBAR	Dental services are administered by DentaQuest.	N/A
D7998	INTRAORAL PLACEMENT OF A FIXATION DEVICE NOT IN CONJ W A FRACTURE	Dental services are administered by DentaQuest.	N/A
D7999	UNSPECIFIED ORAL SURGERY PROCEDURE BY REPORT	Dental services are administered by DentaQuest.	N/A
D8010	LIMITED O'DONTIC TX OF PRIMARY DENTITION	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D8020	LIMITED O'DONTIC TX OF TRANSITIONAL DENTITION	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D8030	LIMITED O'DONTIC TX OF ADOLESCENT DENTITION	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D8040	LIMITED O'DONTIC TX OF ADULT DENTITION	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D8050	INTERCEPTIVE O'DONTIC TX OF PRIMARY DENTITION	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D8060	INTERCEPTIVE O'DONTIC TX OF TRANSITIONAL DENT	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D8070	COMPREHENSIVE O'DONTIC TX OF TRANSITIONAL DENT	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D8080	COMPREHENSIVE O'DONTIC TX OF ADOLESCENT DENT	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D8090	COMPREHENSIVE O'DONTIC TX OF ADULT DENTITION	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D8210	REMOVABLE APPLIANCE THERAPY	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D8220	FIXED APPLIANCE THERAPY	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D8660	PREORTHODONTIC TREATMENT VISIT	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D8670	PERIODIC ORTHODONTIC TX VISIT	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D8680	ORTHODONTIC RETENTION	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D8690	ORTHODONTIC TREATMENT	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D8691	REPR ORTHODONTIC APPLIANCE	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D8692	REPLAC LOST/BROKEN RETAINER	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D8693	REBONDING/RECEMENTING FIXED RETAINR	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D8694	REPAIR FIX RETAINERS INCL REATTACH	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D8999	UNSPECIFIED ORTHODONTIC PROCEDURE BY REPORT	Dental services are administered by DentaQuest.	Prior to 09/01/2019
D9110	PALLIATIVE (EMERGENCY) TREAT DENTAL PAIN MINOR	Dental services are administered by DentaQuest.	N/A
D9210	LOCAL ANES NOT W/OPERATIVE SURGICAL PROCEDURES	Dental services are administered by DentaQuest.	N/A
D9211	REGIONAL BLOCK ANESTHESIA	Dental services are administered by DentaQuest.	N/A
D9212	TRIGEMINAL DIVISION BLOCK ANESTHESIA	Dental services are administered by DentaQuest.	N/A
D9215	LOCAL ANESTHESIA	Dental services are administered by DentaQuest.	N/A
D9219	VAL FOR MOD/DEEP SEDATION/GENERAL ANESTHESIA	Dental services are administered by DentaQuest.	N/A
D9220	DP SEDATION/GEN ANES-1ST 30 MIN	Dental services are administered by DentaQuest.	N/A
D9221	DP SEDAT/GEN ANES-EA ADD 15 MIN	Dental services are administered by DentaQuest.	N/A
D9230	ANALGESIA	Dental services are administered by DentaQuest.	N/A
D9241	IV CONSC SEDAT/ANALG -1ST 30 MIN	Dental services are administered by DentaQuest.	N/A
D9242	IV CONSC SEDAT/ANALG-EA ADD 15 MIN	Dental services are administered by DentaQuest.	N/A
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION	Dental services are administered by DentaQuest.	N/A
D9310	CONSULT DIAGNOSTIC SERV PROV BY DDS OR PHYS OTH THAN REQUESTING DDS	Dental services are administered by DentaQuest.	N/A
D9410	HOUSE CALL	Dental services are administered by DentaQuest.	N/A
D9420	HOSPITAL CALL	Dental services are administered by DentaQuest.	N/A
D9430	OFFICE VISIT OBSERVATION (REG HOURS) ONLY	Dental services are administered by DentaQuest.	N/A
D9440	OFFICE VISIT AFTER REGULAR SCHEDULE HOURS	Dental services are administered by DentaQuest.	N/A
D9450	CASE PRSATION DTL&EXT TX PLANNING	Dental services are administered by DentaQuest.	N/A
D9610	THERAPEUTIC PARENTERAL DRUG, SINGLE ADMINISTRATION	Dental services are administered by DentaQuest.	N/A
D9612	THERAPEUTIC PARENTERAL DRUGS 2 OR MORE ADMIN DIFFERENT MEDS	Dental services are administered by DentaQuest.	N/A
D9630	DRUGS/MEDICAMENTS DISPENSED OFFICE FOR HOME USE	Dental services are administered by DentaQuest.	N/A
D9910	APPLICATION OF DESENSITIZING MEDICAMENT	Dental services are administered by DentaQuest.	N/A
D9911	APPLIC DESENSITIZING RESIN/TOOTH	Dental services are administered by DentaQuest.	N/A
D9920	BEHAVIOR MANAGEMENT BY REPORT	Dental services are administered by DentaQuest.	N/A
D9930	TREAT COMPLICATION (POST SURG) UNUSUAL BY REPORT	Dental services are administered by DentaQuest.	N/A
D9931	CLEANING & INSPECTN REMV APPLIANCE	Dental services are administered by DentaQuest.	N/A
D9940	OCCLUSAL GUARD, BY REPORT	Dental services are administered by DentaQuest.	N/A
D9941	FABRICATION OF ATHLETIC MOUTHGUARD	Dental services are administered by DentaQuest.	N/A
D9942	REPAIR AND/OR RELINE OF OCCLUSAL GUARD	Dental services are administered by DentaQuest.	N/A
D9950	OCCCLUSION ANALYSIS MOUNTED CASE	Dental services are administered by DentaQuest.	N/A
D9951	OCCLUSAL ADJUSTMENT LIMITED	Dental services are administered by DentaQuest.	N/A
D9952	OCCLUSAL ADJUSTMENT COMPLETE	Dental services are administered by DentaQuest.	N/A
D9970	ENAMEL MICROABRASION	Dental services are administered by DentaQuest.	N/A
D9971	ODONTOPLSTY 1-2 TEETH REMOV PROJEC	Dental services are administered by DentaQuest.	N/A
D9972	EXTERNAL BLEACH-PER ARCH-PRFRM OFF	Dental services are administered by DentaQuest.	N/A
D9973	EXT BLEACHING/TOOTH	Dental services are administered by DentaQuest.	N/A
D9974	INT BLEACHING/TOOTH	Dental services are administered by DentaQuest.	N/A
D9975	EXT BLEACH HOM APP-ARCH MATL&TRAYS	Dental services are administered by DentaQuest.	N/A
D9985	SALES TAX	Dental services are administered by DentaQuest.	N/A
D9986	MISSED APPOINTMENT	Dental services are administered by DentaQuest.	N/A
D9987	CANCELLED APPOINTMENT	Dental services are administered by DentaQuest.	N/A

D9999	UNSPECIFIED ADJUNCTIVE PROCEDURE BY REPORT	Dental services are administered by DentaQuest.	N/A
E0100	CANE ALL MATERIAL ADJUSTABLE/FIXED W/TIP	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0105	CANE QUAD/3 PRONG ALL MATERIALS ADJ/FIXED W/TIPS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0110	CRUTCHS FOREARM ALL MAT ADJ/FIXED W/TIP HANDGRP	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0111	CRUTCH FOREARM VAR MAT ADJ/FIX W/TIP HANDGRIP EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0112	CRUTCHS UNDERARM WOOD ADJ/FIX PAIR PAD/TIP GRIP	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0113	CRUTCH UNDERARM WOOD ADJ/FIX PAD/TIP/GRIP EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0114	CRUTCHES UND'ARM NOT WOOD ADJ/FIX W/PAD/TIP/GRIP	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0115	ALLIED RESP: CRUTCHES, UNDERARM ALUM/F-ACH	No pre-authorization is required for all providers.	N/A
E0116	CRUTCH UND'ARM NOT WOOD ADJ/FIX W/PAD/TIP/GRIP	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0117	CRUTCH UNDERARM ARTIC SPRNG ASSTD EA	This service is not covered by Superior HealthPlan.	N/A
E0118	CRUTCH SUBSTITUTE, LOWER LEG PLATFORM, WITH OR WITHOUT WHEELS, EACH	This service is not covered by Superior HealthPlan.	N/A
E0130	WALKER RIGID (PICKUP) ADJUST/FIXED HEIGHT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0135	WALKER FOLDING (PICKUP) ADJUST/FIXED HEIGHT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0140	WALKER, WITH TRUNK SUPPORT, ADJUSTABLE OR FIXED HEIGHT, ANY TYPE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0141	WALKER, RIGID, WHELLED, ADJUSTABLE OR FIXED HEIGHT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0142	RIGID WALKER WHEELED W/SEAT	This is no longer a valid code.	N/A
E0143	WALKER, FOLDING, WHELLED, ADJUSTABLE OR FIXED HEIGHT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0144	WALKER/ENCLSD, 4 SIDED FRMD, RIGID OR FOLDING, WHELLED W POSTERIOR SEAT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0145	WALKER WHEELED W/SEAT & CRUTCH ATTACHMENTS	No pre-authorization is required for all providers.	N/A
E0146	FOLDING WALKER WHEELED W/SEAT	No pre-authorization is required for all providers.	N/A
E0147	WALKER, HEAVY DUTY, MULTIPLE BRAKING SYSTEM, VARIABLE WHEEL RSISTANCE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0148	WALKER HD WO WHEELS RIGID/FLDG	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0149	WALKER, HEAVY DUTY, WHEELED, RIGIT OR FOLDING, ANY TYPE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0153	PLATFORM ATTACHMENT FOREARM CRUTCH EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0154	PLATFORM ATTACHMENT WALKER EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0155	WHEEL ATTACHMENT RIGID PICK-UP WALKER	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0156	SEAT ATTACHMENT WALKER	This service is not covered by Superior HealthPlan.	N/A
E0157	CRUTCH ATTACHMENT WALKER EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0158	LEG EXTENSIONS - WALKER	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0159	BRAKE ATT WHEELED WALKER REPLACEMENT EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0160	SITZ TYPE BATH/EQUIP-PORTABLE-USE W/WO COMMODE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0161	SITZ TYP BATH-PORT-USE W/WO COMMODE-W/FAUCET ATT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0162	SITZ BATH CHAIR	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0163	COMMODE CHAIR STATIONARY W/FIXED ARMS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0164	COMMODE CHAIR MOBILE W/FIXED ARMS	This is no longer a valid code.	N/A
E0165	COMMODE CHAIR, MOBILE OR STATIONARY WITH DETACHABLE ARMS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0166	COMMODE CHAIR MOBILE W/DETACHABLE ARMS	No pre-authorization is required for all providers.	N/A
E0167	PAIL OR PAN FOR USE WITH COMMODE CHAIR, REPLACEMENT ONLY	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0168	COMMODE CHAIR XWD &/OR HD W/WO ARMS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0169	COMMODE CHAIR WITH SEAT LIFT MECHANISM	This is no longer a valid code.	N/A
E0170	COMMODE CHAIR W INTEGRATED SET LIFT MECHANISM ELCTRIC ANY TYPE	Pre-authorization required for all providers.	Prior to 09/01/2019
E0171	COMMODE CHAIR W INTEGRATED SEAT LIFT MECHANISM NON-ELECTRIC ANY TYPE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0172	SEAT LIFT MECHANISM PLACED OVER OR ON TOP OF TOILET ANY TYPE	Pre-authorization required for all providers.	Prior to 09/01/2019
E0175	FOOT REST USE W/COMMODE CHAIR EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0176	AIR PRESSURE PAD CUSHION NONPOSITIONING	No pre-authorization is required for all providers.	N/A
E0179	DRY PRESSURE PAD/CUSHION NONPOSITIONING	No pre-authorization is required for all providers.	N/A
E0180	PRESSURE PAD ALTERNATING W/PUMP	This is no longer a valid code.	N/A
E0181	POWERED PRESSURE REDUCING MATTRSS OVERLAY/PAD.ALTERNATING W PUMP	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0182	PUMP FOR ALTERNATING PRESSURE PAD, FOR REPLACEMENT ONLY	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0184	DRY PRESSURE MATTRESS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0185	GEL/GEL LIKE PRESS PAD STAN MATRS LENGTH/WIDTH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0186	AIR PRESSURE MATTRESS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0187	WATER PRESSURE MATTRESS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0188	SYNTHETIC SHEEPSKIN PAD	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0189	LAMBSWOOL SHEEPSKIN PAD ANY SIZE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0190	POSITIONING CUSHION/PILLOW/WEDGE,ANY SHAPE/SIZE, INCL ALL COMPONENTS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0191	HEEL/ELBOW PROTECTOR EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0193	POWERED AIR FLOTATION BED (LOW AIR LOW THERAPY)	Pre-authorization required for all providers.	Prior to 09/01/2019
E0194	AIR FLUIDIZED BED	Pre-authorization required for all providers.	Prior to 09/01/2019
E0196	GEL PRESSURE MATTRESS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0197	AIR PRESS PAD STAN MATRS LENGTH/WIDTH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0198	H2O PRESS PAD STAN MATRS LENGTH/WIDTH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0199	DRY PRESS PAD STAN MATRS LENGTH/WIDTH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0200	HEAT LAMP WO STAND INCL BULB/INFRARED ELEMENT	This service is not covered by Superior HealthPlan.	N/A
E0202	PHOTOTHERAPY (BILIRUBIN) LIGHT W/PHOTOMETER	Pre-authorization is required for all providers.	Prior to 09/01/2019
E0203	THERAPEUTIC LIGHTBOX, MINIMUM 10,000 LUX, TABLE TOP MODEL	This service is not covered by Superior HealthPlan.	N/A
E0205	HEAT LAMP W/STAND INCL BULB/INFRARED ELEMENT	This service is not covered by Superior HealthPlan.	N/A
E0210	ELECTRIC HEAT PAD STANDARD	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0215	ELECTRIC HEAT PAD MOIST	This service is not covered by Superior HealthPlan.	N/A
E0217	WATER CIRCULATING HEAT PAD W/PUMP	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0218	FLUID CIRCULATING COLD PAD WITH PUMP ANY TYPE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0221	INFRARED HEATING PAD SYSTEM	No pre-authorization is required for all providers.	N/A
E0225	HYDROCOLLATOR UNIT INCL PADS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0231	NON CONTACT WOUND WARMING DEVICE	This service is not covered by Superior HealthPlan.	N/A
E0232	WARMING CARD	This service is not covered by Superior HealthPlan.	N/A
E0235	PARAFFIN BATH UNIT PORTABLE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0236	PUMP WATER CIRCULATING PAD	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0237	PAD-WATER CIRCULATING, WITH PUMP	This is no longer a valid code.	N/A
E0238	NON ELECTRIC HEAT PAD MOIST	No pre-authorization is required for all providers.	N/A
E0239	HYDROCOLLATOR UNIT PORTABLE	This service is not covered by Superior HealthPlan.	N/A
E0240	BATH/SHOWER CHAIR W/WO WHLS ANY SZ	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0241	BATH TUB WALL RAIL EA	This service is not covered by Superior HealthPlan.	N/A
E0242	BATH TUB RAIL FLOOR BASE	This service is not covered by Superior HealthPlan.	N/A
E0243	TOILET RAIL EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0244	RAISED TOILET SEAT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0245	TUB STOOL/BENCH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0246	TRANSFER TUB RAIL ATTACHMENT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0247	TRANSFER BENCH FOR TUB OR TOILET WITH OR WITHOUT COMMODE OPENING	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0248	TRNSFR BENCH, HEAVY DUTY/TUB OR TOILET W OR W/OUT COMMODE OPENING	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0249	PAD WATER CIRCULATING HEAT U	This service is not covered by Superior HealthPlan.	N/A
E0250	HOSP BED FIX HEIGHT W/ANY SIDE RAILS/MATTRESS	No pre-authorization is required for all providers.	N/A
E0251	HOSP BED FIX HEIGHT W/ANY RAILS WO MATTRESS	This service is not covered by Superior HealthPlan.	N/A
E0255	HOSP BED VARIABLE HI-LO W/ANY RAILS W/MATTRESS	Pre-authorization required for all providers.	Prior to 09/01/2019
E0256	HOSP BED VARIABLE HI-LO W/ANY RAILS WO MATTRESS	No pre-authorization is required for all providers.	N/A
E0260	HOSP BED SEMI-ELEC W/ANY RAILS W/MATTRESS	Pre-authorization required for all providers.	Prior to 09/01/2019
E0261	HOSP BED SEMI-ELEC W/ANY RAILS WO MATTRESS	This service is not covered by Superior HealthPlan.	N/A
E0265	HOSP BED TOTAL ELEC W/ANY RAILS W/MATTRESS	Pre-authorization is required for all providers.	Prior to 09/01/2019
E0266	HOSP BED TOTAL ELEC W/ANY RAILS WO MATTRESS	This service is not covered by Superior HealthPlan.	N/A
E0270	HOSP BED INSTITUTION OSCILLATE/CIRCULATE/STRYKER	No pre-authorization is required for all providers.	N/A
E0271	MATTRESS INNERSPRING	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0272	MATTRESS FOAM RUBBER	This service is not covered by Superior HealthPlan.	N/A
E0273	BED BOARD	This service is not covered by Superior HealthPlan.	N/A
E0274	OVER BED TABLE	This service is not covered by Superior HealthPlan.	N/A
E0275	BED PAN STANDARD METAL/PLASTIC	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0276	BED PAD FRACTURE METAL/PLASTIC	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0277	POWERED PRESS-REDUCING AIR MATRS	Pre-authorization is required for all providers.	Prior to 09/01/2019
E0280	BED CRADLE ANY TYPE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0290	HOSP BED FIX HEIGHT WO RAILS W/MATTRESS	No pre-authorization is required for all providers.	N/A
E0291	HOSP BED FIX HEIGHT WO RAILS WO MATTRESS	No pre-authorization is required for all providers.	N/A
E0292	HOSP BED VARIABLE HI-LO WO RAILS W/MATTRESS	This service is not covered by Superior HealthPlan.	N/A

E0293	HOSP BED VARIABLE HI-LO WO RAILS WO MATTRESS	This service is not covered by Superior HealthPlan.	N/A
E0294	HOSP BED SEMI-ELECTRIC WO RAILS W/MATTRESS	This service is not covered by Superior HealthPlan.	N/A
E0295	HOSP BED SEMI-ELECTRIC WO RAILS WO MATTRESS	This service is not covered by Superior HealthPlan.	N/A
E0296	HOSP BED TOTAL-ELECTRIC WO RAILS W/MATTRESS	This service is not covered by Superior HealthPlan.	N/A
E0297	HOSP BED TOTAL-ELECTRIC WO RAILS WO MATTRESS	This service is not covered by Superior HealthPlan.	N/A
E0298	HOSP BED HD XWIDE W/RAILS W/MATT	No pre-authorization is required for all providers.	N/A
E0300	ENCLOSED PED CRIB HOSP GRADE	Pre-authorization required for all providers.	Prior to 09/01/2019
E0301	HOSP BED/HVY DTY/X-TRA WIDE/WGHT CP>350 PDS/LESS OR = 600 /W/OUT MATT	This service is not covered by Superior HealthPlan.	N/A
E0302	HOSP BED/HVY DTY/X-TRA WIDE/WGHT CP> 600 /W/OUT MATT	This service is not covered by Superior HealthPlan.	N/A
E0303	HOSP BED/HVY DTY/X-TRA WIDE/WGHT CP>350 PDS/LESS OR = 600 /W MATT	Pre-authorization required for all providers.	Prior to 09/01/2019
E0304	HOSP BED/HVY DTY/X-TRA WIDE/WGHT CP> 600 /W MATT	No pre-authorization is required for all providers.	N/A
E0305	BED SIDE RAILS HALF LENGTH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0310	BEDSIDE RAILS FULL LENGTH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0315	BED ACCESS BOARD/TABLE OR SUPPRT DEVICE-ANY TYPE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0316	SAFETY ENCLOSURE FRAME/CANOPY FOR USE WITH HOSPITAL BED, ANY TYPE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E0325	URINAL MALE JUG TYPE ANY MATERIAL	No authorization is required for Par Providers unless over the benefits limitation.	Prior to 09/01/2019
E0326	URINAL FEMALE JUG TYPE ANY MATERIAL	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0328	PED HOSPITAL BED MANUAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E0329	PED HOSPITAL BED SEMI/ELECT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E0350	CONTROL UNIT FOR ELECTRON BOWEL IRRIGAT/EVAC SYS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E0352	DISP PACK FOR USE W/ELEC BOWEL IRRIGAT/EVAC SYS	No pre-authorization is required for all providers.	N/A
E0370	AIR PRESS ELEVATOR HEEL	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0371	NONPWR ADV PRESS REDUC MATRS OVERLAY STAN LW	Pre-authorization required for all providers.	Prior to 09/01/2019
E0372	PWR AIR MATRS OVERLAY STAN MATRS LENGTH/WIDTH	Pre-authorization required for all providers.	Prior to 09/01/2019
E0373	NONPWR ADV PRESS REDUC MATRS	Pre-authorization required for all providers.	Prior to 09/01/2019
E0400	ALLIED RESP: CONTENTS H TANK OXYGEN	This is no longer a valid code.	N/A
E0410	ALLIED RESP: OXYGEN CONTENTS, LIQUID PER POUND	This is no longer a valid code.	N/A
E0416	ORSINI NURSING: OXYGEN CONTENTS, E TANK	This is no longer a valid code.	N/A
E0418	ALLIED RESP: CONTENTS, E TANK	No pre-authorization is required for all providers.	N/A
E0424	STATIONARY COMPRESSED O2 SYS RENT; INCL EQUIP	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0425	STATIONARY COMP GAS W/REG GAUGE HUMIDIFIER ETC	No pre-authorization is required for all providers.	N/A
E0430	PORT OXYGEN GAS W/REG GAUGE HUMIDIFIER TUBE ETC	This service is not covered by Superior HealthPlan.	N/A
E0431	PORTABLE GAS O2 SYSTEM RENTAL; INCL EQUIP	Preauthorization required for all providers	Prior to 09/01/2019
E0433	PORTABLE LIQUID OXYGEN SYS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0434	PORTABLE LIQUID O2 SYSTEM RENTAL; INCL EQUIP	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0435	PORTABLE LIQUID O2 SYS PURCHASE; INCL EQUIP	No pre-authorization is required for all providers.	N/A
E0439	STATIONARY LIQUID O2 SYS RENT; INCL EQUIP	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0440	STATIONARY LIQUID O2 SYS PURCHASE; INCL EQUIPS	No pre-authorization is required for all providers.	N/A
E0441	STATIONARY O2 CONTENTS, GAS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0442	STATIONARY O2 CONTENTS, LIQ	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0443	PORTABLE O2 CONTENTS, GAS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0444	PORTABLE O2 CONTENTS, LIQUID	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0445	OXIMETER MSR BLD O2 LEVL NON-INVASV	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0446	TOPICAL OX DELIVER SYS, NOS	This service is not covered by Superior HealthPlan.	N/A
E0447	PRTB O C LQD 1 MO SPL=1 U PRSC AMT R/N EXCD 4LPM	No pre-authorization is required for all providers.	N/A
E0450	VOLUME VENTILATOR STATIONARY/PORTABLE	This is no longer a valid code.	N/A
E0453	THERAPUETIC VENTILATOR USE TO 12 HRS PER DAY	No pre-authorization is required for all providers.	N/A
E0454	PRSS VENT PRSS CNTRL SUPP&FLW TRIG	No pre-authorization is required for all providers.	N/A
E0455	OXYGEN TENT EXC CROUP/PEDIATRIC TENTS	This service is not covered by Superior HealthPlan.	N/A
E0457	CHEST SHELL (CUIRASS)	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0458	ALLIED RESP: BIPAP-ST	This is no longer a valid code.	N/A
E0459	CHEST WRAP	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0460	NEGATIVE PRESSURE VENTILATOR PORTABLE/STATIONARY	This is no longer a valid code.	N/A
E0461	VOL VENT BACKUP RATE NON-INVASV	This is no longer a valid code.	N/A
E0462	ROCKING BED W/WO SIDE RAILS	No authorization is required for Par Providers unless over the benefits limitation.	Prior to 09/01/2019
E0463	PRSSURE SUPP VENT W/VOL CNTRL INVASV INTERFCE	This is no longer a valid code.	N/A
E0464	PRSSURE SUPP VENT W/VOL CNTRL NONINVASV INTERFCE	This is no longer a valid code.	N/A
E0465	HOME VENT ANY TYPE USED INVASV INTF	Pre-authorization required for all providers.	Prior to 09/01/2019
E0466	HOME VENT TYPE USED NON-INVASV INTF	Pre-authorization required for all providers.	Prior to 09/01/2019
E0467	HOME VENTILATOR MULTI-FUNCTION RESPIRATORY DEVC	Pre-authorization required for all providers.	Prior to 09/01/2019
E0470	RSPRTRY DVCE/BI-LVL PRESS CPLTY/WOUT BCKP RATE FTRE/W NNINVSV INTRFC	Pre-authorization required for all providers.	Prior to 09/01/2019
E0471	RSPRTRY DVCE/BI-LVL PRESS CPLTY/W BCKP RATE FTRE/W NNINVSV INTRFC	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0472	RSPRTRY DVCE/BI-LVL PRESS CPLTY/W BCKP RATE FTRE/W INVSV INTRFC	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0480	PERCUSSOR ELECTRIC/PNEUMATIC HOME MODEL	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0481	INTRAPULMONARY PERCUSSIVE VENTILATION SYSTEM AND RELATED ACCESSORIES	This service is not covered by Superior HealthPlan.	N/A
E0482	COUGH STIMULATING DEVICE	Pre-authorization required for all providers.	Prior to 09/01/2019
E0483	HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM EA	Pre-authorization required for all providers.	Prior to 09/01/2019
E0484	OSCILLAT POS EXPIRTORY PRSS NO-ELEC	This service is not covered by Superior HealthPlan.	N/A
E0485	ORAL DEVICE/APPL TO REDUCE UP/AIRWAY COLLAPSIBILITY ADJ OR NON ADJ PREFAB	This service is not covered by Superior HealthPlan.	N/A
E0486	ORAL DEVICE/APPLIANCE TO REDUCE UP/AIRWAY COLLAPSIBILITY ADJUSTABLE OR	No pre-authorization is required for all providers.	N/A
E0487	ELECTRONIC SPIROMETER	This service is not covered by Superior HealthPlan.	N/A
E0500	IPPB MACHINE ALL MAN/AUTO VALVES INT/EXT POWER	Pre-authorization required for all providers.	Prior to 09/01/2019
E0550	HUMIDIFIER DURABLE SUPPLEMENTAL W/IPPB/OXYGEN	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0555	HUMIDIFIER DURABLE BOTTLE TYPE W/REG FLOWMETER	This service is not covered by Superior HealthPlan.	N/A
E0560	HUMIDIFIER DURABLE SUPPLEMENT W/IPPB/OXYGEN	This service is not covered by Superior HealthPlan.	N/A
E0561	HUMIDIFIER, NON-HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0562	HUMIDIFIER, HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0565	COMPRESSOR AIR POWER SOURCE EQUIPMENT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0570	NEBULIZER WITH COMPRESSOR	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0572	EXT DEFIB W/INTEGRATED ECG ANALY	This service is not covered by Superior HealthPlan.	N/A
E0574	US/ELEC AROSL GEN W/SM VOLUME NEB	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0575	NEBULIZER ULTRASONIC	Pre-authorization required for all providers.	Prior to 09/01/2019
E0580	NEBULIZER DURABLE BOTTLE TYPE W/REG/FLOWMETER	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0585	NEBULIZER W/COMPRESSOR & HEATER	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0590	DISPENSING FEE COVERED DRUG AMIN THROUGH DME NEBULIZER	No pre-authorization is required for all providers.	N/A
E0600	SUCTION PUMP HOME MODEL PORTABLE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0601	CONTINUOUS AIRWAY PRESSURE (CPAP) DEVICE	Pre-authorization required for all providers.	Prior to 09/01/2019
E0602	BREAST PUMP ALL TYPES	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0603	BREAST PUMP, ELECTRIC (AC AND/OR DC), ANY TYPE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0604	HOSP GRADE ELEC BREAST PUMP	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0605	VAPORIZER ROOM TYPE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0606	POSTURAL DRAINAGE BOARD	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0607	HOME BLOOD GLUCOSE MONITOR	Pre-authorization required for all providers.	Prior to 09/01/2019
E0608	APNEA MONITOR	No pre-authorization is required for all providers.	N/A
E0609	BLOOD GLUCOSE MONITOR W/SPECIAL FEATURES	No pre-authorization is required for all providers.	N/A
E0610	PACEMAKER MONITOR SELF CONTAIN W/AUD/VIS CHECK	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0615	PACEMAKER MONITOR SELF CONTAIN W/DIG/VIS CHECK	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0617	EXT DEFIB W/INTEGRATED ECG ANALY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E0618	APNEA MONITOR W/O RECORDING FEATURE	Pre-authorization required for all providers.	Prior to 09/01/2019
E0619	APNEA MONITOR W/RECORDING FEATURE	Pre-authorization is required for members over 5 months of age for all providers.	Prior to 09/01/2019
E0620	SKIN PIERCING DEVICE FOR COLLECTION OF CAPILLARY BLOOD, LASER, EACH	No pre-authorization is required for all providers.	N/A
E0621	SLING/SEAT PATIENT LIFT CANVAS/NYLON	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0625	PATIENT LIFT KARTOP BATHROOM/TOILET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E0627	SEAT LIFT MECH COMB LIFT-CHAIR MECH	This service is not covered by Superior HealthPlan.	N/A
E0628	SEP SEAT LIFT USE W/PT OWN FURNITURE ELECTRIC	This is no longer a valid code.	N/A
E0629	SEAT LIFT MECH NON-ELECTRIC ANY TYP	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0630	PATIENT LIFT HYDRAULIC	Pre-authorization required for all providers.	Prior to 09/01/2019
E0635	PATIENT LIFT ELECTRIC W/SEAT/SLING	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0636	MX PSTN PT SUPP SYS LIFT PT CNTRL	This service is not covered by Superior HealthPlan.	N/A
E0637	COMBINATION SIT TO STAND SYS	Pre-authorization required for all providers.	Prior to 09/01/2019
E0638	STANDING FRAME SYS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019

E0639	PT LIFT MOVEABLE ROOM-ROOM W/DISSASSEMBLY&REASSEMBLY	Pre-authorization required for all providers.	Prior to 09/01/2019
E0640	PATIENT LIFT FIX SYS INCLUDES ALL CMPNTS/ACCESS	Pre-authorization required for all providers.	Prior to 09/01/2019
E0641	MULTI-POSITION STAND FRAME SYS	Pre-authorization required for all providers.	Prior to 09/01/2019
E0642	DYNAMIC STANDING FRAME	Pre-authorization required for all providers.	Prior to 09/01/2019
E0650	PNEUMATIC COMPRESSOR NONSEGMENTAL HOME MODEL	Pre-authorization required for all providers.	Prior to 09/01/2019
E0651	PNEUMATIC COMPRESS SEGMENTAL WO GRADIENT PRESS	Pre-authorization required for all providers.	Prior to 09/01/2019
E0652	PNEUMATIC COMPRESS SEGMENTAL W/GRADIENT PRESS	Pre-authorization required for all providers.	Prior to 09/01/2019
E0655	NONSEGMENTAL PNEUMATIC-USE W/COMPRESSOR HALF ARM	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0656	SEGMENTAL PNEUMATIC TRUNK	No pre-authorization is required for all providers.	N/A
E0657	SEGMENTAL PNEUMATIC CHEST	No pre-authorization is required for all providers.	N/A
E0660	NONSEGMENTAL PNEUMATIC-USE W/COMPRESSOR FULL LEG	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0665	NONSEGMENTAL PNEUMATIC-USE W/COMPRESSOR FULL ARM	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0666	NONSEGMENTAL PNEUMATIC-USE W/COMPRESSOR HALF LEG	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0667	SEGMENTAL PNEUMATIC-USE W/COMPRESSOR FULL LEG	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0668	SEGMENTAL PNEUMATIC-USE W/COMPRESSOR FULL ARM	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0669	SEGMENTAL PNEUMATIC-USE W/COMPRESSOR HALF LEG	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0670	SEG PNEUM INT LEGS/TRUNK	Pre-authorization required for all providers.	Prior to 09/01/2019
E0671	SEGMENT GRAD PRESS PNEUMATIC APPLIANCE FULL LEG	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0672	SEGMENT GRAD PRESS PNEUMATIC APPLIANCE FULL ARM	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0673	SEGMENT GRAD PRESS PNEUMATIC APPLIANCE HALF LEG	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0675	PNEUMATIC COMP DVC/HIGH PRESS/RAPID INFLTN/DFLTN CYC/ARTERIAL INSUFF	This service is not covered by Superior HealthPlan.	N/A
E0676	INTERMIT LIMB COMPRESSION DEV (INCL ALL ACCESSORIES), NOT OTHERW SPEC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E0690	ULTRAVIOLET CABINET APPROPRIATE HOME USE	No pre-authorization is required for all providers.	N/A
E0691	UVL PNL 2 SQ FT OR LESS	Pre-authorization required for all providers.	Prior to 09/01/2019
E0692	UV LT TX SYS PANL W/LAMP 4 FT PANL	This service is not covered by Superior HealthPlan.	N/A
E0693	UV LT TX SYS PANL W/LAMP 6 FT PANL	This service is not covered by Superior HealthPlan.	N/A
E0694	UV MX DIR LT TX SYS 6 FT CABINET	This service is not covered by Superior HealthPlan.	N/A
E0699	SEGMENTAL PNEUMATIC APPLIANCE	No pre-authorization is required for all providers.	N/A
E0700	SAFETY EQUIPMENT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0701	HELMET FCE GUARD&SFT INTERFCR PRFAB	No pre-authorization is required for all providers.	N/A
E0705	TRANSFER DEVICE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0710	RESTRAINTS ANY TYPE (BODY CHEST WRIST ANKLE)	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0720	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, 2 LEAD, LOCAL	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0730	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION(TENS)DEVICE,4+ LEADS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0731	FORM FIT CONDUCTIVE GARMENT TENS/NMES	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0740	N-IMPL PELV FLR ELEC STIM CMPL SYS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0744	NEUROMUSCULAR STIMULATOR SCOLIOSIS	No pre-authorization is required for all providers.	N/A
E0745	NEUROMUSCULAR STIMULATOR ELECTRONIC SHOCK UNIT	Pre-authorization required for all providers.	Prior to 09/01/2019
E0746	ELECTROMYOGRAPHY (EMG) BIOFEEDBACK DEVICE	No pre-authorization is required for all providers.	N/A
E0747	O'GENIC STIM ELEC NONINVAS OTH THAN SPINE APPLIC	Pre-authorization required for all providers.	Prior to 09/01/2019
E0748	OSTEOGENIC STIM-ELEC-NON INVAS-SPINE APPLICTNS	Pre-authorization required for all providers.	Prior to 09/01/2019
E0749	OSTEOGENESIS STIM ELEC (SURGICALLY IMPLANTED)	No pre-authorization is required for all providers.	N/A
E0752	IMPLANTABLE NEUROSTIMULATOR ELECTRODE, EACH	No pre-authorization is required for all providers.	N/A
E0753	IMPLANTABLE NEUROSTIMULATOR ELECTRODES, GRP OF 4	No pre-authorization is required for all providers.	N/A
E0754	PATIENT PROGRAMMER EXTERNAL	No pre-authorization is required for all providers.	N/A
E0755	ELECTRONIC SALIVARY REFLEX STIMULATOR	This service is not covered by Superior HealthPlan.	N/A
E0756	IMPLNT NEUROSTIM PULSE GEN	No pre-authorization is required for all providers.	N/A
E0757	IMPLNT NEUROSTIM RADIOFREQ RECEVR	No pre-authorization is required for all providers.	N/A
E0758	RADIOFREQ TRNSMTR USE W/IMP NEURO	No pre-authorization is required for all providers.	N/A
E0759	RADIOFREQUENCY TRANSMITTER	No pre-authorization is required for all providers.	N/A
E0760	OSTEOGENESIS STIM-LOW INTENSITY US NON-INVASIVE	Pre-authorization required for all providers.	Prior to 09/01/2019
E0761	NON-THRML PULS RADIOWAVE ELECMAGNET	This service is not covered by Superior HealthPlan.	N/A
E0762	TRANSCUTANEOUS ELECT JOINT STIMULATION DEVICE SYST INCLS ALL ACCESSORIES	No pre-authorization is required for all providers.	N/A
E0764	FUNCTIONAL NEUROMUSCULARSTIM	Pre-authorization required for all providers.	Prior to 09/01/2019
E0765	NERV STIM W/REPLC BAT TX-NAUS & VOM	No pre-authorization is required for all providers.	N/A
E0766	ELEC STIM CANCER TREATMENT	This service is not covered by Superior HealthPlan.	N/A
E0769	ESTIM/ELECTROMAGNETIC WOUND TREATMENT DEVC NOC	No pre-authorization is required for all providers.	N/A
E0770	FUNCTIONAL ELECTRIC STIM NOS	This service is not covered by Superior HealthPlan.	N/A
E0776	IV POLE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0777	PUMP ENTERAL INFUSION	No pre-authorization is required for all providers.	N/A
E0779	AMBULATORY INFUSION PUMP MECHANICAL REUSABLE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0780	AMBULATORY INFUSION PUMP MECHANICAL REUSABLE FOR INFUSION	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0781	AMBULATORY INFUSION PUMP 1/MULTI CHAN PT WEARS	Pre-authorization required for all providers.	Prior to 09/01/2019
E0782	INFUS PUMP IMPL NON-PROGRAMMABLE	Pre-authorization required for all providers.	Prior to 09/01/2019
E0783	INFUS PUMP SYST IMPLNT PROGRAMMABLE (INCL COMPON)	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
E0784	EXTERNAL AMBULATORY INFUSION PUMP, INSULIN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E0785	IMPLANT INTRASPINAL CATH W/FUS PUMP REPLAC	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
E0786	IMPLNT PROGRAM INFUS PUMP REPLCMT	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
E0787	EXTERNAL AMB INFUS PUMP INSULIN DOS RATE ADJ	This service is not covered by Superior HealthPlan.	N/A
E0790	PARENTERAL INFUSION PUMP	This is no longer a valid code.	N/A
E0791	PARENTERAL INFUSION PUMP STATIONARY 1/MULTICHANL	Pre-authorization required for all providers.	Prior to 09/01/2019
E0830	ORSINI: EXTREMITY TRACTION, FREE STANDING, BUCK	This service is not covered by Superior HealthPlan.	N/A
E0840	TRACTION FRAME TO HEADBOARD CERV TRACTION	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0849	TRACTION EQP CERV FREESTAND STAND/FRME PNEUMATIC	This service is not covered by Superior HealthPlan.	N/A
E0850	TRACTION STAND FREESTANDING CERV TRACTION	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0855	CERV TRACT EQUIP NOT REQ ADD STAND/FRAME	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0856	CERVIC COLLAR W AIR BLADDERS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0860	TRACTION EQUIPMENT OVERDOOR CERV	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0870	TRACTION FRAME TO FOOTBOARD EXTREMITY TRACTION	No pre-authorization is required for all providers.	N/A
E0880	TRACTION STAND FREESTANDING EXTREMITY TRACTION	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0890	TRACTION FRAME TO FOOTBOARD PELVIC TRACTION	No pre-authorization is required for all providers.	N/A
E0900	TRACTION STAND FREESTANDING PELVIC TRACTION	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0910	TRAPEZE BARS TO BED W/GRAB BAR (PT HELPER)	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0911	TRAPEZE BAR HEAVY DUTY FOR PATIENT WT CAP GR THAN 250 LBS ATTACH TO BED	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0912	TRAPEZE BAR HEAVY DUTY FOR PATIENT WT CAP GR THAN 250 LBS FREE STANDING	Pre-authorization required for all providers.	Prior to 09/01/2019
E0920	FRACTURE FRAME TO BED INCL WEIGHTS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0925	CONTINUOUS PASSIVE MOTION DEVICE	No pre-authorization is required for all providers.	N/A
E0930	FRACTURE FRAME FREESTANDING W/WEIGHTS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0935	PASSIVE MOTION EXERCISE DEVICE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0936	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE OTHER THAN KNEE	This service is not covered by Superior HealthPlan.	N/A
E0940	TRAPEZE BAR FREESTANDING COMPLETE W/GRAB BAR	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0941	GRAVITY ASSIST TRACTION DEVICE ANY TYPE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0942	CERVICAL HEAD HARNESS/HALTER	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0943	CERVICAL PILLOW	No pre-authorization is required for all providers.	N/A
E0944	PELVIC BELT/HARNESS/HALTER	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0945	EXTREMITY BELT/HARNESS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0946	FX FRAME DUAL W/CROSS BARS ATTACH BED	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0947	FX FRAME ATTACH COMPLEX PELVIC TRACTION	This service is not covered by Superior HealthPlan.	N/A
E0948	FX FRAME ATTACH COMPLEX CERVICAL TRACTION	This service is not covered by Superior HealthPlan.	N/A
E0950	WHEELCHAIR ACCESSORY, TRAY, EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0951	HEEL LOOP/HOLDER, WITH OR WITHOUT ANKLE STRAP, EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0952	TOE LOOP/HOLDER, EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0953	WC AC LAT THIGH/KNEE SUPP ANY TY EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0954	WHEELCHAIR AC FOOT BOX ANY TY EA FT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0955	WHEELCHAIR /HEADREST/CUSHIONED/PREFABRICATED/INCL FIXED MNTNG HARDWARE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0956	WHEELCHAIR/LATERAL TRUNK, HIP SUPPORT, PREFBRCTD, INCL FIXED MNTNG HRDWR	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0957	WHEELCHAIR/MEDIAL THIGH SUPP/PREFAB/ INCL FIXED MOUNTING HARDWARE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0958	MANUAL WHEELCHAIR ACCESSORY, ONE-ARM DRIVE ATTACHMENT, EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0959	MANUAL WHEELCHAIR ACCESSORY, ADAPTER FOR AMPUTEE, EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0960	WHEELCHAIR/SHOLDER HARNESS/STRAPS/CHEST STRAP/INCL ANY TYPE MNTNG HRDWR	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0961	MANUAL WHEELCHAIR ACCESSORY, WHEEL LOCK BRAKE EXTENSION (HANDLE), EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019

E0966	MANUAL WHEELCHIR ACCESSORY, HEADREST EXTENSION, EACH	No pre-authorization is required for all providers.	N/A
E0967	MNL WC AC HND RIM PROJ REPL ONL EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0968	COMMODE SEAT WHEELCHAIR	This service is not covered by Superior HealthPlan.	N/A
E0969	NARROWING DEVICE WHEELCHAIR	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0970	# 2 FOOTPLATES EXCEPT ELEVATING LEG REST	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0971	ANTI TIPPING DEVICE WHEELCHAIRS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0972	WHEELCHAIR ACCESSORY, TRANSFER BOARD OR DEVICE, EACH	No pre-authorization is required for all providers.	N/A
E0973	WHEELCHAIR ADJUSTABLE HEIGHT, DETACH ARMREST, CMPLTD ASSEMBLY	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0974	MANUAL WHEELCHAIR ACCESSORY, ANTI-ROLLBACK DEVICE, EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0977	WEDGE CUSHION WHEELCHAIR	This is no longer a valid code.	N/A
E0978	WHEELCHAIR ACCESSORY, SAFETY BELT/ PELVIC STRAP, EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0980	SAFETY VEST WHEELCHAIR	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0981	WHEELCHAIR ACCESSORY, SEAT UPHOLSTERY, REPLACEMENT ONLY, EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0982	WHEELCHAIR ACCESSORY, BACK UPHOLSTERY, REPLACEMENT ONLY, EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0983	MNL WHEELCHAIR/ PWR ADD-ON-CNVRT MNAL WHEELCHAIR-MTRZD WHEELCHAIR	This service is not covered by Superior HealthPlan.	N/A
E0984	WHEELCHAIR/PWR ADD-ON- CNVRT MNAL WHEELCHAIR- MTRZD WHEELCHAIR, TILLER	This service is not covered by Superior HealthPlan.	N/A
E0985	WHEELCHAIR ACCESSORY, SEAT LIFT MECHANISM	No pre-authorization is required for all providers.	N/A
E0986	MAN W/C PUSH-RIM POWR SYSTEM	This service is not covered by Superior HealthPlan.	N/A
E0988	LEVER-ACTIVATED WHEEL DRIVE	This service is not covered by Superior HealthPlan.	N/A
E0990	WHEELCHAIR ACCESSORY, ELEVATING LEG REST, COMPLETE ASSEMBLY, EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0991	UPHOLSTERY SEAT	No pre-authorization is required for all providers.	N/A
E0992	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT INSERT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0994	ARM REST EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0995	WC AC CALF REST/PAD REPL ONLY EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E0996	TIRE SOLID EA	No pre-authorization is required for all providers.	N/A
E0997	CASTER W/FORK	This is no longer a valid code.	N/A
E0998	CASTER WO FORK	This is no longer a valid code.	N/A
E0999	PNEUMATIC TIRE W/WHEEL	This is no longer a valid code.	N/A
E1000	TIRE PNEUMATIC CASTER	No pre-authorization is required for all providers.	N/A
E1001	WHEEL SINGLE	No pre-authorization is required for all providers.	N/A
E1002	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, TILT ONLY	Pre-authorization required for all providers.	Prior to 09/01/2019
E1003	WHEELCHAIR/PWR SEATING SYS/RCLN ONLY/WOUT SHEAR REDUCTION	No pre-authorization is required for all providers.	N/A
E1004	WHEELCHAIR PWR SEATING SYS/RCLNE ONLY/ W MECHNCL SHEAR REDUCTION	Pre-authorization required for all providers.	Prior to 09/01/2019
E1005	WHEELCHAIR/PWR SEATING SYS/RCLNE ONLY/W PWR SHEAR REDUCTION	Pre-authorization required for all providers.	Prior to 09/01/2019
E1006	WHEELCHAIR/ PWR SEATING SYS/CMBNTN TILT&RCLNE/WOUT SHEAR REDUCTION	Pre-authorization required for all providers.	Prior to 09/01/2019
E1007	WHEELCHAIR/PWR SEATING SYS/CMBNTN TILT&RCLNE/ W MCHNCL SHEAR REDUCTION	Pre-authorization required for all providers.	Prior to 09/01/2019
E1008	WHEELCHAIR/PWR SEATING SYS/CMBNTN TILT&RCLNE/ W PWR SHEAR REDUCTION	Pre-authorization required for all providers.	Prior to 09/01/2019
E1009	WHEELCHAIR, ADD TO PWR SEATING SYS/INCL PUSHROD&LEG REST	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E1010	WHEELCHAIR/ADD TO PWR SEATING SYS	Pre-authorization required for all providers.	Prior to 09/01/2019
E1011	MOD PED WHLCHAIR WIDTH ADJ PKG	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E1012	WC ACCESS PWR SEAT SYS CNTR MNT EA	Pre-authorization required for all providers.	Prior to 09/01/2019
E1014	RECLIN BACK ADD PEDIATRIC WHLCHAIR	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1015	SHOCK ABSORBER MANUAL WHEELCHAIR EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1016	SHOCK ABSORBER POWER WHEELCHAIR EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1017	HEVY DUTY SHOCK ABSORBR MNL WC EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E1018	HEVY DUTY SHOCK ABSORBR PWR WC EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E1019	WHEELCHAIR/PWR SEATING SYS/HVY DUTY FTR/WGHT CP >250 PDS&LESS OR=400 PDS	No pre-authorization is required for all providers.	N/A
E1020	RESIDUAL LIMB SUPPORT SYSTEM	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1021	WHEELCHAIR/PWR SEATING SYS/EXTRA HVY DTY FTR/WGHT CP >400 PDS	No pre-authorization is required for all providers.	N/A
E1025	LAT THOR SUPP NON-CONTOUR PED WC EA	No pre-authorization is required for all providers.	N/A
E1026	LAT THOR SUPP CONTOURED PED WC EA	No pre-authorization is required for all providers.	N/A
E1027	LAT/ANT SUPPORT PED WHLCHAIR EA	No pre-authorization is required for all providers.	N/A
E1028	WHEELCHAIR/MNL SWINGAWAY/RTRCTBL OR RMVBLE MNTNG HRWRE FOR JOYSTICK	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1029	WHEELCHAIR ACCESSORY, VENTILATOR TRAY, FIXED	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1030	WHEELCHAIR ACCESSORY, VENTILATOR TRAY, GIMBALED	This service is not covered by Superior HealthPlan.	N/A
E1031	ROLLABOUT CHAIR ALL TYPES W/CASTORS 5 /MORE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1035	PATIENT TRANSFER SYSTEM <300	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E1036	PATIENT TRANSFER SYSTEM >300	No pre-authorization is required for all providers.	N/A
E1037	TRANSPORT CHAIR PEDIATRIC SIZE	This service is not covered by Superior HealthPlan.	N/A
E1038	TRANSPORT CHAIR ADULT SIZE	Pre-authorization is required for Dual Long-term, Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
E1039	TRNSPRT CHAIR ADLT HVY DUTY PT WT CAP 250 LB/GT	This service is not covered by Superior HealthPlan.	N/A
E1050	FULL RECLINE WHEELCHAIR FIX ARM DETACHABLE LEGS	This service is not covered by Superior HealthPlan.	N/A
E1060	FULL RECLINE WHEELCHAIR DETACH ARMS/LEGS	This service is not covered by Superior HealthPlan.	N/A
E1065	POWER ATTACHMENT TO CONVERT ANY WHEELCHAIR	No pre-authorization is required for all providers.	N/A
E1066	BATTERY CHARGER	No pre-authorization is required for all providers.	N/A
E1070	FULL RECLINE WHEELCHAIR DETACH ARMS/FOOTREST	This service is not covered by Superior HealthPlan.	N/A
E1082	ALLIED RESP: PUMP FOR APP	No pre-authorization is required for all providers.	N/A
E1083	HEMI WHEELCHAIR FIXED FULL ARMS DETACH LEGREST	This service is not covered by Superior HealthPlan.	N/A
E1084	HEMI WHEELCHAIR DETACH ARMS/LEGS FOOTREST	This service is not covered by Superior HealthPlan.	N/A
E1085	HEMI WHEELCHAIR FIXED ARMS DETACH FOOTRESTS	This service is not covered by Superior HealthPlan.	N/A
E1086	HEMI WHEELCHAIR DETACH ARMS DESK FOOTRESTS	This service is not covered by Superior HealthPlan.	N/A
E1087	HI STR LITE WHEELCHAIR FIX FULL ARM DET LEGS	This service is not covered by Superior HealthPlan.	N/A
E1088	HI STR LITE WHEELCHAIR DETACH ARMS DESK LEGS	This service is not covered by Superior HealthPlan.	N/A
E1089	HI STR LITE WHEELCHAIR FIX ARMS DETACH FOOTREST	This service is not covered by Superior HealthPlan.	N/A
E1090	HI STR LITE WHEELCHAIR DETACH ARMS DESK FOOTREST	This service is not covered by Superior HealthPlan.	N/A
E1092	WIDE HEAVY DUTY WHEELCHAIR DETACH ARM DESK LEG	This service is not covered by Superior HealthPlan.	N/A
E1093	WIDE HVY DUTY WHEELCHAIR DETACH FULL ARM DESK FT	This service is not covered by Superior HealthPlan.	N/A
E1100	SEMI RECLINE WHEELCHAIR FIX FULL ARMS DETACH LEG	This service is not covered by Superior HealthPlan.	N/A
E1110	SEMI RECLINE DETACH ARM (DESK FULL) ELEVATE LEG	This service is not covered by Superior HealthPlan.	N/A
E1130	STANDARD WHEELCHAIR FIX FULL ARMS DETACH FOOT	This service is not covered by Superior HealthPlan.	N/A
E1140	WHEELCHAIR DETACH ARMS (DESK FULL) DETACH FOOT	This service is not covered by Superior HealthPlan.	N/A
E1150	WHEELCHAIR DETACH ARMS (DESK FULL) DETACH LEG	This service is not covered by Superior HealthPlan.	N/A
E1160	WHEELCHAIR FIX FULL ARMS DETACH LEGRESTS	This service is not covered by Superior HealthPlan.	N/A
E1161	MANUAL ADLT SZ WC INCL TILT SPACE	Pre-authorization required for all providers.	Prior to 09/01/2019
E1170	AMPUTEE WHEELCHAIR FIX FULL ARM DETACH LEGRESTS	This service is not covered by Superior HealthPlan.	N/A
E1171	AMPUTEE WHEELCHAIR FIX FULL ARM W/O FOOT/LEG	No pre-authorization is required for all providers.	N/A
E1172	AMPUTEE WHEELCHAIR DETACH ARMS WO FOOT/LEG	This service is not covered by Superior HealthPlan.	N/A
E1180	AMPUTEE WHEELCHAIR DETACH ARMS DETACH FOOTRESTS	This service is not covered by Superior HealthPlan.	N/A
E1190	AMPUTEE WHEELCHAIR DETACH ARMS DETACH ELEV LEG	This service is not covered by Superior HealthPlan.	N/A
E1195	HVY DTY WHEELCHAIR FIX FULL ARMS DETACH ELEV LEG	This service is not covered by Superior HealthPlan.	N/A
E1200	AMPUTEE WHEELCHAIR FIX FULL ARMS DETACH FOOTREST	This service is not covered by Superior HealthPlan.	N/A
E1210	MOTOR WHEELCHAIR FIX FULL ARMS DETACH ELEV LEG	No pre-authorization is required for all providers.	N/A
E1211	MOTOR WHEELCHAIR DETACH ARMS DETACH ELEV LEG	No pre-authorization is required for all providers.	N/A
E1212	MOTOR WHEELCHAIR FIX FULL ARMS DETACH FOOTRESTS	No pre-authorization is required for all providers.	N/A
E1213	MOTOR WHEELCHAIR DETACH ARMS DETACH FOOTRESTS	No pre-authorization is required for all providers.	N/A
E1220	WHEELCHAIR SPECIAL SIZE/CONSTRUCT & JUSTIFY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E1221	WHEELCHAIR W/FIX ARM FOOTRESTS	No pre-authorization is required for all providers.	N/A
E1222	WHEELCHAIR W/FIX ARM ELEVATING LEGRESTS	This service is not covered by Superior HealthPlan.	N/A
E1223	WHEELCHAIR W/DETACH ARMS FOOTRESTS	This service is not covered by Superior HealthPlan.	N/A
E1224	WHEELCHAIR W/DETACH ARMS ELEVATING LEGRESTS	This service is not covered by Superior HealthPlan.	N/A
E1225	MNL WHEELCHAIR/SEMI-RCLNG BACK/RCLNE>15 DGRS/LESS THAN 80 DGRS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1226	MANUAL WHEELCHAIR ACCESSORY, FULLY RECLINING BACK, EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1227	SPECIAL HEIGHT ARMS FOR WHEELCHAIR	No pre-authorization is required for all providers.	N/A
E1228	SPECIAL BACK HEIGHT FOR WHEELCHAIR	No pre-authorization is required for all providers.	N/A
E1230	POWER OP VEHICLE (3-4 WHEEL) BRAND/NAME/MODEL #	Pre-authorization required for all providers.	Prior to 09/01/2019
E1231	WC PED SZ TILT-IN-SPACE RIGD W/SEAT	No pre-authorization is required for all providers.	N/A
E1232	WC PED SZ TILT-IN-SPACE FOLD W/SEAT	Pre-authorization required for all providers.	Prior to 09/01/2019
E1233	WC PED SZ TILT-IN-SPCE RIGD NO SEAT	Pre-authorization required for all providers.	Prior to 09/01/2019
E1234	WC PED SZ TILT-IN-SPCE FOLD NO SEAT	Pre-authorization required for all providers.	Prior to 09/01/2019
E1235	WC PED SZ RIGD ADJUSTBL W/SEAT SYS	Pre-authorization required for all providers.	Prior to 09/01/2019
E1236	WC PED SZ FOLD ADJUSTBL W/SEAT SYS	Pre-authorization required for all providers.	Prior to 09/01/2019

E1237	WC PED SZ RIGD ADJUSTBL NO SEAT SYS	Pre-authorization required for all providers.	Prior to 09/01/2019
E1238	WC PED SZ FOLD ADJUSTBL NO SEAT SYS	Pre-authorization required for all providers.	Prior to 09/01/2019
E1239	POWER WHEELCHAIR PEDIATRIC SIZE NOS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E1240	LITE WHEELCHAIR DETACH ARM DETACH ELEV LEGREST	This service is not covered by Superior HealthPlan.	N/A
E1250	LITE WHEELCHAIR FIX FULL ARMS DETACH FOOTREST	This service is not covered by Superior HealthPlan.	N/A
E1260	LITE WHEELCHAIR DETACH ARMS DETACH FOOTREST	This service is not covered by Superior HealthPlan.	N/A
E1270	LITE WHEELCHAIR FIX FULL ARMS DETACH ELEV LEG	No pre-authorization is required for all providers.	N/A
E1280	HEAVY DUTY WHEELCHAIR DETACH ARMS ELEV LEGRESTS	This service is not covered by Superior HealthPlan.	N/A
E1285	HVY DTY WHEELCHAIR FIX FULL ARMS DETACH FOOTREST	This service is not covered by Superior HealthPlan.	N/A
E1290	HEAVY DTY WHEELCHAIR DETACH ARMS DETACH FOOTREST	This service is not covered by Superior HealthPlan.	N/A
E1295	HEAVY DUTY WHEELCHAIR FIX FULL ARMS ELEV LEGREST	This service is not covered by Superior HealthPlan.	N/A
E1296	SPECIAL WHEELCHAIR SEAT HEIGHT FROM FLOOR	This service is not covered by Superior HealthPlan.	N/A
E1297	SPECIAL WHEELCHAIR SEAT DEPTH BY UPHOLSTERY	This service is not covered by Superior HealthPlan.	N/A
E1298	SPECIAL WHEELCHAIR SEAT DEPTH/WIDTH BY CONST	This service is not covered by Superior HealthPlan.	N/A
E1299	SPECIAL SEAT WIDTH	No pre-authorization is required for all providers.	N/A
E1300	WHIRLPOOL PORTABLE (OVER TUB TYPE)	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1310	WHIRLPOOL NON PORTABLE (BUILT IN TYPE)	Pre-authorization required for all providers.	Prior to 09/01/2019
E1352	O2 FLOW REG POS INSPIR PRESS	This service is not covered by Superior HealthPlan.	N/A
E1353	REGULATOR	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1354	WHEELED CART PORT CYL CONC	This service is not covered by Superior HealthPlan.	N/A
E1355	STAND/RACK	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1356	BATT PACK CART PORT CONC	This service is not covered by Superior HealthPlan.	N/A
E1357	BATTERY CHARGER PORT CONC	This service is not covered by Superior HealthPlan.	N/A
E1358	DC POWER ADAPTER PORT CONC	This service is not covered by Superior HealthPlan.	N/A
E1372	IMMERSION EXTERNAL HEATER FOR NEBULIZER	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1375	NEBULIZER PORTABLE W/SMALL COMPRESS LIMIT FLOW	No pre-authorization is required for all providers.	N/A
E1380	OXYGEN CONCENTRATE HI HUMIDITY TO 976 CU FT	No pre-authorization is required for all providers.	N/A
E1382	OXYGEN CONCENTRATE HI HUMIDITY TO 1464 CU FT	No pre-authorization is required for all providers.	N/A
E1383	OXYGEN CONCENTRATE HI HUMIDITY TO 1708 CU FT	No pre-authorization is required for all providers.	N/A
E1390	OXY CNCNTRTR/1 DLVRY PORT/CPBLE OF DLVRNG 85%OR>OXY CNCNTRTN	Preauthorization required for all providers	Prior to 09/01/2019
E1391	OXY CNCNTRTR/DUAL DLVRY PRT/CPBL DLVRNG 85%OR>OXY CNCNTRTN	This service is not covered by Superior HealthPlan.	N/A
E1392	PORTABLE OXYGEN CONCENTRATOR	This service is not covered by Superior HealthPlan.	N/A
E1396	ALLIED RESP: OXYGEN CONCENTRATOR (ALL)	This is no longer a valid code.	N/A
E1399	DURABLE MEDICAL EQUIPMENT MISCELLANEOUS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E1403	OXYGEN CONCENTRATE 4-5 LITER/MIN 85% CONCENTRATE	No pre-authorization is required for all providers.	N/A
E1405	OXYGEN & WATER VAPOR ENRICH W/HEATED DELIVERY	No pre-authorization is required for all providers.	N/A
E1406	OXYGEN & WATER VAPOR ENRICH WO HEATED DELIVERY	No pre-authorization is required for all providers.	N/A
E1500	CENTRIFUGE, FOR DIALYSIS	This service is not covered by Superior HealthPlan.	N/A
E1510	KIDNEY DIALYSATE DELIVERY SYSTEM (COMPLETE)	Pre-authorization is required for all providers.	Prior to 09/01/2019
E1520	HEPARIN INFUSION PUMP FOR DIALYSIS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1530	AIR BUBBLE DETECTOR FOR DIALYSIS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1540	PRESSURE ALARM FOR DIALYSIS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1550	BATH CONDUCTIVITY METER FOR DIALYSIS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1560	BLOOD LEAK DETECTOR FOR DIALYSIS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E1570	ADJUSTABLE CHAIR FOR ESRD PATIENTS	No pre-authorization is required for all providers.	N/A
E1575	TRANSDUCER PROTECTORS FLUID BARRIER ANY SIZE EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1580	UNIPUNCTURE CONTROL SYSTEM FOR DIALYSIS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E1590	HEMODIALYSIS MACHINE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E1592	AUTOMATIC INTERMITTENT PERITONEAL DIALYSIS SYS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E1594	CYCLER DIALYSIS MACHINE FOR PERITONEAL DIALYSIS	Pre-authorization is required for all providers.	Prior to 09/01/2019
E1600	DELIVERY/INSTALL CHARGES RENAL DIALYSIS EQUIP	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1610	REVERSE OSMOSIS WATER PURIFICATION SYSTEM	No pre-authorization is required for all providers.	N/A
E1615	DEIONIZER WATER PURIFICATION SYSTEM	No pre-authorization is required for all providers.	N/A
E1620	BLOOD PUMP FOR DIALYSIS	Pre-authorization is required for all providers.	Prior to 09/01/2019
E1625	WATER SOFTENING SYSTEM	This service is not covered by Superior HealthPlan.	N/A
E1630	RECIPROCATING PERITONEAL DIALYSIS SYSTEM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E1632	WEARABLE ARTIFICIAL KIDNEY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E1634	PERITONEAL DIALYSIS CLAMPS, EACH	No pre-authorization is required for all providers.	N/A
E1635	COMPACT (PORTABLE) TRAVEL HEMODIALYZER SYSTEM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E1636	SORBENT CARTRIDGES PER CASE	This service is not covered by Superior HealthPlan.	N/A
E1637	HEMOSTATS EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1638	HEATING PAD, FOR PERITONEAL DIALYSIS, ANY SIZE, EACH	No pre-authorization is required for all providers.	N/A
E1639	SCALE EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1640	REPLACE COMPONENT HEMO/PERITONEALDIALYSIS PT OWN	No pre-authorization is required for all providers.	N/A
E1699	DIALYSIS EQUIPMENT UNSPECIFIED BY REPORT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E1700	JAW MOTION REHAB SYST	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1701	REPLAC CUSHIONS-JAW MOTION REHAB SYST PKG-6	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1702	REPLAC MEASUR SCALES-JAW MOTION REHAB PKG-200	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1800	DYN ADJUS ELBOW EXTENSION/FLEXION DEVICE	Pre-authorization required for all providers.	Prior to 09/01/2019
E1801	SPS ELBOW DEVICE	Pre-authorization required for all providers.	Prior to 09/01/2019
E1802	DYN ADJUSTBL FORARM PRON/SUPIN DEVC	Pre-authorization required for all providers.	Prior to 09/01/2019
E1805	DYN ADJUS WRIST EXTENSION/FLEXION DEVICE	Pre-authorization required for all providers.	Prior to 09/01/2019
E1806	SPS WRIST DEVICE	Pre-authorization required for all providers.	Prior to 09/01/2019
E1810	DYN ADJUS KNEE EXTENSION/FLEXION DEVICE	Pre-authorization required for all providers.	Prior to 09/01/2019
E1811	SPS KNEE DEVICE	Pre-authorization required for all providers.	Prior to 09/01/2019
E1812	DYNAMIC KNEE EXTENSION/FLEXION DEVICE W ACTIVE RESISTANCE CONTROL	Pre-authorization is required for all providers.	Prior to 09/01/2019
E1815	DYN ADJUS ANKLE EXTENSION/FLEXION DEVICE	Pre-authorization required for all providers.	Prior to 09/01/2019
E1816	SPS ANKLE DEVICE	Pre-authorization is required for all providers.	Prior to 09/01/2019
E1818	SPS FOREARM DEVICE	Pre-authorization required for all providers.	Prior to 09/01/2019
E1820	SOFT INTERFACE MAT, DYN ADJUS EXTEN/FLEX DEVICE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1821	REPLACEMENT SOFT INTERFACE MATERIAL/ CUFFS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1825	DYN ADJUS FINGER EXTEN/FLEXION DEVICE	Pre-authorization required for all providers.	Prior to 09/01/2019
E1830	DYN ADJUS TOE EXTENSION/FLEXION DEVICE	No pre-authorization is required for all providers.	N/A
E1831	STATIC STR TOE DEV EXT/FLEX	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E1840	DYNAMIC ADJUSTABLE SHOULDER FLEXION	Pre-authorization required for all providers.	Prior to 09/01/2019
E1841	STATIC STR SHLDR DEV ROM ADJ	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E1900	SYNTHESIZED SPEECH AUGMENTATIVE COMMUNICATION DEVICE	No pre-authorization is required for all providers.	N/A
E1902	COMMUNICATION BOARD.NON ELECTRONIC	Pre-authorization is required Nursing Facility members. For all other members, no pre-authorization is required for all providers.	Prior to 09/01/2019
E2000	GASTRIC SUCTION PUMP, HOME MODEL, PORTABLE OR STATIONARY, ELECTRIC	This service is not covered by Superior HealthPlan.	N/A
E2100	BLOOD GLUCOSE MONITOR WITH INTEGRATED VOICE SYNTHESIZER	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2101	BLOOD GLUCOSE MONITOR WITH INTEGRATED LANCING/BLOOD SAMPLE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2120	PULSE GNRTR SYS/TYMPANIC TRTMNT OF INNER EAR ENDOLYMPHATIC FLUID	This service is not covered by Superior HealthPlan.	N/A
E2201	MNL WHEELCHAIR/N-STNDRD SEAT FRME/WIDTH>OR=20 IN&LESS 24 IN	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2202	MANUAL WHEELCHAIR/N-STNDRD SEAT FRAME WIDTH, 24-27 INCHES	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2203	MANUAL WHELLCHAIR/N-STNDRD SEAT FRAME DEPTH, 20 TO LESS THAN 22 INCHES	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2204	MANUAL WHEELCHAIR/N-STNDRD SEAT FRAME DEPTH, 22 TO 25 INCHES	Pre-authorization required for all providers.	Prior to 09/01/2019
E2205	MANUAL WC ACCESSORY, HANDRIM	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2206	MANL WC AC WL ASM Cmpl REPL ONLY EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2207	WHEELCHAIR ACCESSORY CRUTCH & CANE HOLDER EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2208	WHEELCHAIR ACCESSORY CYLINDER TANK CARRIER EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2209	ACCESSORY, ARM TROUGH, W OR W/OUT HAND SUPPORT, EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2210	WHEELCHAIR ACCESSORY BEARINGS ANY TYPE REPLACE ONLY EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2211	MANUAL WHEELCHAIR ACCESSORY PNEUMATIC PROPULSION TIRE ANY SIZE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2212	MANUAL WHEELCHAIR ACCESSORY TUBE FOR PNEUMATIC PROPULSION TIRE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2213	MANUAL WHEELCHAIR ACCESS INSERT FOR PNEUM PROPULSION TIRE REMOVABLE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2214	MANUAL WHEELCHAIR ACCESSORY PNEUMATIC CASTER TIRE ANY SIZE EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2215	MANUAL WHEELCHAIR ACCESSORY TUBE FOR PNEUMATIC CASTER TIRE A	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2216	MANUAL WHEELCHAIR ACCESSORY FOAM FILLED PROPULSION TIRE ANY SIZE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2217	MANUAL WHEELCHAIR ACCESSORY FOAM FILLED CASTER TIRE ANY SIZE EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2218	MANUAL WHEELCHAIR ACCESSORY FOAM PROPULSION TIRE ANY SIZE EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2219	MANUAL WHEELCHAIR ACCESSORY FOAM CASTER TIRE ANY SIZE EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019

E2220	MNL WC AC SLD PROP T SZ RPL ONLY EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2221	MNL WC AC SLD C TIR SZ REPL ONLY EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2222	MNL WC AC SLD C TIRE I WHL SZ RPL E	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2224	MNL WC AC P WHL EXCL T SZ RPL ONL E	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2225	MANUAL WHEELCHAIR ACCESSORY CASTER WHEEL EXCLUDES TIRE REPLACE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2226	MANUAL WHEELCHAIR ACCESSORY CASTER FORK ANY SIZE REPLACE ONLY	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2227	GEAR REDUCTION DRIVE WHEEL	No pre-authorization is required for all providers.	N/A
E2228	MWC ACC WHEELCHAIR BRAKE	Pre-authorization required for all providers.	Prior to 09/01/2019
E2230	MANUAL STANDING SYSTEM	This service is not covered by Superior HealthPlan.	N/A
E2231	SOLID SEAT SUPPORT BASE	This service is not covered by Superior HealthPlan.	N/A
E2291	BACK PLANAR PED SZ WC INCL FIX ATTCHING HARDWARE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2292	SEAT PLANAR PED SZ WC INCL FIX ATTCHING HARDWARE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2293	BACK CONTOURED PED WC INCL FIX ATTCH HARDWARE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2294	SEAT CONTOURED PED WC INCL FIX ATTCH HARDWARE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2295	PED DYNAMIC SEATING FRAME	This service is not covered by Superior HealthPlan.	N/A
E2300	POWER WHEELCHAIR ACCESSORY, POWER SEAT ELEVATION SYSTEM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2301	POWER WHEELCHAIR ACCESSORY, POWER STANDING SYSTEM	This service is not covered by Superior HealthPlan.	N/A
E2310	PWR WHEELCHAIR/ELEC CNCTN BETW WHEELCHAIR CNTRLLR &1 PWR SEATING SYS MTR	Pre-authorization required for all providers.	Prior to 09/01/2019
E2311	PWR WHEELCHAIR/ELEC CNCTN BETW WHEELCHAIR CNTRL&2> PWR SEATING SYS MTR	Pre-authorization required for all providers.	Prior to 09/01/2019
E2312	MINI-PROP REMOTE JOYSTICK	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2313	PWC HARNESS EXPAND CONTROL	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2320	PWR WHEELCHAIR/HAND/CHIN CNTRL INTERFCE/ RMTE JYSTCK/TOUCHPAD	This is no longer a valid code.	N/A
E2321	PWR WHEELCHAIR/HAND/CHIN CNTRL INTERFCE/ RMTE JYSTCK/TOUCHPAD/ N-PRPRTNL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2322	PWR WHEELCHAIR/HAND CNTRL INTRFCE/MLTIPLE MECH SWTCHS, N-PRPRTNL	No pre-authorization is required for all providers.	N/A
E2323	PWR WHEELCHAIR/SPCLTY JYSTCK HNDLE/HAND CNTRL INTRFCE, PRFBRTD	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2324	POWER WHEELCHAIR ACCESSORY, CHIN CUP FOR CHIN CONTROL INTERFACE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2325	PWR WHEELCHAIR/SIP&PUFF INTRFCE/N-PRPRTNL INCL ALL RLTD ELECT	Pre-authorization required for all providers.	Prior to 09/01/2019
E2326	POWER WHEELCHAIR ACCESSORY, BREATH TUBE KIT FOR SIP AND PUFF INTERFACE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2327	PWR WHEELCHAIR/HEAD CNTRL INTRFCE/MECH, PRPRTNL	No pre-authorization is required for all providers.	N/A
E2328	PWR WHEELCHAIR/HEAD CNTRL/EXTRMITY CNTRL INTRFCE/ELECT/PRPRTNL	Pre-authorization required for all providers.	Prior to 09/01/2019
E2329	PWR WHEELCHAIR/HEAD CNTRL INTRFCE/CNTCT SWTCH MECHAN/N-PRPRTNL	Pre-authorization required for all providers.	Prior to 09/01/2019
E2330	PWR WHEELCHAIR/HEAD CNTRL INTRFCE/PRXMTY SWTCH MECHAN/N-PRPRTNL	Pre-authorization required for all providers.	Prior to 09/01/2019
E2331	PWR WHEELCHAIR/ATTENDANT CNTRL/PRPRTNL	This service is not covered by Superior HealthPlan.	N/A
E2340	PWR WHEELCHAIR/N-STANDARD SEAT FROME WIDTH, 20-23 INCHES	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2341	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME WIDTH, 24-27 INCHES	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2342	PWR WHEELCHAIR ACC, NONSTANDARD SEAT FRAME DEPTH, 20 OR 21 INCHES	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2343	PWR WHEELCHAIR ACC NONSTANDARD SEAT FRAME DEPTH, 20-25 INCHES	Pre-authorization required for all providers.	Prior to 09/01/2019
E2351	PWR WHEELCHAIR ACC/ELECTR INTRFCE TO OPERATE SPEECH GNRTRNG DVCE	Pre-authorization required for all providers.	Prior to 09/01/2019
E2358	GR 34 NONSEALED LEADACID	No pre-authorization is required for all providers.	N/A
E2359	GR34 SEALED LEADACID BATTERY	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2360	POWER WHEELCHAIR ACCESSORY, 22 NF NON-SEALED LEAD ACID BATTERY, EACH	This service is not covered by Superior HealthPlan.	N/A
E2361	PWR WHEELCHAIR ACC 22 NF SEALED LEAD ACID BATT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2362	POWER WHEELCHAIR ACCESSORY, GROUP 24 NON-SEALED LEAD ACID BATTERY, EACH	This service is not covered by Superior HealthPlan.	N/A
E2363	PWR WHEELCHAIR ACC, GROUP 24 SEALED LEAD ACID BATTERY	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2364	POWER WHEELCHAIR ACCESSORY, U-1 NON-SEALED LEAD ACID BATTERY, EACH	This service is not covered by Superior HealthPlan.	N/A
E2365	PWR WHEELCHAIR ACC, U-1 SEALED LEAD ACID BATTERY, EACH	This service is not covered by Superior HealthPlan.	N/A
E2366	PWR WHEELCHAIR ACC, BATTERY CHARGER, SINGLE MODE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2367	PWR WHEELCHAIR ACC, BATTERY CHARGER, DUAL MODE	This service is not covered by Superior HealthPlan.	N/A
E2368	PWR WC DRIVEWHEEL MOTOR REPL	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2369	PWR WC DRIVEWHEEL GEAR REPL	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2370	PWR WC DR WH MOTOR/GEAR COMB	Pre-authorization required for all providers.	Prior to 09/01/2019
E2371	POWER WHEELCHAIR ACCESSORY GROUP 27 SEALED LEAD ACID BATTERY	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2372	POWER WHEELCHAIR ACCESSORY GROUP 27 NON-SEALED LEAD ACID BATTERY	This service is not covered by Superior HealthPlan.	N/A
E2373	HAND/CHIN CTRL SPEC JOYSTICK	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2374	POWER WHEELCHR ACC HAND CHIN CONTROL INTFACE STND REMOTE JOYSTICK	Pre-authorization required for all providers.	Prior to 09/01/2019
E2375	POWER WHEELCHR ACC NON-EXPAND CONTR INCL ALL REL ELECT & MOUNT	Pre-authorization required for all providers.	Prior to 09/01/2019
E2376	POWER WHEELCHR ACC EXPAND CONTR INCL ALL REL ELECT & MOUNT HARDW	Pre-authorization required for all providers.	Prior to 09/01/2019
E2377	POWER WHEELCHR ACC EXPAND CONTR INCL ALL REL ELECT & MOUNT HARDW	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2378	PW ACTUATOR REPLACEMENT	Pre-authorization required for all providers.	Prior to 09/01/2019
E2381	POWER WHEELCHR ACC PNEUMATIC DR WHEEL TIRE ANY SIZE REPLACEMENT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2382	POWER WHEELCHR ACC TUBE FOR PNEUMATIC DR WHEEL TIRE ANY SIZE REPL	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2383	POWER WHEELCHR ACC INSERT FOR PNEUMATIC DR WHEEL TIRE (REMOVABLE)	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2384	POWER WHEELCHR ACC PNEUMATIC CASTER TIRE ANY SIZE REPLACEMENT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2385	POWER WHEELCHR ACC TUBE FOR PNEUMATIC CASTER TIRE ANY SIZE REPL	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2386	POWER WHEELCHR ACC, FOAM FILLED DR WHEEL TIRE, ANY SIZE, REPLACEMNT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2387	POWER WHEELCHR ACC, FOAM FILLED CASTER TIRE, ANY SIZE, REPLACEMENT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2388	POWER WHEELCHR ACC, FOAM DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2389	POWER WHEELCHR ACC, FOAM CASTER TIRE, ANY SIZE, REPLACE ONLY, EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2390	POWER WHEELCHR ACC, SOLID (RUBBER/PLASTIC) DR WHEEL TIRE ANY SIZE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2391	POWER WHEELCHR ACC, SOLID (RUBBER/PLASTIC) CASTER TIRE (REMOVABLE),	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2392	POWER WHEELCHR ACC SOLID (RUBBER/PLASTIC) CASTER TIRE W INTEGRATED	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2394	POWER WHEELCHR ACC, DR WHEEL EXCL TIRE, ANY SIZE, REPLACEMENT ONLY,	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2395	POWER WHEELCHR ACC, CASTER WHEEL EXCL TIRE, ANY SIZE, REPLACE ONLY	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2396	POWER WHEELCHR ACC CASTER FORK, ANY SIZE, REPLACEMENT ONLY, EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2397	PWC ACC LITH-BASED BATTERY	This service is not covered by Superior HealthPlan.	N/A
E2398	WHEELCHAIR ACCESSORY DYNAMIC POS HARDWARE BACK	No pre-authorization is required for all providers.	N/A
E2402	NEG PRESSURE WOUND THERAPY ELECTRICAL PUMP, STATIONARY OR PORTABLE	Pre-authorization required for all providers.	Prior to 09/01/2019
E2500	SPEECH GNRTRNG DVC/DGTZD SPEECH/PRE-RECORDED MSSGS, LESS OR-TO 8 MIN TIME	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2502	SPEECH GEN DVC/DGTZD SPEECH/PRE-RCRDD MESS>8 MIN/LESS THAN OR-TO 20 MIN	Pre-authorization required for all providers.	Prior to 09/01/2019
E2504	SPEECH GEN DVC/DGTZD SPEECH/PRE-RCRD MESS>20 MIN/LESS THAN OR-TO 40 MIN	Pre-authorization required for all providers.	Prior to 09/01/2019
E2506	SPEECH GEN DVC/DGTZD SPEECH/PRE-RCRDD MESS>40 MIN RECORDING TIME	Pre-authorization required for all providers.	Prior to 09/01/2019
E2508	SPEECH GEN DVC/SYNTHSZD SPEECH, RQRUNG MESS FRMLTN BY SPELLING& ACCESS	Pre-authorization required for all providers.	Prior to 09/01/2019
E2510	SPEECH GEN DVC/SYNTH SPEECH, PERMITTING MLTPL METH OF MSGE FRMLTN	Pre-authorization required for all providers.	Prior to 09/01/2019
E2511	SPEECH GEN SFTWAE PRGRM/PERSONAL CMPTR OR PERSONAL DIGITAL ASSISTANT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2512	ACCESSORY FOR SPEECH GENERATIONG DEVICE, MOUNTING SYSTEM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2599	ACCESSORY FOR SPEECH GENERATIONG DEVICE, NOT OTHERWISE CLASSIFIED	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2601	GENERAL WHLCHAIR SEAT CUSHN WIDTH < 22 IN DEPTH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2602	GENERAL WHLCHAIR SEAT CUSHN WIDTH 22 IN/GT DEPTH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2603	SKN PROTECTION WC SEAT CUSHN WIDTH < 22 IN DEPTH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2604	SKN PROTECTION WC SEAT CUSHN WDTH 22 IN/GT DEPTH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2605	PSTN WHEELCHAIR SEAT CUSHN WIDTH < 22 IN DEPTH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2606	PSTN WHEELCHAIR SEAT CUSHN WIDTH 22 IN/GT DEPTH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2607	SKN PROTECT&PSTN WC SEAT CUSHN WDTH <22 IN DEPTH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2608	SKN PROTCT&PSTN WC SEAT CUSHN WDTH 22 IN/GT DPTH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2609	CUSTOM FABRICATED WHEELCHAIR SEAT CUSHION SIZE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2610	WHEELCHAIR SEAT CUSHION POWERED	This service is not covered by Superior HealthPlan.	N/A
E2611	GEN WC BACK CUSHN WDTH < 22 IN HT MOUNT HARDWARE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2612	GEN WC BACK CUSHN WDTH 22 IN/GT HT MOUNT HARDWRE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2613	PSTN WC BACK CUSHN POST WIDTH < 22 IN ANY HEIGHT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2614	PSTN WC BACK CUSHN POST WIDTH 22 IN/> ANY HEIGHT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2615	PSTN WC BACK CUSHN POSTLAT WIDTH < 22 IN ANY HT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2616	PSTN WC BACK CUSHN POSTLAT WIDTH 22 IN/> ANY HT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2617	CSTM FAB WC BACK CUSHN ANY SZ ANY MOUNT HARDWARE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2619	REPL COVER WHEELCHAIR SEAT CUSHN/BACK CUSHN EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2620	PSTN WC BACK CUSHN PLANAR LAT SUPP WDTH <22 IN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E2621	PSTN WC BACK CUSHN PLANAR LAT SUPP WDTH 22 IN/>	No pre-authorization is required for all providers.	N/A
E2622	ADJ SKIN PRO W/C CUS WD<22IN	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2623	ADJ SKIN PRO WC CUS WD>=22IN	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2624	ADJ SKIN PRO/POS CUS<22IN	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2625	ADJ SKIN PRO/POS WC CUS>=22	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2626	SEO MOBILE ARM SUP ATT TO WC	No pre-authorization is required for all providers.	N/A

E2627	ARM SUPP ATT TO WC RANCHO TY	No pre-authorization is required for all providers.	N/A
E2628	MOBILE ARM SUPPORTS RECLININ	Pre-authorization required for all providers.	Prior to 09/01/2019
E2629	FRICTION DAMPENING ARM SUPP	No pre-authorization is required for all providers.	N/A
E2630	MONOSUSPENSION ARM/HAND SUPP	No pre-authorization is required for all providers.	N/A
E2631	ELEVAT PROXIMAL ARM SUPPORT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2632	OFFSET/LAT ROCKER ARM W/ELA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E2633	MOBILE ARM SUPPORT SUPINATOR	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
E7937	WHEELCHAIR ACCESSORY ABDUCTION WEDGE - EACH	No pre-authorization is required for all providers.	N/A
E8000	GAIT TRAINER PED SZ POST SUPP W/ALL ACSS&CMPNTS	This service is not covered by Superior HealthPlan.	N/A
E8001	GAIT TRAINER PED SZ UPRT SUPP W/ALL ACSS&CMPNTS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
E8002	GAIT TRAINER PED SZ ANT SUPP W/ALL ACSS&CMPNTS	This service is not covered by Superior HealthPlan.	N/A
E9002	ALLIED RESP: FOOD PUMP/AMBULATORY PUMP	No pre-authorization is required for all providers.	N/A
G0004	PT DEMAND RECORD/30 DA; INCL TRANSM/MD INTERPT	No pre-authorization is required for all providers.	N/A
G0005	PT DEMAND RECORD/30 DA; RECORDING	No pre-authorization is required for all providers.	N/A
G0006	PT DEMAND RECORD/30 DA; 24HR ATTEND MONIT-ANALYS	No pre-authorization is required for all providers.	N/A
G0007	PT DEMAND RECORD/30 DA; MD REVIEW & INTERPT	No pre-authorization is required for all providers.	N/A
G0008	ADMIN FLU VIRUS VAC-NO MD FEE SCHED SRV SAME DAY	This service is not covered by Superior HealthPlan.	N/A
G0009	ADMIN PNEUMOCOC VAC-NO MD FEE SCHED SRV SAME DAY	This service is not covered by Superior HealthPlan.	N/A
G0010	ADMIN HEPATITIS B VAC-NO MD FEE SCHED SRV ON DAY	This service is not covered by Superior HealthPlan.	N/A
G0051	DESTRUCTION BY ANY METHOD, OF ALL BENIGN OR PREMALIGNANT LESIONS	This is no longer a valid code.	N/A
G0052	DESTRUCTION BY ANY METHOD, OF ALL BENIGN OR PREMALIGNANT LESIONS, 2-14	No pre-authorization is required for all providers.	N/A
G0053	DESTRUCTION BY ANY METHOD, OF ALL BENIGN/PREMALIGNANT LESIONS,15 OR MORE	This is no longer a valid code.	N/A
G0054	BLOOD CHOLESTEROL TEST, BY MON	No pre-authorization is required for all providers.	N/A
G0055	GLUCOSE POST DOSE	No pre-authorization is required for all providers.	N/A
G0056	GLUCOSE TOLERANCE TEST/DIRECT	No pre-authorization is required for all providers.	N/A
G0057	GLUCOSE TOLERANCE TEST	No pre-authorization is required for all providers.	N/A
G0062	PERIPHERAL SKELETAL BONE MINERAL DENSITY STUDIES e.g.,RADIUS, WRIST,HEEL	No pre-authorization is required for all providers.	N/A
G0063	CENTRAL SKELETAL BONE MINERAL DENSITY STUDIES (e.g., SPINE, PELVIS)	This is no longer a valid code.	N/A
G0064	PHYSICIANS SUPERVISION OF A PATIENT UNDER CARE OF A HOME HEALTH AGENCY	This is no longer a valid code.	N/A
G0065	PHYSICIANS SUPERVISION OF A HOSPICE PATIENT	This is no longer a valid code.	N/A
G0066	PHYSICIAN SUPERVISION OF A NURSING FACILITY PATIENT	This is no longer a valid code.	N/A
G0072	INDIVIDUAL PSYCHOTHERAPY,FACE-TO-FACE WITH THE PATIENT 20-30 MINUTES	This is no longer a valid code.	N/A
G0073	INDIVIDUAL PSYCHOTHERAPY, FACE-TO-FACE WITH THE PATIENT 45 TO 50 MINUTES	This is no longer a valid code.	N/A
G0074	INDIVIDUAL PSYCHOTHERAPY, FACE-TO-FACE WITH THE PATIENT 45 TO 50 MINUTES	This is no longer a valid code.	N/A
G0075	INDIVIDUAL PSYCHOTHERAPY, FACE-TO-FACE WITH THE PATIENT 75 TO 80 MINUTES	This is no longer a valid code.	N/A
G0077	LIMITED CARE MANAGEMENT HOME VISIT NEW PATIENT	Pre-authorization required for all providers.	Prior to 09/01/2019
G0088	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED 75-80 MIN. W/ PATIENT	This is no longer a valid code.	N/A
G0089	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, 20-30 MIN. W/ PATIENT	This is no longer a valid code.	N/A
G0090	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, 20-30 MIN. W/ PATIENT	This is no longer a valid code.	N/A
G0091	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, 45-50 MIN. W/ PATIENT	This is no longer a valid code.	N/A
G0092	INDIVIDUAL PSYCHOTHERAPY,INTERACTIVE, 45 TO 50 MIN. W/ PATIENT	This is no longer a valid code.	N/A
G0093	INDIVIDUAL PSYCHOTHERAPY,INTERACTIVE, 75 TO 80 MIN. W/ PATIENT	This is no longer a valid code.	N/A
G0094	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE 75 TO 80 MIN. W/ PATIENT	This is no longer a valid code.	N/A
G0101	CERV/VAG CA SCREEN PELVIC/CLIN BREAST EXAM	This service is not covered by Superior HealthPlan.	N/A
G0102	PROSTATE CANCER SCREENING DIGITAL RECTAL EXAM	No pre-authorization is required for all providers.	N/A
G0103	PROSTATE CANCER SCREENING, DIGITAL RECTAL EXAMINATION	This service is not covered by Superior HealthPlan.	N/A
G0104	COLORECTAL CA SCREEN FLEX SIGMOIDOSCOPY	No pre-authorization is required for all providers.	N/A
G0105	COLORECTAL CA SCREEN COLONOSCOPE HI RISK IND	No pre-authorization is required for all providers.	N/A
G0106	COLORECTAL CA SCREEN ALT TO G0104 BARIUM ENEMA	No pre-authorization is required for all providers.	N/A
G0107	COLORECTAL CA SCREEN FECAL-OCULT BLD 1-3 DETERM	This is no longer a valid code.	N/A
G0108	DIAB OUTPT SELF-MGMT TRAINING INDIV-PER SESSION	This service is not covered by Superior HealthPlan.	N/A
G0109	DIAB SELF-MGMT GROUP TRAIN SESSION PER INDIV	This service is not covered by Superior HealthPlan.	N/A
G0110	NETT PULM-REHAB ED/SKILLS TRAIN INDIV	No pre-authorization is required for all providers.	N/A
G0111	NETT PULM-REHAB ED/SKILLS TRAIN GROUP	No pre-authorization is required for all providers.	N/A
G0112	NETT PULM-REHAB NUTR GUID INIT	No pre-authorization is required for all providers.	N/A
G0113	NETT PULM-REHAB NUTR GUID SUBSQT	No pre-authorization is required for all providers.	N/A
G0114	NETT PULM REHAB PSYCHOSOCIAL CONSULT	No pre-authorization is required for all providers.	N/A
G0115	NETT PULM REHAB PSYCHOLOGICAL TEST	No pre-authorization is required for all providers.	N/A
G0116	NETT PULM REHAB PSYCHOSOCIAL COUNSEL	No pre-authorization is required for all providers.	N/A
G0117	GLAUCOMA SCREENING FOR HIGH RISK PATIENTS	This service is not covered by Superior HealthPlan.	N/A
G0118	GLAUCOMA SCREENING SUPERVISED BY OPTOMETRIST	This service is not covered by Superior HealthPlan.	N/A
G0120	COLORECTAL CA SCRIN ALT G0105 SCOPE BARIUM ENEMA	No pre-authorization is required for all providers.	N/A
G0121	COLORECTAL CA SCREEN SCOPE INDIV NOT HI-RISK	No pre-authorization is required for all providers.	N/A
G0122	COLORECTAL CANCER SCREENING, BARIUM ENEMA	No pre-authorization is required for all providers.	N/A
G0123	SCREEN CERV/VAG THIN LAY-SCRN TECH W/PHYS SUPVS	No pre-authorization is required for all providers.	N/A
G0124	SCREEN CYTO CERV/VAG THIN LAY REQ INTRP BY PHYS	No pre-authorization is required for all providers.	N/A
G0125	PET IMAG RGN/WHOLE BDY;1 PULM NODUL	No pre-authorization is required for all providers.	N/A
G0127	TRIM DYSTROPHIC NAILS ANY NUMBER	No pre-authorization is required for all providers.	N/A
G0128	DIR SKILL NSG SERV RN OUTPT REHAB FAC EA 10 MIN	No pre-authorization is required for all providers.	N/A
G0129	OCCUPATIONAL THERAPY REQUIRING SKILLS OF QUALIFIED OCCUP THERAPIST	This service is not covered by Superior HealthPlan.	N/A
G0130	SEXA BONE DENS STUDY APPENDICULAR SKEL >=1 SITE	No pre-authorization is required for all providers.	N/A
G0141	SCR CERV/VAG CYTO SMEAR AUTO-MAN RESCREEN-MD	No pre-authorization is required for all providers.	N/A
G0143	SCR CERV/VAG THIN PREP-MAN SCR/RESCREEN-TECH	No pre-authorization is required for all providers.	N/A
G0144	SCR CYTOPATH CERV/VAG AUTO PHYS	No pre-authorization is required for all providers.	N/A
G0145	SCR CYTO CERV/VAG AUTO&MNL RESCR MD	No pre-authorization is required for all providers.	N/A
G0147	SCR CYTO CERV/VAG SMEARS-AUTO SYST MD SUPERVIS	No pre-authorization is required for all providers.	N/A
G0148	SCR SMEARS CERV/VAG-AUTO SYST-MAN RESCREEN	No pre-authorization is required for all providers.	N/A
G0151	HHCP-SERV OF PT,EA 15 MIN	This service is not covered by Superior HealthPlan.	N/A
G0152	HHCP-SERV OF OT,EA 15 MIN	This service is not covered by Superior HealthPlan.	N/A
G0153	HHCP-SVS OF S/L PATH,EA 15MN	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
G0154	HHCP-SVS OF RN,EA 15 MIN	This is no longer a valid code.	N/A
G0155	HHCP-SVS OF CSW,EA 15 MIN	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
G0156	HHCP-SVS OF AIDE,EA 15 MIN	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
G0157	HHC PT ASSISTANT EA 15	This service is not covered by Superior HealthPlan.	N/A
G0158	HHC OT ASSISTANT EA 15	This service is not covered by Superior HealthPlan.	N/A
G0159	HHC PT MAINT EA 15 MIN	This service is not covered by Superior HealthPlan.	N/A
G0160	HHC OCCUP THERAPY EA 15	This service is not covered by Superior HealthPlan.	N/A
G0161	HHC SLP EA 15 MIN	This service is not covered by Superior HealthPlan.	N/A
G0162	HHC RN E&M PLAN SVS, 15 MIN	Preauthorization required for all providers	Prior to 09/01/2019
G0163	HHC LPN/RN OBS/ASSES EA 15	This is no longer a valid code.	N/A
G0164	HHC LIS NURSE TRAIN EA 15	This is no longer a valid code.	N/A
G0165	PET WHOLE BODY FOR RECURRENCE OF MELANOMA	No pre-authorization is required for all providers.	N/A
G0166	EXT COUNTERPULSATION PER TX SES	No pre-authorization is required for all providers.	N/A
G0168	WOUND CLO UTILIZ TISS ADHES ONLY	No pre-authorization is required for all providers.	N/A
G0173	STEREOTAC RADIOSURG-THER=1 SESS	This is no longer a valid code.	N/A
G0175	SCHDLD INTERDIS TEAM CONF W/PT PRES	This service is not covered by Superior HealthPlan.	N/A
G0176	ACT THER-PT MENTAL PRB/SESS-45/>MIN	This service is not covered by Superior HealthPlan.	N/A
G0177	TRNG-PT W/MENTAL PRB/SESS-45/> MIN	This service is not covered by Superior HealthPlan.	N/A
G0179	PHYS RE-CERT MCR-COVR HOM HLTH SRVC	This service is not covered by Superior HealthPlan.	N/A
G0180	PHYS CERT MCR-COVR HOM HLTH SRVC	This service is not covered by Superior HealthPlan.	N/A
G0181	PHYS SUPVSN HAA PT-CMPLX/MO-30/>MIN	This service is not covered by Superior HealthPlan.	N/A
G0182	PHYS SUPV HOSPIC PT-CMPLX/MO-30/>MI	This service is not covered by Superior HealthPlan.	N/A
G0186	PHOTOCOAG FDR VES TECH->=1SES	No pre-authorization is required for all providers.	N/A
G0202	SCR MAMM BILAT INCL CAD WHEN PERF	This is no longer a valid code.	N/A
G0204	DX MAMM INCL CAD WHEN PERF; BILAT	This is no longer a valid code.	N/A
G0206	DX MAMM INCL CAD WHEN PERF; UNILAT	This is no longer a valid code.	N/A
G0212	PET BDY; RESTAG; LUNG CA; NON-SM	No pre-authorization is required for all providers.	N/A
G0217	PET WHOLE BDY; INIT STAG; MELANOMA	No pre-authorization is required for all providers.	N/A
G0219	PET BDY; MELANOMA NON-COVR INDICAT	This service is not covered by Superior HealthPlan.	N/A
G0224	PET; INIT;HEAD&NCK CA;NOT THYRD&CNS	No pre-authorization is required for all providers.	N/A

G0227	PET WHOLE BDY; INIT STAG; ESOPH CA	This is no longer a valid code.	N/A
G0230	PET,ASSESS MYOCARD FLW INCONCL STDY	No pre-authorization is required for all providers.	N/A
G0231	PET, WHOLE BODY, FOR RECURRENCE OF COLORECTAL CANCER, GAMMA CAMARAS	No pre-authorization is required for all providers.	N/A
G0234	PET, REGIONAL OR WHOLE BODY	No pre-authorization is required for all providers.	N/A
G0235	PET IMAGING ANY SITE NOT OTHERWISE SPECIFIED	This service is not covered by Superior HealthPlan.	N/A
G0236	DIGITIZ X-RAY LES DETECT DX MAMMO	No pre-authorization is required for all providers.	N/A
G0237	THER PROCEDURES TO INCREASE STRENGTH OR ENDURANCE	This service is not covered by Superior HealthPlan.	N/A
G0238	THER PROCEDURES TO IMPROVE RESPIRATORY FUNCTION	This service is not covered by Superior HealthPlan.	N/A
G0239	TX PROC IMPRV RESP FUNCT 2> IND	This service is not covered by Superior HealthPlan.	N/A
G0242	MULTI SOURCE PHOTON STERIODTACTIC RADIOSURGERY	No pre-authorization is required for all providers.	N/A
G0243	MULTI SOURCE PHOTON STERIODTACTIC RADIOSURGERY	This is no longer a valid code.	N/A
G0244	OBSERVATION CARE PROVIDED BY A FAC	No pre-authorization is required for all providers.	N/A
G0245	INIT PHYS E&M DIABETIC PT W/LOPS	This service is not covered by Superior HealthPlan.	N/A
G0246	F/U EVAL DIABETIC PT W/LOPS	This service is not covered by Superior HealthPlan.	N/A
G0247	ROUTINE FOOT CARE/PHYSICIAN/DIABETIC PATIENT W DIABETIC SENSORY NEUR	This service is not covered by Superior HealthPlan.	N/A
G0248	DEMONSTRATE USE HOME INR MON	This service is not covered by Superior HealthPlan.	N/A
G0249	PROVIDE INR TEST MATER/EQUIP	This service is not covered by Superior HealthPlan.	N/A
G0250	MD INR TEST REVIE INTER MGMT	This service is not covered by Superior HealthPlan.	N/A
G0251	LINR RADIOSRG TX ALL LES MAX 5 SESS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G0252	PET IMAG DX BREST CA&SURG PLAN	This service is not covered by Superior HealthPlan.	N/A
G0254	PET IMAG BREAST CA EVAL RSPN TX	No pre-authorization is required for all providers.	N/A
G0255	CPT/SNCT PER LIMB ANY NERVE	No pre-authorization is required for all providers.	N/A
G0256	PROS BRACHYTX PERM IMPL PALLDM SEED	No pre-authorization is required for all providers.	N/A
G0257	UNSCHD/EMRG DIALYS HOS OP NOT CERT	No pre-authorization is required for all providers.	N/A
G0259	INJECTION PROC SI JNT; ARTHROGRAPY	This service is not covered by Superior HealthPlan.	N/A
G0260	INJ SI JNT; ANES &TX AGT &ARTHROG	This service is not covered by Superior HealthPlan.	N/A
G0261	PROS BRACHYTX PERM IMPL IODINE SEED	No pre-authorization is required for all providers.	N/A
G0262	SM INTST IMAG;INTRALUM DR INTPR&RPT	No pre-authorization is required for all providers.	N/A
G0263	DIR ADMIS PT DX CHF PAIN/ASTHMA OBS	No pre-authorization is required for all providers.	N/A
G0264	INIT NRS ASSES OBS DX NOT CHF/ASTHM	No pre-authorization is required for all providers.	N/A
G0268	REMV IMP CERUMN SAME DATE FUNCT TST	This service is not covered by Superior HealthPlan.	N/A
G0269	PLCMT OCCL DEVC POST SURG/INTRVNL	This service is not covered by Superior HealthPlan.	N/A
G0270	MED NUT TX; REASSESS W/PT EA 15 MIN	This service is not covered by Superior HealthPlan.	N/A
G0271	MED NUT TX REASSESS GRP EA 30 MIN	This service is not covered by Superior HealthPlan.	N/A
G0273	RADOPHRM PRE-TX PLAN NON-HODG LYMPH	No pre-authorization is required for all providers.	N/A
G0274	RADOPHRM TX NON-HODGKIN LYMPHOMA	No pre-authorization is required for all providers.	N/A
G0275	RENAL ART ANGIO W/CARD CATH RAD S&I	This is no longer a valid code.	N/A
G0276	PILD/PLACEBO CONTROL CLIN TR	This service is not covered by Superior HealthPlan.	N/A
G0277	HBOT, FULL BODY CHAMBER, 30M	No pre-authorization is required for all providers.	N/A
G0278	ILIAC AND/OR FEMORAL ARTERY ANGIOGRAPHY, NON-SELECTIVE, BILATERAL	This service is not covered by Superior HealthPlan.	N/A
G0279	DX DIGTL BRST TOMOSYNTHESIS UNI/BIL	This service is not covered by Superior HealthPlan.	N/A
G0280	XTRACORP SHOCK WAV; NOT ELB EPICOND	No pre-authorization is required for all providers.	N/A
G0281	E-STIM 1/> CHRN STAGE III&IV ULCRS	This service is not covered by Superior HealthPlan.	N/A
G0282	E-STIM 1/> AREAS WND CARE NOT G0281	This service is not covered by Superior HealthPlan.	N/A
G0283	E-STIM 1/>NOT WND CARE PART TX PLAN	This service is not covered by Superior HealthPlan.	N/A
G0288	RECON CT ANGIO AORTA PLAN VASC SURG	This service is not covered by Superior HealthPlan.	N/A
G0289	SCPE KNEE REMV FB TM SURG DIFF COMP	This service is not covered by Superior HealthPlan.	N/A
G0293	NONCOVR SURG SEDAT ANES-MCR QUAL	This service is not covered by Superior HealthPlan.	N/A
G0294	NONCOVR PROC NO ANES/LOC-MCR QUAL	This service is not covered by Superior HealthPlan.	N/A
G0295	ELECTROMAGNET STIM 1/MORE AREAS	This service is not covered by Superior HealthPlan.	N/A
G0296	CNSL VST DISCUSS LDCT LW DS CT SCAN	This service is not covered by Superior HealthPlan.	N/A
G0297	LOW DOSE CT SCAN FOR LUNG CANCR SCR	Pre-authorization is required through NIA for these services.	Prior to 09/01/2019
G0298	INSERTION OF DUAL CHAMBER PACING CARIOVERTER DEFIBRILLATOR PULSE GEN	This is no longer a valid code.	N/A
G0299	DIR SNS RN HH/HOSPICE SET EA 15 MIN	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
G0300	DIR SNS LPN HH/HOSPICE SET EA 15 MIN	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
G0302	PRE-OPERATIVE PULMONARY SURGERY SERVICES FOR PREPARATION FOR LVRS	No pre-authorization is required for all providers.	N/A
G0303	PRE-OPERATIVE PULMONARY SURGERY SERVICES FOR PREPARATION FOR LVRS, 10	No pre-authorization is required for all providers.	N/A
G0304	PRE-OPERATIVE PULMONARY SURGERY SERVICES FOR PREPARATION FOR LVRS, 1	No pre-authorization is required for all providers.	N/A
G0305	POST-DISCHARGE PULMONARY SURGERY SERVICES AFTER LVRS, MINIMUM OF 6 DAYS	No pre-authorization is required for all providers.	N/A
G0306	COMPLETE CBC, AUTOMATED AND AUTOMATED WBC DIFFERENTIAL COUNT	No pre-authorization is required for all providers.	N/A
G0307	COMPLETE CBC, AUTOMATED (HGB, HCT, RBC, WBC WITHOUT PLATELET COUNT)	No pre-authorization is required for all providers.	N/A
G0328	FECAL BLOOD SCREENING IMMUNOASSAY	No pre-authorization is required for all providers.	N/A
G0329	ELECMAGNET TX ULCERS NOT HEALING 30 DAYS CARE	This service is not covered by Superior HealthPlan.	N/A
G0330	PET IMAGING INITIAL DIAGNOSIS CERVICAL	No pre-authorization is required for all providers.	N/A
G0331	PET IMAGING RESTAGING OVARIAN	This is no longer a valid code.	N/A
G0333	PHARMACY DISPENSING FEE FOR INHAL RX INITIAL 30 DAYS SUPPLY AS A BENEFIC	This service is not covered by Superior HealthPlan.	N/A
G0336	PET IMAGING BRAIN DIFFERENTIAL DX ALZHEIMERS DZ	This is no longer a valid code.	N/A
G0337	HOSPICE EVALUATION & CNSL SERVICES PREELECTION	This service is not covered by Superior HealthPlan.	N/A
G0338	LINEAR ACCELERATOR BASED STEREOTACTIC RADIOSURGERY PLAN	No pre-authorization is required for all providers.	N/A
G0339	IMAGE GUIDED ROBOTIC LINEAR ACCELERATOR BASE STEREOTACTIC RADIOSURGERY	No pre-authorization is required for all providers.	N/A
G0340	IMAGE GUIDED ROBOTIC LINEAR ACCELERATOR BASE STEREOTACTIC RADIOSURGERY	No pre-authorization is required for all providers.	N/A
G0341	PERQ ISLET CELL TPLNT INCL PORTL VEIN CATH&INFUS	This service is not covered by Superior HealthPlan.	N/A
G0342	LAP ISLET CELL TPLNT INCL PORTAL VEIN CATH&INFUS	This service is not covered by Superior HealthPlan.	N/A
G0343	LAPAROT ISLET CELL TPLNT W/PORTL VEIN CATH&INFUS	This service is not covered by Superior HealthPlan.	N/A
G0345	INTRAVENOUS INFUS HYDRATION; INIT UP TO 1 HOUR	No pre-authorization is required for all providers.	N/A
G0346	INTRAVENOUS INFUS HYDRATION; EA ADD HR TO 8 HR	No pre-authorization is required for all providers.	N/A
G0347	IV INFUS TX/DX SPEC SBSTNC/RX; INIT UP TO 1 HR	No pre-authorization is required for all providers.	N/A
G0348	IV INFUS TX/DX SPEC SBSTNC/RX; EA ADD HR TO 8 HR	No pre-authorization is required for all providers.	N/A
G0349	ADDITIONAL SEQUENTIAL INFUSION UP TO 1 HOUR	No pre-authorization is required for all providers.	N/A
G0350	CONCURRNT INFUS RPT ONCE PER SBSTNC/RX W/G0345	No pre-authorization is required for all providers.	N/A
G0351	THERAPEUTIC/DX INJ SPECIFY SUBSTANCE/RX; SUBQ/IM	No pre-authorization is required for all providers.	N/A
G0353	INTRAVENOUS PUSH SINGLE/INITIAL SUBSTANCE/DRUG	No pre-authorization is required for all providers.	N/A
G0354	EACH ADDITIONAL SEQUENTIAL INTRAVENOUS PUSH	No pre-authorization is required for all providers.	N/A
G0355	CHEMO ADMN SUBQ/IM NONHORMONAL ANTINEOPLASTIC	No pre-authorization is required for all providers.	N/A
G0357	IV PUSH TECHNIQUE SINGLE/INIT SUBSTANCE/DRUG	No pre-authorization is required for all providers.	N/A
G0358	IV PUSH TECHNIQUE EACH ADD SUBSTANCE/DRUG	No pre-authorization is required for all providers.	N/A
G0359	CHEMO ADMIN IV INFUS; TO 1 HR 1/INIT SBSTNC/RX	No pre-authorization is required for all providers.	N/A
G0360	CHEMO ADMIN IV INFUS; EACH ADD HR 1 TO 8 HOURS	No pre-authorization is required for all providers.	N/A
G0361	INIT PROLNG CHEMO INFUS RQR PORTABLE/IMPL PUMP	No pre-authorization is required for all providers.	N/A
G0362	EA ADD SEQUENTL INFUS DIFF DRUG TO 1 HR W/G0359	No pre-authorization is required for all providers.	N/A
G0363	IRRIG IMPLANTED VENOUS ACCESS DEVICE DRUG DEL SYS	No pre-authorization is required for all providers.	N/A
G0364	BN MARROW ASPIR PRFRM W/BX SAME INCI SAME DOS	This is no longer a valid code.	N/A
G0365	VESSEL MAPPING OF VESSELS FOR HEMODIALYSIS ACCESS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G0369	PHARMACY SUPPLY FEE INITIAL IMMUNOSUPP RXS 1ST MO FOLLOW TRANSPLANT	No pre-authorization is required for all providers.	N/A
G0370	PHARM SUPPLY FEE FOR ORAL ANTI-CANCER ORAL ANTI-EMETIC OR IMMUNO RX	No pre-authorization is required for all providers.	N/A
G0371	PHARMACY DISPENSING FEE FOR INHALATION DRUGS /30 DAYS	No pre-authorization is required for all providers.	N/A
G0372	PHYS SVC REQ TO ESTABLISH & DOCUMENT NEED FOR A POWER MOBILITY DEVICE	This service is not covered by Superior HealthPlan.	N/A
G0374	PHARMACY DISPENSING FEE FOR INHALATION DRUGS /90 DAYS	No pre-authorization is required for all providers.	N/A
G0378	HOSPITAL OBSERVATION SERVICE /HOUR	This service is not covered by Superior HealthPlan.	N/A
G0379	DIRECT REFER HOSPITAL OBSERV	This service is not covered by Superior HealthPlan.	N/A
G0380	LEV 1 HOSP TYPE B ED VISIT	This service is not covered by Superior HealthPlan.	N/A
G0381	LEV 2 HOSP TYPE B ED VISIT	This service is not covered by Superior HealthPlan.	N/A
G0382	LEV 3 HOSP TYPE B ED VISIT	This service is not covered by Superior HealthPlan.	N/A
G0383	LEV 4 HOSP TYPE B ED VISIT	This service is not covered by Superior HealthPlan.	N/A
G0384	LEV 5 HOSP TYPE B ED VISIT	This service is not covered by Superior HealthPlan.	N/A
G0389	ULTRASOUND B-SCAN &/OR REAL TIME W IMAGE DOC FOR ABD AORTIC ANRYSM	This is no longer a valid code.	N/A
G0390	TRAUMA RESPONSE TEAM ASSOCIATED WITH HOSPITAL CRITICAL CARE SERVICE	This service is not covered by Superior HealthPlan.	N/A
G0394	BLOOD OCCULT TEST (EG GUA/AC) FECES SINGLE DET FOR COLORECT NEOPL	No pre-authorization is required for all providers.	N/A
G0396	ALCOHOL/SUBS INTERV 15-30MIN	This service is not covered by Superior HealthPlan.	N/A
G0397	ALCOHOL/SUBS INTERV >30 MIN	This service is not covered by Superior HealthPlan.	N/A

G0398	HOME SLEEP STUDY TEST WITH TYPE II PORTABLE MONITOR	Pre-authorization is required for all providers; if billed with a professional services modifier (26), no pre-authorization is required.	Prior to 09/01/2019
G0399	HOME SLEEP STUDY TEST WITH TYPE III PORTABLE MONITOR	Pre-authorization is required for all providers; if billed with a professional services modifier (26), no pre-authorization is required.	Prior to 09/01/2019
G0400	HOME SLEEP STUDY TEST WITH TYPE IV PORTABLE MONITOR	Pre-authorization is required for all providers; if billed with a professional services modifier (26), no pre-authorization is required.	Prior to 09/01/2019
G0402	INITIAL PREVENTIVE EXAM	This service is not covered by Superior HealthPlan.	N/A
G0403	EKG FOR INITIAL PREVENT EXAM	This service is not covered by Superior HealthPlan.	N/A
G0404	EKG TRACING FOR INITIAL PREV	This service is not covered by Superior HealthPlan.	N/A
G0405	EKG INTERPRET & REPORT PREVE	This service is not covered by Superior HealthPlan.	N/A
G0406	INPT/TELE FOLLOW UP 15	No pre-authorization is required for all providers.	N/A
G0407	INPT/TELE FOLLOW UP 25	No pre-authorization is required for all providers.	N/A
G0408	INPT/TELE FOLLOW UP 35	No pre-authorization is required for all providers.	N/A
G0409	CORF RELATED SERV 15 MINS EA	This service is not covered by Superior HealthPlan.	N/A
G0410	GRP PSYCH PARTIAL HOSP 45-50	This service is not covered by Superior HealthPlan.	N/A
G0411	INTER ACTIVE GRP PSYCH PARTI	This service is not covered by Superior HealthPlan.	N/A
G0412	OPEN TX ILIAC SPINE UNI BIL	This service is not covered by Superior HealthPlan.	N/A
G0413	PELVIC RING FRACTURE UNI BIL	This service is not covered by Superior HealthPlan.	N/A
G0414	PELVIC RING FX TREAT INT FIX	This service is not covered by Superior HealthPlan.	N/A
G0415	OPEN TX POST PELVIC FXCTURE	This service is not covered by Superior HealthPlan.	N/A
G0416	PROSTATE BIOPSY, ANY MTHD	This service is not covered by Superior HealthPlan.	N/A
G0417	BIOPSY, PROSTATE 21-40 SPEC	This is no longer a valid code.	N/A
G0418	BIOPSY, PROSTATE 41-60 SPEC	This is no longer a valid code.	N/A
G0419	BIOPSY, PROSTATE > 60 SPEC	This is no longer a valid code.	N/A
G0420	ED SVC CKD IND PER SESSION	This service is not covered by Superior HealthPlan.	N/A
G0421	ED SVC CKD GRP PER SESSION	This service is not covered by Superior HealthPlan.	N/A
G0422	INTENS CARDIAC REHAB W/EXERC	This service is not covered by Superior HealthPlan.	N/A
G0423	INTENS CARDIAC REHAB NO EXER	This service is not covered by Superior HealthPlan.	N/A
G0424	PULMONARY REHAB W EXER	This service is not covered by Superior HealthPlan.	N/A
G0425	INPT/ED TELECONSULT30	No pre-authorization is required for all providers.	N/A
G0426	INPT/ED TELECONSULT50	No pre-authorization is required for all providers.	N/A
G0427	INPT/ED TELECONSULT70	No pre-authorization is required for all providers.	N/A
G0428	INPT TELEHEALTH CONSULT 80M	This service is not covered by Superior HealthPlan.	N/A
G0429	DERMAL FILLER INJECTION(S)	This service is not covered by Superior HealthPlan.	N/A
G0430	DRUG SCREEN MULTI CLASS	No pre-authorization is required for all providers.	N/A
G0431	#N/A	This is no longer a valid code.	N/A
G0432	EIA HIV-1/HIV-2 SCREEN	This service is not covered by Superior HealthPlan.	N/A
G0433	ELISA HIV-1/HIV-2 SCREEN	This service is not covered by Superior HealthPlan.	N/A
G0434	#N/A	This is no longer a valid code.	N/A
G0435	ORAL HIV-1/HIV-2 SCREEN	This service is not covered by Superior HealthPlan.	N/A
G0438	ANNUAL WELLNES VST; PERSNL PPS INIT	This service is not covered by Superior HealthPlan.	N/A
G0439	ANNUAL WELLNESS VST; PPS SUBSQT VST	This service is not covered by Superior HealthPlan.	N/A
G0452	MOLECULAR PATHOLOGY INTERPR	This service is not covered by Superior HealthPlan.	N/A
G0453	CONT INTRAOP NEURO MONITOR	This service is not covered by Superior HealthPlan.	N/A
G0454	MD DOCUMENT VISIT BY NPP	This service is not covered by Superior HealthPlan.	N/A
G0455	FECAL MICROBIOTA PREP INSTIL	This service is not covered by Superior HealthPlan.	N/A
G0456	NEG PRE WOUND <=50 SQ CM	This is no longer a valid code.	N/A
G0457	NEG PRES WOUND >50 SQ CM	This is no longer a valid code.	N/A
G0458	LDR PROSTATE BRACHY COMP RAT	This service is not covered by Superior HealthPlan.	N/A
G0459	INPATIENT TELEHEALTH PHARMACOL MGMT	No pre-authorization is required for all providers.	N/A
G0460	AUTOLOGOUS PRP FOR ULCERS	No pre-authorization is required for all providers.	N/A
G0461	IMMUNOHISTO/CYTO CHEM 1ST ST	This is no longer a valid code.	N/A
G0462	IMMUNOHISTO/CYTO CHEM ADD	This is no longer a valid code.	N/A
G0463	HOSPITAL OUTPT CLINIC VISIT	This service is not covered by Superior HealthPlan.	N/A
G0464	COLOREC CA SCR, STO BAS DNA	This service is not covered by Superior HealthPlan.	N/A
G0466	FQHC VISIT NEW PATIEN	This service is not covered by Superior HealthPlan.	N/A
G0467	FQHC VISIT ESTABLISHED PATIEN	This service is not covered by Superior HealthPlan.	N/A
G0468	FQHC VISIT IPPE/AW	This service is not covered by Superior HealthPlan.	N/A
G0469	FQHC VISIT MENTAL HEALTH NEW P	This service is not covered by Superior HealthPlan.	N/A
G0470	FQHC VISIT MENTAL HEALTH ESTAB P	This service is not covered by Superior HealthPlan.	N/A
G0471	VEN BLOOD COLL SNF/HHA	This service is not covered by Superior HealthPlan.	N/A
G0472	HEP C SCREEN HIGH RISK/OTHER	No authorization required. Code is for informational purposes only.	N/A
G0473	GROUP BEHAVE COUNS 2-10	This service is not covered by Superior HealthPlan.	N/A
G0475	HIV ANTIGEN/ANTIBODY COMB ASSAY SCR	No pre-authorization is required for all providers.	N/A
G0476	INF AGT DTCT DNA/RNA; HPV ADD PAP T	No pre-authorization is required for all providers.	N/A
G0477	DRUG TEST PRESUMP OPTICAL	No pre-authorization is required for all providers.	N/A
G0478	DRUG TEST PRESUMP OPT INST	No pre-authorization is required for all providers.	N/A
G0479	DRUG TEST PRESUMP NOT OPT	No pre-authorization is required for all providers.	N/A
G0480	DR TST DEFIN DR ID M P D 1-7 DR CL	Pre-authorization required for all providers.	Prior to 09/01/2019
G0481	DR TST DEFIN DR ID M P D 8-14 DR CL	Pre-authorization required for all providers.	Prior to 09/01/2019
G0482	DR TST DEFIN DR ID M P D 15-21 DR CL	Pre-authorization required for all providers.	Prior to 09/01/2019
G0483	DR TST DEFIN DR ID M P D 22/M DR CL	Pre-authorization required for all providers.	Prior to 09/01/2019
G0491	DIALYSIS ACU KIDNEY NO ESRD	No pre-authorization is required for all providers.	N/A
G0492	MD/OTH EVAL ACUT KID NO ESRD	No pre-authorization is required for all providers.	N/A
G0493	RN CARE EA 15 MIN HH/HOSPICE	This service is not covered by Superior HealthPlan.	N/A
G0494	LPN CARE EA 15MIN HH/HOSPICE	This service is not covered by Superior HealthPlan.	N/A
G0495	RN CARE TRAIN/EDU IN HH	This service is not covered by Superior HealthPlan.	N/A
G0496	LPN CARE TRAIN/EDU IN HH	This service is not covered by Superior HealthPlan.	N/A
G0499	HEPATITIS B SCREENING IN NON-PREG HIGH RISK IND	Authorization is required for non-participating independent labs. For all other providers, no authorization is	Prior to 09/01/2019
G0500	MOD SEDAT ENDO SERVICE >5YRS	No pre-authorization is required for all providers.	N/A
G0501	RESOURCE-INTEN SVC DURING OV	No pre-authorization is required for all providers.	N/A
G0502	INIT PSYCH CARE MANAG 70MIN	This is no longer a valid code.	N/A
G0503	SUBSEQ PSYCH CARE MAN60MI	This is no longer a valid code.	N/A
G0504	INIT/SUB PSYCH CARE ADD 30 M	This is no longer a valid code.	N/A
G0505	COG/FUNC ASSESSMENT OUTPT	This is no longer a valid code.	N/A
G0506	COMP ASSES CARE PLAN CCM SVC	No pre-authorization is required for all providers.	N/A
G0507	CARE MANAGE SERV MINIMUM 20	This is no longer a valid code.	N/A
G0508	CRIT CARE TELEHEA CONSULT 60	No pre-authorization is required for all providers.	N/A
G0509	CRIT CARE TELEHEA CONSULT 50	No pre-authorization is required for all providers.	N/A
G0511	RHC/FQHC G C MGMT 20 M/>C T-CAL MO	No pre-authorization is required for all providers.	N/A
G0512	RHC/FQHC PS COCM 60 M/>C TM-CAL MO	No pre-authorization is required for all providers.	N/A
G0513	PRLNG PREV SVC OFC/OTH O/P - 1ST 30 M	No pre-authorization is required for all providers.	N/A
G0514	PRLNG PRV SVC OFC/O O/P - EA ADD 30 M	No pre-authorization is required for all providers.	N/A
G0515	DVLP CS IMP AT M PROB SLV EA 15 MN	No pre-authorization is required for all providers.	N/A
G0516	INSERT DRUG IMPLANT >= 4	No pre-authorization is required for all providers.	N/A
G0517	REMV NON-BIODEGRAD RX DEL IMPL 4/>	No pre-authorization is required for all providers.	N/A
G0518	REMV REINS NON-BIODEG RX D IMPL 4/>	No pre-authorization is required for all providers.	N/A
G0659	DRUG TEST DEF SIMPLE ALL C	Pre-authorization is required for all providers.	Prior to 09/01/2019
G0831	HEART FAIL PAT W LT VENT SYST DYSF (KVSD) NOT DOCUMENT ON BETA BLOCKER T	No pre-authorization is required for all providers.	N/A
G0832	CLINICIAN DOCUMENT HEART FAIL PAT W/N ELIG FOR BETA BLOCKER THERAPY MEAS	No pre-authorization is required for all providers.	N/A
G0851	FEMALE PAT DOCUMENTED TO HAVE BEEN ASSESSED FOR OSTEOPOROSIS	No pre-authorization is required for all providers.	N/A
G0908	HGB > 12 G/DL	This is no longer a valid code.	N/A
G0909	HGB NOT DOC	This is no longer a valid code.	N/A
G0910	HGB <= 12 G/DL	This is no longer a valid code.	N/A
G0919	FLU IMMUNIZE NOT AVAIL	This is no longer a valid code.	N/A
G0920	TYPE LOC ACT DOC	This is no longer a valid code.	N/A
G0921	DOC PT REAS NO ASSESS	This is no longer a valid code.	N/A
G0922	TYPE LOC ACT NOT DOC	This is no longer a valid code.	N/A
G1000	CDS MECH APPL P/W DFND MCR APPROP USE CRITERIA	No authorization required. Code is for informational purposes only.	N/A
G1001	CLIN DEC SUPP MECH EVICORE DEFIND MCR AUC PROG	No authorization required. Code is for informational purposes only.	N/A
G1002	CLIN DEC SUPP MECH MEDCURRENT DFIND MCR AUC PROG	No authorization required. Code is for informational purposes only.	N/A
G1003	CLIN DEC SUPP MECH MEDICALIS DEFIND MCR AUC PROG	No authorization required. Code is for informational purposes only.	N/A

G1004	CLINICAL DEC SUPP MECH NDSC DEFINED MCR AUC PROG	No authorization required. Code is for informational purposes only.	N/A
G1005	CLINICAL DEC SUPP MECH NIA DEFINED MCR AUC PROG	No authorization required. Code is for informational purposes only.	N/A
G1006	CLINICAL DEC SUPP MECH TEST APPROP DFIND MCR AUC	No authorization required. Code is for informational purposes only.	N/A
G1007	CLINICAL DEC SUPP MECH AIM DEFINED MCR AUC PROG	No authorization required. Code is for informational purposes only.	N/A
G1008	CLIN DEC SUPP MECH CRANBERRY PEAK DFIND MCR AUC	No authorization required. Code is for informational purposes only.	N/A
G1009	CLIN DEC SUPP MECH SAGE HMS DEFINED MCR AUC PROG	No authorization required. Code is for informational purposes only.	N/A
G1010	CLIN DEC SUPP MECH STANSON DEFINED MCR AUC PROG	No authorization required. Code is for informational purposes only.	N/A
G1011	CLIN DEC SUPP MECH QUAL TOOL NOS DFIND MCR AUC	No authorization required. Code is for informational purposes only.	N/A
G1012	CLINICAL DECISION SUPPORT MECHANISM AGILEMD	No authorization required. Code is for informational purposes only.	N/A
G1013	CLINICAL DECISION SUPP MECH EVIDENCE CARE IMAG ADV	No authorization required. Code is for informational purposes only.	N/A
G1014	CLINICAL DECISION SUPP MECH INVENIQA SMNTC ANSWRS MED	No authorization required. Code is for informational purposes only.	N/A
G1015	CLINICAL DECISION SUPP MECH RELIANT MEDICAL GRP	No authorization required. Code is for informational purposes only.	N/A
G1016	CLINICAL DECISION SUPP MECHANISM SPEED OF CARE	No authorization required. Code is for informational purposes only.	N/A
G1017	CLINICAL DECISION SUPPORT MECHANISM HEALTHHELP	No authorization required. Code is for informational purposes only.	N/A
G1019	CLINICAL DECISION SUPPORT MECHANISM LOGICNETS	No authorization required. Code is for informational purposes only.	N/A
G2000	BLINDED ADMINISTRATION OF CONVULSIVE TX PROC	No authorization required. Code is for informational purposes only.	N/A
G2001	BRIEF 20 MINUTES IN-HOME VISIT NEW PT POST-D/C	No authorization required. Code is for informational purposes only.	N/A
G2002	LIMITED 30 MINUTES IN-HOME VISIT NEW PT POST-D/C	No authorization required. Code is for informational purposes only.	N/A
G2003	MODERATE 45 MINS IN-HOME VISIT NEW PT POST-D/C	No authorization required. Code is for informational purposes only.	N/A
G2004	COMP 60 MINUTES IN-HOME VISIT NEW PT POST-D/C	No authorization required. Code is for informational purposes only.	N/A
G2005	EXTENSIVE 75 MINS IN-HOME VISIT NEW PT POST-D/C	No authorization required. Code is for informational purposes only.	N/A
G2006	BRIEF 20 MINUTES IN-HOME VISIT EXIST PT POST-D/C	No authorization required. Code is for informational purposes only.	N/A
G2007	LIMITED 30 MINS IN-HOME VISIT EXIST PT POST-D/C	No authorization required. Code is for informational purposes only.	N/A
G2008	MODERATE 45 MINS IN-HOME VISIT EXIST PT POST-D/C	No authorization required. Code is for informational purposes only.	N/A
G2009	COMP 60 MINS IN-HOME VISIT EXIST PT POST-D/C	No authorization required. Code is for informational purposes only.	N/A
G2010	REMOTE EVAL RECORDED VIDEO AND/ IMAGES SB ESTAB PT	This service is not covered by Superior HealthPlan.	N/A
G2011	ALC AND/SA STRCT ASSESS AND BRIEF INTERVENT 5-14 MIN	No pre-authorization is required for all providers.	N/A
G2012	BRIEF COMMUNICATION TBS 5-10 MIN MED DISCUSSION	This service is not covered by Superior HealthPlan.	N/A
G2013	EXTSV 75 MINS IN-HOME VISIT EXIST PT POST-D/C	No authorization required. Code is for informational purposes only.	N/A
G2014	LIMITED 30 MINUTES CARE PLAN OVERSIGHT	No authorization required. Code is for informational purposes only.	N/A
G2015	COMPREHENSIVE 60 MINS HOME CARE PLAN OVERSIGHT	No authorization required. Code is for informational purposes only.	N/A
G2021	HEALTH CARE PRACTITIONERS RENDERING TIP	No authorization required. Code is for informational purposes only.	N/A
G2022	MDL PRTCP BENEFICIARY REFUSES SRVC COVR UND MDL	No authorization required. Code is for informational purposes only.	N/A
G2058	CCM SRVC EA ADD 20 MIN CLIN STF TM DIR HCP CA MO	This service is not covered by Superior HealthPlan.	N/A
G2061	Q NPHYS HC PROF ONLN A AND MGT EST PT TO 7 D 5-10 M	This service is not covered by Superior HealthPlan.	N/A
G2062	Q NPHYS HC PROF ONLN A AND MGMT EST PT TO 7 D 11-20 M	This service is not covered by Superior HealthPlan.	N/A
G2063	QUAL NPHYS HC PROF ASMT AND MGMT EST PT TO 7 D 21/>M	This service is not covered by Superior HealthPlan.	N/A
G2064	CCM SRVC 1 HR DZ AL 30 M PHYS/HCP TIME CA MO	This service is not covered by Superior HealthPlan.	N/A
G2065	CCM 1 HOUR DZ SRVC PCM AT LEAST 30 MIN CAL MONTH	This service is not covered by Superior HealthPlan.	N/A
G2066	INTG DVC EVAL RMT TO 30 D RCPT TRANS AND TECH RVW	No pre-authorization is required for all providers.	N/A
G2067	MEDICATION ASSISTED TX METHADONE WEEKLY BUNDLE	No authorization required. Code is for informational purposes only.	N/A
G2068	MED ASST TX BUPRENORPHINE ORAL WEEKLY BUNDLE	No authorization required. Code is for informational purposes only.	N/A
G2069	MED ASST TX BUPRENORPHINE INJ WEEKLY BUNDLE	No authorization required. Code is for informational purposes only.	N/A
G2070	MAT BUPRENORPHINE IMPLANT INSR WEEKLY BUNDLE	No authorization required. Code is for informational purposes only.	N/A
G2071	MAT BUPRENORPHINE IMPL REMOVAL WEEKLY BUNDLE	No authorization required. Code is for informational purposes only.	N/A
G2072	MAT BUPRENORPHINE IMPLANT I AND R WEEKLY BUNDLE	No authorization required. Code is for informational purposes only.	N/A
G2073	MEDICATION ASSIST TX NALTREXONE WEEKLY BUNDLE	No authorization required. Code is for informational purposes only.	N/A
G2074	MEDICATION ASSIST WEEKLY BUNDLE NOT INCL DRUG	No authorization required. Code is for informational purposes only.	N/A
G2075	MEDICATION ASST TX MEDICATION NOS WEEKLY BUNDLE	No authorization required. Code is for informational purposes only.	N/A
G2076	INTK ACT INCL INT MED EX Cmpl DOC P EVL AND INT ASMT	No authorization required. Code is for informational purposes only.	N/A
G2077	PA ASSESS PRD Q PERS DET MOST APPR COMB SRVC AND TX	No authorization required. Code is for informational purposes only.	N/A
G2078	TAKE HOME SUP METHADONE UP TO 7 ADD DAY SUP	No authorization required. Code is for informational purposes only.	N/A
G2079	TAKE HOME SUP BUPRENORPHINE ORAL TO 7 ADD D SUP	No authorization required. Code is for informational purposes only.	N/A
G2080	EA ADD 30 MIN CNSL WK MED ASSISTED TREATMENT	No authorization required. Code is for informational purposes only.	N/A
G2081	PT 66 AND> INST SNP/RESID LTC >90 DAYS DUR MSR PRD	No authorization required. Code is for informational purposes only.	N/A
G2082	OFF/OTH OP E AND M EST PT PROV 56 MG ESKETAMINE N SA	This service is not covered by Superior HealthPlan.	N/A
G2083	OFF/OTH OP E AND M EST PT PROV-56 MG ESKETAMINE N SA	This service is not covered by Superior HealthPlan.	N/A
G2086	OFF-BASED TX OPIOID USE D/O AL 70 MIN 1ST CA MO	No authorization required. Code is for informational purposes only.	N/A
G2087	OFF-BASED TX OUD AL 60 MIN SUBSEQ CALENDAR MO	No authorization required. Code is for informational purposes only.	N/A
G2088	OFF-BASED TX OUD EA ADD 30 MIN BYD 1ST 120 MIN	No authorization required. Code is for informational purposes only.	N/A
G2089	MOST RECENT HEMOGLOBIN A1C LEVEL 7.0 PERC TO 9.0 PERC	No authorization required. Code is for informational purposes only.	N/A
G2090	PT 66 Y AND >1 CLM FRLTY AND DIS MED DMNT MP/YR PRI MP	No authorization required. Code is for informational purposes only.	N/A
G2091	PT 66 AND >1 CLM FRLTY AND 1 AC IP ADV ILL MP/YR PRI MP	No authorization required. Code is for informational purposes only.	N/A
G2092	ACE INHIB/ARB/ARNI TH PRSC/CURRENTLY BEING TAKEN	No authorization required. Code is for informational purposes only.	N/A
G2093	DOC MED REASN NO PRSC ACE INHIB/ARB/ARNI TH	No authorization required. Code is for informational purposes only.	N/A
G2094	DOC PT REASON NO PRSC ACE INHIB/ARB/ARNI THERAPY	No authorization required. Code is for informational purposes only.	N/A
G2095	DOC SYS RSN NOT PRSC ACE INHIB/ARB/ARNI THERAPY	No authorization required. Code is for informational purposes only.	N/A
G2096	ACE INHIB/ARB/ARNI TH WAS NOT PRSC RSN NOT GIVEN	No authorization required. Code is for informational purposes only.	N/A
G2097	CHILD COMP DX UR INF W/I 3 DAYS DX PHARYNGITIS	No authorization required. Code is for informational purposes only.	N/A
G2098	PT 66 Y AND >1 CLM FRLTY AND DIS MED DMNT MP/YR PRI MP	No authorization required. Code is for informational purposes only.	N/A
G2099	PT 66 AND >1 CLM FRLTY DUR MSR AND DUR/YR PRI MSR PRD	No authorization required. Code is for informational purposes only.	N/A
G2100	PT 66 Y AND >1 CLM FRLTY AND DIS MED DMNT MP/YR PRI MP	No authorization required. Code is for informational purposes only.	N/A
G2101	PT 66 AND >1 CLM FRLTY AND 1 AC IP ADV ILL DR/YR PRI MSR	No authorization required. Code is for informational purposes only.	N/A
G2102	DILAT RET EYE EXAM INTERPR OPH/OPTOM DOC AND REV	No authorization required. Code is for informational purposes only.	N/A
G2103	7 STD FIELD STEREO PH INTERPR OPH/OPTM DOC AND REV	No authorization required. Code is for informational purposes only.	N/A
G2104	EYE IMG VAL DX 7 SD FLD STEREO PHOTOS RSLT DOC AND R	No authorization required. Code is for informational purposes only.	N/A
G2105	PT AGE 66/> INST SNP/RESID LTC >90 D DUR MSR PRD	No authorization required. Code is for informational purposes only.	N/A
G2106	PT 66 Y AND >1 CLM FRALTY AND D MED DMNT MP/YR PRI MP	No authorization required. Code is for informational purposes only.	N/A
G2107	PT 66 AND >1 CLM FRLTY AND 1 AC IP ADV ILL MP/YR PRI MP	No authorization required. Code is for informational purposes only.	N/A
G2108	PT 66/OLDR INST SNP/RES LTC >90 D DUR MSR PRD	No authorization required. Code is for informational purposes only.	N/A
G2109	PT 66 AND >1 CLM FRLTY AND 1 AC IP ADV ILL MP/YR PRI MP	No authorization required. Code is for informational purposes only.	N/A
G2110	PT 66 AND >1 CLM FRLTY AND 1 AC IP ADV ILL MP/YR PRI MP	No authorization required. Code is for informational purposes only.	N/A
G2112	PT RECV <=5 MG DA PDN/RA ACT WORSE/GCC <6 MO	No authorization required. Code is for informational purposes only.	N/A
G2113	PT RECV >5 MG DA PRD>6 MO AND IMP/NO CHNGE DZ ACT	No authorization required. Code is for informational purposes only.	N/A
G2114	PT 66-80 1 CLAIM FRALTY AND DIS MED DEMENTIA DUR	No authorization required. Code is for informational purposes only.	N/A
G2115	PT 66 AND >1 CLM FRLTY AND DISP MED DEMENT MP/YR MP	No authorization required. Code is for informational purposes only.	N/A
G2116	PT 66 AND >1 CLM FRLTY AND 1 IP ADV ILL DUR/YR PRI MP	No authorization required. Code is for informational purposes only.	N/A
G2117	PT 66-80 1 CLAIM FRLTY AND 1 AC IP ENC ADV ILL MP	No authorization required. Code is for informational purposes only.	N/A
G2118	PT 81 YEARS AND > EVID FRALTY DUR MSR PERIOD	No authorization required. Code is for informational purposes only.	N/A
G2119	W/I PAST 2 YR CALCIUM AND / VITD OPT ORDERED/PERF	No authorization required. Code is for informational purposes only.	N/A
G2120	W/I PAST 2 YR CALCIUM AND / VIT D OPT NOT ORD/PERF	No authorization required. Code is for informational purposes only.	N/A
G2121	PSYCHOSIS DEPRESSION ANXIETY APATHY AND ICD ASSESS	No authorization required. Code is for informational purposes only.	N/A
G2122	PSYCHOSIS DEPR ANXIETY APATHY AND ICD NOT ASSESSED	No authorization required. Code is for informational purposes only.	N/A
G2123	PT 66-80 YR / AND AL 1 CLAIM FRALTY DUR MSR PERIOD	No authorization required. Code is for informational purposes only.	N/A
G2124	PT 66-80 Y AND AL 1 CLM FRALTY MP AND DIS DEMENT MED	No authorization required. Code is for informational purposes only.	N/A
G2125	PT 81 YR AGE AND OLDR EVIDENCE FRALTY DUR MSR PRD	No authorization required. Code is for informational purposes only.	N/A
G2126	PT 66 YR AGE/OLDR AND AL 1 CLM FRALTY DUR MSR PRD	No authorization required. Code is for informational purposes only.	N/A
G2127	PT 66/> AND 1 CLAIM FRALTY DUR MP AND DIS DMNT MED	No authorization required. Code is for informational purposes only.	N/A
G2128	DOC MED RSN NOT ON DAILY ASP/OTH ANTIPLATELET	No authorization required. Code is for informational purposes only.	N/A
G2129	PROC RELATED BPS NOT TAKEN DURING AN OP VISIT	No authorization required. Code is for informational purposes only.	N/A
G2130	PT 66/OLDR INST SNP/RESID LT CARE >90 DAYS MSR	No authorization required. Code is for informational purposes only.	N/A
G2131	PATIENTS 81 YEARS AND OLDER WITH A DX FRALTY	No authorization required. Code is for informational purposes only.	N/A
G2132	PT 66-80 1 CLM FRALTY AND DIS MED DEMENTIA DUR MP	No authorization required. Code is for informational purposes only.	N/A
G2133	PT 66-80 1 CLAIM FRLTY AND 1 AC IP ENC ADV ILL MP	No authorization required. Code is for informational purposes only.	N/A
G2134	PT 66< W/1+ FRALTY DISP MED DEMENTIA DUR/YR PRI	No authorization required. Code is for informational purposes only.	N/A
G2135	PT 66< W/1+ FRALTY 1+ ENCNT ADV ILLNS DUR/YR PR	No authorization required. Code is for informational purposes only.	N/A
G2136	BACK PAIN MEAS VAS 3 MON PO<=3.0 IMPRV 5.0 PNT/<	No authorization required. Code is for informational purposes only.	N/A
G2137	BACK PAIN MEAS VAS 3 MON PO>3.0 CHG IMPV 5 PNT/<	No authorization required. Code is for informational purposes only.	N/A
G2138	BACK PAIN MEAS VAS 1 YR PO>3.0 DEMS CHNG 5 PNT/>	No authorization required. Code is for informational purposes only.	N/A
G2139	BACK PAIN MEAS VAS 1 YR PO>3.0 DEMS CHNG <5 PNTS	No authorization required. Code is for informational purposes only.	N/A
G2140	LEG PAIN MEAS VAS 3 MNT PO<=3.0 DEM CHNG 5 PNT/>	No authorization required. Code is for informational purposes only.	N/A

G2141	LEG PAIN MEAS VAS 3 MNT PO>3.0 DEMS CHNG <5 PNTS	No authorization required. Code is for informational purposes only.	N/A
G2142	FUNC ST ODI 1YR PO<=22 ODI 3 MN PREO 1YR PO 30>	No authorization required. Code is for informational purposes only.	N/A
G2143	FUNC ST ODI 1YR PO >=22 ODI 3 MN PREO 1YR PO 30>	No authorization required. Code is for informational purposes only.	N/A
G2144	FUNC ST ODI 3MO PO <=22 ODI 3 MN PREO 1YR PO 30>	No authorization required. Code is for informational purposes only.	N/A
G2145	FUNC ST ODI 3MO PO >=22 ODI 3 MN PREO 1YR PO 30>	No authorization required. Code is for informational purposes only.	N/A
G2146	LEG PAIN MEAS VAS 1 YR PO>=3.0 DEM CHNG 5 PNT/7>	No authorization required. Code is for informational purposes only.	N/A
G2147	LEG PAIN MEAS VAS 1 YR PO>3.0 DEMS CHNG <5 PNTS	No authorization required. Code is for informational purposes only.	N/A
G2148	PERFORMANCE MET MULTIMODAL PAIN MGMNT WAS USED	No authorization required. Code is for informational purposes only.	N/A
G2149	DOCUMENT MEDICAL REASON NOT USNG MULTIMODAL PAIN	No authorization required. Code is for informational purposes only.	N/A
G2150	PERFORM MET MULTIMODAL PAIN MGMNT WAS NOT USED	No authorization required. Code is for informational purposes only.	N/A
G2151	PT W DX DEGEN NEURO COND ANY TIME B4/DURING EPIS	No authorization required. Code is for informational purposes only.	N/A
G2152	PERFORMANCE MET RESIDUAL CHNG SCORE = TO OR > 0	No authorization required. Code is for informational purposes only.	N/A
G2153	IN HOSPICE/ USING HOSPICE DURING MEASUREMENT PER	No authorization required. Code is for informational purposes only.	N/A
G2154	PT REC1 TD VAC OR/1 TDAP BTW 9YR PRI START MEASR	No authorization required. Code is for informational purposes only.	N/A
G2155	PT HX 1+ CONTR ANAPH TDAP VAC ANAP TD ENCPH TDAP	No authorization required. Code is for informational purposes only.	N/A
G2156	PT NOT RECD 1 TD VAC OR/1 TDAP BTW 9YR PRI START	No authorization required. Code is for informational purposes only.	N/A
G2157	PT REC 13-VALENT PNEUM CONJ AND 23-VAL POLYS12 M=60	No authorization required. Code is for informational purposes only.	N/A
G2158	PT PRIOR PNEUM VAC ADV REAC ANY TIME DUR/B4 MEAS	No authorization required. Code is for informational purposes only.	N/A
G2159	PT NOT REC 13-VALENT PNEUM CONJ AND 23-VAL 12 MNT>60	No authorization required. Code is for informational purposes only.	N/A
G2160	PT REC AT LEAST 1DS HERP ZOST LIV OR 2DS RCM=>50	No authorization required. Code is for informational purposes only.	N/A
G2161	PT PRIOR ADV REAC ZOSTER VA ANY TIME DUR/B4 MEAS	No authorization required. Code is for informational purposes only.	N/A
G2162	PT NOT REC AT LEAST 1DS HERP ZOST OR 2DS RCM=>50	No authorization required. Code is for informational purposes only.	N/A
G2163	PT REC INFLUENZA VAC ON/BTW JULY1 YR PRI AND JUN30	No authorization required. Code is for informational purposes only.	N/A
G2164	PT HAD PRIOR INFLUENZA ADVS REACT ANY TIME	No authorization required. Code is for informational purposes only.	N/A
G2165	PT NOT RECV FLU VAC 7/1 YR PRI MSR AND 6/30 MSR	No authorization required. Code is for informational purposes only.	N/A
G2166	PATIENT REFUSED PARTICIPATE ADMISSION AND / D/C	No authorization required. Code is for informational purposes only.	N/A
G2167	PERFORMANCE NOT MET RESIDUAL CHANGE SCORE < 0	No authorization required. Code is for informational purposes only.	N/A
G2168	SERVICES PRFRM BY PT ASST HH SETTING EA 15 MIN	This service is not covered by Superior HealthPlan.	N/A
G2169	SERVICES PRFRM BY OT ASST HH SETTING EA 15 MIN	This service is not covered by Superior HealthPlan.	N/A
G2170	PERQ AVF DIR SITE TISS APP TR E AND SEC PROC RDR BF	This service is not covered by Superior HealthPlan.	N/A
G2171	PERQ AVF DIR ANY SITE MAG-GD ART AND V CATH AND RF E	No authorization required. Code is for informational purposes only.	N/A
G3001	ADMINISTRATION AND SUPPLY OF TOSITUMOMAB, 450 MG	This is no longer a valid code.	N/A
G5060	PAT NOT DOCUMENTED FOR ASSESSMENT OF URINARY INCONTINENCE	No pre-authorization is required for all providers.	N/A
G6001	ECHO GUIDANCE RADIOTHERAPY	No pre-authorization is required for all providers.	N/A
G6002	STEREOSCOPIC X-RAY GUIDANCE	No pre-authorization is required for all providers.	N/A
G6003	RADIATION TREATMENT DELIVERY	No pre-authorization is required for all providers.	N/A
G6004	RADIATION TREATMENT DELIVERY	No pre-authorization is required for all providers.	N/A
G6005	RADIATION TREATMENT DELIVERY	No pre-authorization is required for all providers.	N/A
G6006	RADIATION TREATMENT DELIVERY	No pre-authorization is required for all providers.	N/A
G6007	RADIATION TREATMENT DELIVERY	No pre-authorization is required for all providers.	N/A
G6008	RADIATION TREATMENT DELIVERY	No pre-authorization is required for all providers.	N/A
G6009	RADIATION TREATMENT DELIVERY	No pre-authorization is required for all providers.	N/A
G6010	RADIATION TREATMENT DELIVERY	No pre-authorization is required for all providers.	N/A
G6011	RADIATION TREATMENT DELIVERY	No pre-authorization is required for all providers.	N/A
G6012	RADIATION TREATMENT DELIVERY	No pre-authorization is required for all providers.	N/A
G6013	RADIATION TREATMENT DELIVERY	No pre-authorization is required for all providers.	N/A
G6014	RADIATION TREATMENT DELIVERY	No pre-authorization is required for all providers.	N/A
G6015	RADIATION TX DELIVERY IMRT	No pre-authorization is required for all providers.	N/A
G6016	DELIVERY COMP IMRT	No pre-authorization is required for all providers.	N/A
G6017	INTRAFACTION TRACK MOTION	No pre-authorization is required for all providers.	N/A
G6018	ILEOSCOPY W/STENT	This is no longer a valid code.	N/A
G6019	COLONOSCOPY LESION REMOVAL	This is no longer a valid code.	N/A
G6020	COLONOSCOPY W/STENT	This is no longer a valid code.	N/A
G6021	UNLISTED PX SMALL INTESTINE	This is no longer a valid code.	N/A
G6022	SIGMOIDOSCOPY W/ABLATE TUMR	This is no longer a valid code.	N/A
G6023	SIGMOIDOSCOPY W/STENT	This is no longer a valid code.	N/A
G6024	LESION REMOVAL COLONOSCOPY	This is no longer a valid code.	N/A
G6025	COLONOSCOPY W/STENT	This is no longer a valid code.	N/A
G6027	ANOSCOPY HRA W/SPEC COLLECT	This is no longer a valid code.	N/A
G6028	ANOSCOPY HRA W/BIOPSY	This is no longer a valid code.	N/A
G6030	ASSAY OF AMITRIPTYLINE	This is no longer a valid code.	N/A
G6031	ASSAY OF BENZODIAZEPINES	This is no longer a valid code.	N/A
G6032	ASSAY OF DESIPRAMINE	This is no longer a valid code.	N/A
G6034	ASSAY OF DOXEPIN	This is no longer a valid code.	N/A
G6035	ASSAY OF GOLD	This is no longer a valid code.	N/A
G6036	ASSAY OF IMPRAMINE	This is no longer a valid code.	N/A
G6037	ASSAY OF NORTIPTYLINE	This is no longer a valid code.	N/A
G6038	#N/A	This is no longer a valid code.	N/A
G6039	#N/A	This is no longer a valid code.	N/A
G6040	ASSAY OF ETHANOL	This is no longer a valid code.	N/A
G6041	ASSAY OF URINE ALKALOIDS	This is no longer a valid code.	N/A
G6042	ASSAY OF AMPHETAMINES	This is no longer a valid code.	N/A
G6043	ASSAY OF BARBITURATES	This is no longer a valid code.	N/A
G6044	ASSAY OF COCAINE	This is no longer a valid code.	N/A
G6045	ASSAY OF DIHYDROCODEINONE	This is no longer a valid code.	N/A
G6046	ASSAY OF DIHYDROMORPHINE	This is no longer a valid code.	N/A
G6047	ASSAY OF DIHYDROTESTOSTERONE	This is no longer a valid code.	N/A
G6048	ASSAY OF DIMETHADIONE	This is no longer a valid code.	N/A
G6049	ASSAY OF EPIANDROSTERONE	This is no longer a valid code.	N/A
G6050	ASSAY OF ETHCHLORVYNOL	This is no longer a valid code.	N/A
G6051	ASSAY OF FLURAZEPAM	This is no longer a valid code.	N/A
G6052	ASSAY OF MeproBamate	This is no longer a valid code.	N/A
G6053	ASSAY OF METHADONE	This is no longer a valid code.	N/A
G6054	ASSAY OF METHSUXIMIDE	This is no longer a valid code.	N/A
G6055	ASSAY OF NICOTINE	This is no longer a valid code.	N/A
G6056	ASSAY OF OPIATES	This is no longer a valid code.	N/A
G6057	ASSAY OF PHENOTHIAZINE	This is no longer a valid code.	N/A
G6058	DRUG CONFIRMATION	This is no longer a valid code.	N/A
G8126	PAT DOCUMENT AS TREATED W ANTIDEPRESSANT MEDS DURING THE ENTIRE 12 WK AC	This is no longer a valid code.	N/A
G8127	PAT NOT DOCUMENT AS TREATED W ANTIDEPRESSANT MEDS DURING THE ENTIRE 12 W	This is no longer a valid code.	N/A
G8128	PAT NOT TREATED W ANTIDEPRESSANT MED OR WAS NOT ELIG FOR COMP OF 12 WK	This is no longer a valid code.	N/A
G8135	PAT NOT DOCUMENT TO HAV RECD ANTIBIOTIC PROPHYLAXIS 1HR PRIOR TO INCISIO	No pre-authorization is required for all providers.	N/A
G8158	PAT DOCUMENT TO HAVE RECD CABG W USE OF INTERNAL MAMMARY ARTERY	No pre-authorization is required for all providers.	N/A
G8160	CLINICAN DOCUMENT PAT W/N ELIG FOR CABG W USE OF INTERNAL MAMMARY ARTERY	No pre-authorization is required for all providers.	N/A
G8161	PAT W ISOLATED CABG DOCUMENT TO HAVE RECD PRE-OP BETA-BLOCKADE	No pre-authorization is required for all providers.	N/A
G8163	CLINICIAN DOCUMENT PAT W ISOLATED CABG W/N ELIG FOR PRE-OP BETA-BLOCKADE	No pre-authorization is required for all providers.	N/A
G8191	CLIN DOC ORDER FOR PROPHC ANTIBIOTIC TO BE GIVEN WITHIN 1 HR PRIOR	No pre-authorization is required for all providers.	N/A
G8192	#N/A	No pre-authorization is required for all providers.	N/A
G8194	CLIN DOC PAT WAS NOT ELIGIBLE CANDIDATE FOR PROPHY ANTIBIOTIC	No pre-authorization is required for all providers.	N/A
G8195	CLIN DOC TO HAVE GIVEN PROPHY ANTIBIOTIC W/IN 1 HR PRIOR TO SURG	No pre-authorization is required for all providers.	N/A
G8197	PAT DOC ORDER FOR PROPHY ANTIBIOTIC TO BE GIVEN W/IN 1 HR PRIOR TO SURG	No pre-authorization is required for all providers.	N/A
G8198	PAT DOC ORDER FOR CEFAZOLIN OR CEFUROXIME FOR ANTIMICROBIAL PROPHYLAXIS	No pre-authorization is required for all providers.	N/A
G8199	CLIN DOC ORDER FOR CEFAZOLIN OR CEFUROXIME FOR ANTIMICROBIAL PROPHY	No pre-authorization is required for all providers.	N/A
G8201	PAT NOT ELIGIBLE FOR CEFAZOLIN OR CEFUROXIME FOR ANTIMICROBIAL PROPHY	This is no longer a valid code.	N/A
G8202	CLIN DOC ORDER TO STOP PROPHYC ANTIBIOTICS W/IN 24 HRS OF SURG END	This is no longer a valid code.	N/A
G8203	CLIN DOC PROPHY ANTIBIOTICS WERE STOPPED W/IN 24 HRS OF SURG END TIME	This is no longer a valid code.	N/A
G8205	CLIN DOC PAT NOT ELIG FOR PROPHY ANTIBIOTIC DISC W/IN 24 HRS OF SURG END	This is no longer a valid code.	N/A
G8206	CLIN DOCUMENTED THAT PROPHYLACTIC ANTIBIOTIC WAS GIVEN	This is no longer a valid code.	N/A
G8207	CLIN DOC ORDER GIVEN TO DISC PROPHY ANTIBIOTICS W/IN 48 HRS OF SURG END	No pre-authorization is required for all providers.	N/A
G8208	CLIN DOC PROPHY ANTIBIOTICS STOP W/IN 48 HS OF SURGICAL END TIME	This is no longer a valid code.	N/A
G8210	CLIN DOC PATNOT ELIG PROPHY ANTIBIOTIC DISC W/IN 48 HRS OF SURG END TIME	This is no longer a valid code.	N/A

G8211	CLINICIAN DOCUMENTED THAT A PROPHYLACTIC ANTIBIOTIC WAS GIVEN	This is no longer a valid code.	N/A
G8212	CLIN DOC ORDER GIVEN FOR APPROP VENOUS THROMBOEMBOLISM (VTE) PROPHY	This is no longer a valid code.	N/A
G8213	CLIN DOC GIVEN VTE PROPHY W/IN 24 HRS PRIOR TO OR 24 HRS AFTER SURG	No pre-authorization is required for all providers.	N/A
G8215	CLIN DOC PAT WAS NOT ELIG FOR VENOUS TROMOEMBOLISM (VTE) PROPHY	This is no longer a valid code.	N/A
G8216	PAT DOC TO HAVE RECD DVT PROPHYLAXIS BY END OF HOSP DAY 2	This is no longer a valid code.	N/A
G8218	PT INEL FOR DVT PROPHY BY END OF HOSP DAY 2, INCL PHYS DOC PAT IS AMB	No pre-authorization is required for all providers.	N/A
G8222	PAT DOCUMENTED TO BE PRESCRIBED ANTIPLATELET THERAPY AT DISCHARGE	This is no longer a valid code.	N/A
G8224	CLIN DOC PT INELIG FOR ANTIPLAT THER @ DISCH ID PAT IS ON ANTICOAG THER	This is no longer a valid code.	N/A
G8225	PAT DOCUMENTED TO HAVE BEEN PRESCRIBED ANTICOAGULANT AT DISCHARGE	No pre-authorization is required for all providers.	N/A
G8227	PAT NOT DOC TO HAVE PERM, PERSISTENT, OR PAROXYSMAL ATRIAL FIBRILLATION	This is no longer a valid code.	N/A
G8228	CLIN DOC PAT NOT ELIG FOR ANTICOAGULNT THERAPY AT DISCHARGE	No pre-authorization is required for all providers.	N/A
G8229	PAT DOCUMENTED TO HAVE BEEN ADMINISTERED OR CONSIDERED FOR TPA	This is no longer a valid code.	N/A
G8230	PAT INEL FOR TPA ADMIN, ISCHEMIC STROKE SYMP ONSET OF MORE THAN 3 HRS	No pre-authorization is required for all providers.	N/A
G8232	PAT DOC TO HAVE RECD DYSPH SCR PRIOR TO FOODS, FLUIDS, OR MED BY MOUTH	This is no longer a valid code.	N/A
G8235	PT NOT OR INEL TO RECV FOOD,FLUIDS,OR MED BY MOUTH,OR DOC OF NPO	This is no longer a valid code.	N/A
G8236	CLIN DOC PAT INEL DYSPH SCR PRIOR TO FOODS, FLUIDS, OR MED BY MOUTH	No pre-authorization is required for all providers.	N/A
G8237	PAT DOC HAVE RECD ORDER FOR REHAB SERV OR DOC OF CONS FOR REHAB SERV	This is no longer a valid code.	N/A
G8239	INTERNAL CAROTID STENOSIS PAT BELOW 30%, REF TO MEASURE DISTAL INT	This is no longer a valid code.	N/A
G8241	CLIN DOC THAT PA WHOSE FINAL REP OF CAROTID IMAG STUDY PERFORMED (NECK	No pre-authorization is required for all providers.	N/A
G8242	PAT DOC TO HAVE RECD CT OR MRI W PRESENCE OR ABSENCE OF HEMORRHAGE,	No pre-authorization is required for all providers.	N/A
G8245	CLIN DOCUMENTED PRESENCE OR ABSENCE ALARM SYMPTOMS	This is no longer a valid code.	N/A
G8247	PAT W ALARM SYMPT DOC TO HAVE HAD UPPER ENDOSC PERF OR REFL FOR UP ENDO	This is no longer a valid code.	N/A
G8249	CLIN DOC THAT PAT WAS INEL CANDIDATE FOR UPPER ENDOSCOPY	No pre-authorization is required for all providers.	N/A
G8250	PAT W SUSPICION OF BARRETT'S ESOPHAGUS IN ENDOSCOPY REPORT & DOC	This is no longer a valid code.	N/A
G8252	CLIN DOC THAT PAT INELIBL CANDIDATE FOR ESOPHAGEAL BIOPSY	This is no longer a valid code.	N/A
G8253	PAT DOCUMENTED TO HAVE RECEIVED AN ORDER FOR A BARIUM SWALLOW TEST	No pre-authorization is required for all providers.	N/A
G8255	CLIN DOC THAT PAT WAS ELIG CANDIDATE FOR BARIUM SWALLOW TEST	No pre-authorization is required for all providers.	N/A
G8256	CLIN DOC RECONCILIATION OF DISCHG MEDS W CURRENT MED LIST IN MED REC	This is no longer a valid code.	N/A
G8258	PAT WAS NOT AN ELIG CANDIDATE FOR DISCHARGE MEDICATIONS REVIEW	No pre-authorization is required for all providers.	N/A
G8259	PAT DOC TO HAVE SURROGATE DEC MAKER OR ADVANCE CARE PLAN IN MED REC	This is no longer a valid code.	N/A
G8261	CLIN DOC THAT PAT WAS INEL FOR SURROG DEC MAKER OR ADV CARE PLAN	This is no longer a valid code.	N/A
G8262	PAT DOC TO HAVE BEEN ASSESS FOR PRESENCE OR ABSENCE OF URINARY INCONT	This is no longer a valid code.	N/A
G8264	CLINI DOC PAT INEL CAND FOR ASSESS OF PRESENCE OR ABSENCE OF URINARY	No pre-authorization is required for all providers.	N/A
G8265	PAT DOC TO HAVE RECD CHARACTERIZATION OF URINARY INCONTINENCE	This is no longer a valid code.	N/A
G8267	PAT DOCD TO HAVE RECD A PLAN OF CARE FOR URINARY INCONTINENCE	No pre-authorization is required for all providers.	N/A
G8269	CLIN NOT PROV PT CARE FOR REQ TIME TO DEV PLAN OF CARE FOR URIN INCON	No pre-authorization is required for all providers.	N/A
G8270	PAT DOC TO HAVE RECD SCREEN FOR FALL RISK (2 OR MORE FALLS IN PAST YR OR	This is no longer a valid code.	N/A
G8272	CLINICIAN DOC PAT WAS INELIBL CANDIDATE FOR FALL RISK SCREENING	This is no longer a valid code.	N/A
G8273	CLIN NOT PROV CARE FOR PAT FOR THE REQ TIME TO SCREEN FOR FALL RISK	No pre-authorization is required for all providers.	N/A
G8275	PAT DOC TO HAVE MED HIST TAKEN WH INCL ASSESS OF NEW OR CHANGING MOLES	This is no longer a valid code.	N/A
G8277	PAT INELIBL FOR MED HIST REV W ASSESSMENT OF NEW OR CHANGING MOLES	This is no longer a valid code.	N/A
G8278	PAT DOCUMENTED TO HAVE RECEIVED COMPLETE PHYSICAL SKIN EXAM	No pre-authorization is required for all providers.	N/A
G8280	PAT NOT AN ELIG CANDIDATE FOR COMPLETE PHYSL SKIN EXAM DURING REPT YR	No pre-authorization is required for all providers.	N/A
G8281	PAT DOC TO HAVE RECD COUNSELING TO PERFORM A SELF-EXAMINATION	This is no longer a valid code.	N/A
G8283	PAT INEL FOR COUNSELING TO PERFORM A SELF-EXAMINATION	This is no longer a valid code.	N/A
G8284	PAT DOC TO HAVE RECD PRECRIPT FOR PHARM THER FOR OSTEOPOROSIS	This is no longer a valid code.	N/A
G8286	CLIN DOC PAT INEL CANDIDATE FOR PHARMACOLOGIC THERAPY	This is no longer a valid code.	N/A
G8287	CLIN HAS NOT PROV CARE FOR PAT FOR THE REQ TIME FOR THE PHARM THERAPY	This is no longer a valid code.	N/A
G8288	PAT DOCTO HAVE RECD CALCIUM & VIT D OR COUNSEL ON BOTH CALCIUM & VIT D	No pre-authorization is required for all providers.	N/A
G8290	CLIN DOC PAT INEL FOR CALCIUM & VITAMIN D&EXERCISE DURING REPT YR	This is no longer a valid code.	N/A
G8291	CLIN NOT PROV CARE FOR PAT FOR REQ TIME FOR CALCIUM, VIT D & EXERC	This is no longer a valid code.	N/A
G8292	COPD PAT WITH SPIROMETRY RESULTS DOCUMENTED	This is no longer a valid code.	N/A
G8294	COPD PAT WAS INEL FOR SPIROMETRY RESULTS	This is no longer a valid code.	N/A
G8295	COPD PAT DOCUMENTED TO HAVE RECD INHALED BRONCHODILATOR THRPY	This is no longer a valid code.	N/A
G8297	COPD PAT WAS INELIBL FOR INHALED BRONCHODILATOR THRPY	No pre-authorization is required for all providers.	N/A
G8300	CLIN DOC PAT INEL FOR OPTIC NERVE HEAD EVAL DURING THE REPORTING YEAR	This is no longer a valid code.	N/A
G8301	CLIN NOT PROV CARE FOR PRIMARY OPEN-ANGLE GLAUCOMA PAT FOR REQTIME FOR	This is no longer a valid code.	N/A
G8309	PAT DOC TO HAVE BEEN PRESC RECOMMEND ANTIOXIDANT VITAMIN OR MINERAL	This is no longer a valid code.	N/A
G8311	CLIN DOC PAT INEL FOR ANTIOXIDANT VIT OR MIN SUPPL DUR THE REPORT YR	This is no longer a valid code.	N/A
G8312	CLIN NOT PROV CARE FOR AGE-RELATED MACULAR DEGEN PAT FOR REQ TIME FOR	No pre-authorization is required for all providers.	N/A
G8313	PAT DOC TO HAVE RECED MACULAR EXAM, INCL DOC OF PRESENCE OR ABSENCE OF	This is no longer a valid code.	N/A
G8315	CLIN DOC PAT WAS INEL FOR MACULAR EXAM DURING THE REPORTING YEAR	This is no longer a valid code.	N/A
G8316	CLIN HAS NOT PROV CARE FOR AGE-RELATED MACULAR DEGEN PAT FOR REQ TIME	This is no longer a valid code.	N/A
G8317	PAT DOCUMENTED TO HAVE VISUAL FIELD FUNCTIONAL STATUS ASSESSED	This is no longer a valid code.	N/A
G8319	CLIN DOC THAT PAT INEL FOR ASSESS OF VISUAL FUNCTIONAL STATUS	No pre-authorization is required for all providers.	N/A
G8320	CLIN NOT PROV CARE FOR CATARACT PAT FOR REQ TIME FOR ASSESS OF VISUAL	No pre-authorization is required for all providers.	N/A
G8321	PAT DOC HAD PRE-SURG AXIAL LENGTH, CORNEAL POWER MEASURE & METHOD OF	No pre-authorization is required for all providers.	N/A
G8323	CLIN DOC PAT INEL FOR PRE-SURG AXIAL LENGTH, CORNEAL POWER MEASURE	No pre-authorization is required for all providers.	N/A
G8324	CLIN NOT PROV CARE FOR CATARACT PAT FOR REQ TIME FOR PRE-SURG MEASURE &	No pre-authorization is required for all providers.	N/A
G8325	PAT DOC TO HAVE RECD FUNDUS EVAL W 6 MO PRIOR TO CATARACT SURGERY	No pre-authorization is required for all providers.	N/A
G8327	PAT WAS NOT AN ELIGIBLE CANDIDATE FOR PRE-SURGICAL FUNDUS EVAL	No pre-authorization is required for all providers.	N/A
G8328	CLIN NOT PROV CARE FOR CATARACT PAT FOR REQ TIME FOR FUNDUS EVAL	No pre-authorization is required for all providers.	N/A
G8329	PAT DOC TO HAVE REC DILATED MACULAR OR FUNDUS EXAM W LEVEL OF SEVERITY	No pre-authorization is required for all providers.	N/A
G8331	CLIN DOC PAT INEL FOR DILATED MACULAR OR FUNDUS EXAM DURING THE	No pre-authorization is required for all providers.	N/A
G8332	CLIN NOT PROV CARE FOR DIABETIC RETINOPATHY PAT FOR REQ TIME FOR MACULAR	No pre-authorization is required for all providers.	N/A
G8333	PAT DOC HAD FINDINGS OF MACULAR OR FUNDUS EXAM COMMUNICATED TO PHYS	No pre-authorization is required for all providers.	N/A
G8335	CLIN DOC THAT PAT WAS INEL FOR FINDINGS OF THEIR MACULAR OR FUNDUS	No pre-authorization is required for all providers.	N/A
G8336	CLIN NOT PROV CARE FOR DIABETIC RETINOPATHY PAT FOR REQ TIME FOR PHYS	No pre-authorization is required for all providers.	N/A
G8337	CLIN DOC COMM SENT TO PHYS MANAG CARE OF PAT THAT A FRACT OCCURRED AND	No pre-authorization is required for all providers.	N/A
G8339	PAT INEL FOR COMM W PHYS MANAGING PAT ONGOING CARE THAT A FRACTURE	No pre-authorization is required for all providers.	N/A
G8340	PAT DOC HAD A CENTRAL DEXA PERF & RESULTS DOC OR CENTRAL DEXA ORDERED	No pre-authorization is required for all providers.	N/A
G8342	CLIN DOC PAT WAS INEL FOR CENTRAL DEXA MEASURE OR PRESC PHARMACOL	No pre-authorization is required for all providers.	N/A
G8343	CLIN NOT PROV CARE FOR PAT FOR REQ TIME FOR CENTR DEXA MEASURE OR PHARM	No pre-authorization is required for all providers.	N/A
G8344	PAT DOC HAD CENT DEXA ORDER OR PERFORM & RESLTS DOC OR PHARM THRPY	No pre-authorization is required for all providers.	N/A
G8346	CLIN DOC PAT INEL FOR CENTRAL DEXA MEASURE OR PRESCR PHARMACOLOGIC	No pre-authorization is required for all providers.	N/A
G8347	CLIN NOT PROV CARE FOR PAT FOR REQ TIME FOR CENTRAL DEXA MEASURE OR PHAR	No pre-authorization is required for all providers.	N/A
G8395	LVEF>=40% DOC NORMAL OR MILD	This service is not covered by Superior HealthPlan.	N/A
G8396	LVEF NOT PERFORMED	This service is not covered by Superior HealthPlan.	N/A
G8397	DIL MACULA/FUNDUS EXAM/W DOC	This service is not covered by Superior HealthPlan.	N/A
G8398	DIL MACULAR/FUNDUS NOT PERFO	This service is not covered by Superior HealthPlan.	N/A
G8399	PT W/DXA RESULTS DOCUMENT	This service is not covered by Superior HealthPlan.	N/A
G8400	PT W/DXA NO RESULTS DOC	This service is not covered by Superior HealthPlan.	N/A
G8401	PT INELIG OSTEO SCREEN MEASU	This is no longer a valid code.	N/A
G8404	LOW EXTEMITY NEUR EXAM DOCUM	This service is not covered by Superior HealthPlan.	N/A
G8405	LOW EXTEMITY NEUR NOT PERFOR	This service is not covered by Superior HealthPlan.	N/A
G8406	PT INELIG LOWER EXTREM NEURO	This is no longer a valid code.	N/A
G8410	EVAL ON FOOT DOCUMENTED	This service is not covered by Superior HealthPlan.	N/A
G8415	EVAL ON FOOT NOT PERFORMED	This service is not covered by Superior HealthPlan.	N/A
G8416	PT INELIG FOOTWEAR EVALUATIO	This service is not covered by Superior HealthPlan.	N/A
G8417	CALC BMI ABV UP PARAM F/U	This service is not covered by Superior HealthPlan.	N/A
G8418	CALC BMI BLW LOW PARAM F/U	This service is not covered by Superior HealthPlan.	N/A
G8419	CALC BMI OUT NRM PARAM NOF/U	This service is not covered by Superior HealthPlan.	N/A
G8420	CALC BMI NORM PARAMETERS	This service is not covered by Superior HealthPlan.	N/A
G8421	BMI NOT CALCULATED	This service is not covered by Superior HealthPlan.	N/A
G8422	PT INELIG BMI CALCULATION	This service is not covered by Superior HealthPlan.	N/A
G8427	ELIG CLIN DOC M UPDTD REC PT MEDS	This service is not covered by Superior HealthPlan.	N/A
G8428	CUR MEDS NO DOC ELG CLN RSN NOT GVN	This service is not covered by Superior HealthPlan.	N/A
G8430	EC AT DOC MEDREC PT NOT ELIG	This service is not covered by Superior HealthPlan.	N/A
G8431	SCR CLIN DEPR DOC POS & F/U PLN DOC	No pre-authorization is required for all providers.	N/A
G8432	DEPRESSION SCR NOT DOC RSN NOT GVN	No pre-authorization is required for all providers.	N/A
G8433	SCR FOR DEP NOT CPT DOC RSN	This service is not covered by Superior HealthPlan.	N/A

G8442	PA NO DOC PRF DOC PT NOT ELG PA ENC	This service is not covered by Superior HealthPlan.	N/A
G8450	BETA-BLOC RX PT W/ABN LVEF	This service is not covered by Superior HealthPlan.	N/A
G8451	PT W/ABN LVEF INELIG B-BLOC	This service is not covered by Superior HealthPlan.	N/A
G8452	PT W/ABN LVEF B-BLOC NO RX	This service is not covered by Superior HealthPlan.	N/A
G8458	PT INELIG GENO NO ANTVIR TX	This is no longer a valid code.	N/A
G8459	DOC PT REC ANTVIR TREAT	This is no longer a valid code.	N/A
G8460	PT INELIG RNA NO ANTVIR TX	This is no longer a valid code.	N/A
G8461	PT REC ANTVIR TREAT HEP C	This is no longer a valid code.	N/A
G8462	PT INELIG COUNS NO ANTVIR TX	This is no longer a valid code.	N/A
G8463	PT REC ANTVIRAL TREAT DOC	This is no longer a valid code.	N/A
G8464	PT INELIG LO TO NO DTER RSK	This is no longer a valid code.	N/A
G8465	HIGH RISK RECURRENCE PRO CA	This service is not covered by Superior HealthPlan.	N/A
G8473	ACE/ARB THXPY RX'D	This service is not covered by Superior HealthPlan.	N/A
G8474	ACE/ARB NOT RX'D DOC REAS	This service is not covered by Superior HealthPlan.	N/A
G8475	ACE/ARB THXPY NOT RX'D	This service is not covered by Superior HealthPlan.	N/A
G8476	BP SYS <140 AND DIAS <90	This service is not covered by Superior HealthPlan.	N/A
G8477	BP SYS >=140 AND/OR DIAS >=90	This service is not covered by Superior HealthPlan.	N/A
G8478	BP NOT PERFORMED/DOC	This service is not covered by Superior HealthPlan.	N/A
G8482	FLU IMMUNIZE ORDER/ADMIN	This service is not covered by Superior HealthPlan.	N/A
G8483	FLU IMM NO ADMIN DOC REA	This service is not covered by Superior HealthPlan.	N/A
G8484	FLU IMMUNIZE NO ADMIN	This service is not covered by Superior HealthPlan.	N/A
G8485	REPORT, DIABETES MEASURES	This is no longer a valid code.	N/A
G8486	REPORT PREV CARE MEASURES	This is no longer a valid code.	N/A
G8487	REPORT CKD MEASURES	This is no longer a valid code.	N/A
G8489	CAD MEASURES GRP	This is no longer a valid code.	N/A
G8490	RA MEASURES GRP	This is no longer a valid code.	N/A
G8491	HIV AIDS MEASURES GRP	This is no longer a valid code.	N/A
G8492	PERIOP CARE MEASURES GRP	This is no longer a valid code.	N/A
G8493	BACK PAIN MEASURES GRP	This is no longer a valid code.	N/A
G8494	DM MEAS QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8495	CKD MEAS QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8496	PREV CARE MG QUAL ACT PERFRM	This is no longer a valid code.	N/A
G8497	CABG MEAS QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8498	CAD MEAS QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8499	RA MEAS QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8500	HIV MEAS QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8501	PERIO MEAS QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8502	BACK PAIN MG QUAL ACT PERFRM	This is no longer a valid code.	N/A
G8506	PT REC ACE ARB	This service is not covered by Superior HealthPlan.	N/A
G8509	POS PAIN ASSESS NO F/U DOC	This service is not covered by Superior HealthPlan.	N/A
G8510	SCR DEPR DOC NEG A F/U PLAN NOT RQR	No pre-authorization is required for all providers.	N/A
G8511	SCR DEP DOC POS F/U PLN NO DOC NO R	This service is not covered by Superior HealthPlan.	N/A
G8530	AUTO AV FISTULA RECD	This is no longer a valid code.	N/A
G8531	PT INELIG AUTO AV FISTULA	This is no longer a valid code.	N/A
G8532	NO AUTO AV FISTULA NO REAS	This is no longer a valid code.	N/A
G8535	EM SCR NO D - D PT NOT ELG EM SCR ENC	This service is not covered by Superior HealthPlan.	N/A
G8536	NO DOC ELDER MAL SCRIN	This service is not covered by Superior HealthPlan.	N/A
G8539	DOC FUNCT AND CARE PLAN	This service is not covered by Superior HealthPlan.	N/A
G8540	FNC OC ASMT NO D P D PT NOT ELG ENC	This service is not covered by Superior HealthPlan.	N/A
G8541	NO DOC CUR FUNCT ASSESS	This service is not covered by Superior HealthPlan.	N/A
G8542	DOC FUNCT NO DEFICIENCIES	This service is not covered by Superior HealthPlan.	N/A
G8543	CUR FUNCT ASSES NO CARE PLN	This service is not covered by Superior HealthPlan.	N/A
G8544	CABG MEASURES GRP	This is no longer a valid code.	N/A
G8545	HEPC MEASURES GRP	This is no longer a valid code.	N/A
G8547	IVD MEASURES GRP	This is no longer a valid code.	N/A
G8548	HF MEASURES GRP	This is no longer a valid code.	N/A
G8549	HEPC MG QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8551	HF MG QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8552	IVD MG QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8553	PRESCRIP TRASMIT VIA ERX SY	This is no longer a valid code.	N/A
G8556	REF TO DOC OTOLOG EVAL	This is no longer a valid code.	N/A
G8557	PT INELIG REF OTOLOG EVAL	This is no longer a valid code.	N/A
G8558	NO REF TO DOC OTOLOG EVAL	This is no longer a valid code.	N/A
G8559	PT REF DOC OTO EVAL	This service is not covered by Superior HealthPlan.	N/A
G8560	PT HX ACT DRAIN PREV 90 DAYS	This service is not covered by Superior HealthPlan.	N/A
G8561	PT INELIG FOR REF OTO EVAL	This service is not covered by Superior HealthPlan.	N/A
G8562	PT NO HX ACT DRAIN 90 D	This service is not covered by Superior HealthPlan.	N/A
G8563	PT NO REF OTO REAS NO SPEC	This service is not covered by Superior HealthPlan.	N/A
G8564	PT REF OTO EVAL	This service is not covered by Superior HealthPlan.	N/A
G8565	VER DOC HEAR LOSS	This service is not covered by Superior HealthPlan.	N/A
G8566	PT INELIG REF OTO EVAL	This service is not covered by Superior HealthPlan.	N/A
G8567	PT NO DOC HEAR LOSS	This service is not covered by Superior HealthPlan.	N/A
G8568	PT NO REF OTOLO NO SPEC	This service is not covered by Superior HealthPlan.	N/A
G8569	PROL INTUBATION REQ	This service is not covered by Superior HealthPlan.	N/A
G8570	NO PROL INTUB REQ	This service is not covered by Superior HealthPlan.	N/A
G8571	STER WD IFX 30 D POSTOP	This service is not covered by Superior HealthPlan.	N/A
G8572	NO STER WD IFX	This service is not covered by Superior HealthPlan.	N/A
G8573	STK CABG	This service is not covered by Superior HealthPlan.	N/A
G8574	NO STRK CABG	This service is not covered by Superior HealthPlan.	N/A
G8575	POSTOP REN FAIL	This service is not covered by Superior HealthPlan.	N/A
G8576	NO POSTOP REN FAIL	This service is not covered by Superior HealthPlan.	N/A
G8577	REOP REQ BLD GRFT OTH	This service is not covered by Superior HealthPlan.	N/A
G8578	NO REOP REQ BLD GRFT OTH	This service is not covered by Superior HealthPlan.	N/A
G8579	ANTPLT MED DISCH	This is no longer a valid code.	N/A
G8580	ANTPLT MED CONTRAIND	This is no longer a valid code.	N/A
G8581	NO ANTPLT MED DISCH	This is no longer a valid code.	N/A
G8582	BBLOCK DISCH	This is no longer a valid code.	N/A
G8583	BBLOCK CONTRAIND	This is no longer a valid code.	N/A
G8584	NO BBLOCK DISCH	This is no longer a valid code.	N/A
G8585	ANTILIPID TREAT DISCH	This is no longer a valid code.	N/A
G8586	ANTLIP DISCH CONTRA	This is no longer a valid code.	N/A
G8587	NO ANTLIPID TREAT DISCH	This is no longer a valid code.	N/A
G8588	SYS BP <140	This is no longer a valid code.	N/A
G8589	SYS BP >= 140	This is no longer a valid code.	N/A
G8590	DIA BP < 90	This is no longer a valid code.	N/A
G8591	DIA BP >= 90	This is no longer a valid code.	N/A
G8592	NO BP MEASURE	This is no longer a valid code.	N/A
G8593	LIPID PN RESULTS	This is no longer a valid code.	N/A
G8594	NO LIPID PROF PERF	This is no longer a valid code.	N/A
G8595	LDL < 100	This is no longer a valid code.	N/A
G8596	NO LDL PERF	This is no longer a valid code.	N/A
G8597	LDL >= 100	This is no longer a valid code.	N/A
G8598	ASPIRIN/ANOTHER ANTIPLATELT TX USED	This service is not covered by Superior HealthPlan.	N/A
G8599	ASP/OTH ANTITHROMB NOT USED NO RSN	This service is not covered by Superior HealthPlan.	N/A
G8600	TPA INITI W/IN 3 HRS	This service is not covered by Superior HealthPlan.	N/A
G8601	NO ELIG TPA INIT W/IN 3 HRS	This service is not covered by Superior HealthPlan.	N/A
G8602	NO TPA INIT W/IN 3 HRS	This service is not covered by Superior HealthPlan.	N/A
G8603	SPOK LANG COMP SCORE	This is no longer a valid code.	N/A
G8604	NO HIGH SCORE SPOK LANG	This is no longer a valid code.	N/A
G8605	NO SPOK LANG COMP SCORE	This is no longer a valid code.	N/A
G8606	ATTENTION SCORE	This is no longer a valid code.	N/A

G8607	NO HIGH SCORE ATTENTION	This is no longer a valid code.	N/A
G8608	NO ATTENTION SCORE	This is no longer a valid code.	N/A
G8609	MEMORY SCORE	This is no longer a valid code.	N/A
G8610	NO HIGH SCORE MEMORY	This is no longer a valid code.	N/A
G8611	NO MEMORY SCORE	This is no longer a valid code.	N/A
G8612	MOTO SPEECH SCORE	This is no longer a valid code.	N/A
G8613	NO HIGH SCORE MOTO SPEECH	This is no longer a valid code.	N/A
G8614	NO MOTO SPEECH SCORE	This is no longer a valid code.	N/A
G8615	READING SCORE	This is no longer a valid code.	N/A
G8616	NO HIGH SCORE READING	This is no longer a valid code.	N/A
G8617	NO READING SCORE	This is no longer a valid code.	N/A
G8618	SPOK LANG EXP SCORE	This is no longer a valid code.	N/A
G8619	NO HIGH SCORE SPOK LANG EXP	This is no longer a valid code.	N/A
G8620	NO SPOK LANG EXP SCORE	This is no longer a valid code.	N/A
G8621	WRITING SCORE	This is no longer a valid code.	N/A
G8622	NO HIGH SCORE WRITING	This is no longer a valid code.	N/A
G8623	NO WRITING SCORE	This is no longer a valid code.	N/A
G8624	SWALLOWING SCORE	This is no longer a valid code.	N/A
G8625	NO HIGH SCORE SWALLOWING	This is no longer a valid code.	N/A
G8626	NO SWALLOWING SCORE	This is no longer a valid code.	N/A
G8627	SURG PROC W/IN 30 DAYS	This service is not covered by Superior HealthPlan.	N/A
G8628	NO SURG PROC W/IN 30 DAYS	This service is not covered by Superior HealthPlan.	N/A
G8629	DOC ANTIBIO ORDER B/4 SURG	This is no longer a valid code.	N/A
G8630	DOC ANTIBIO GIVEN B/4 SURG	This is no longer a valid code.	N/A
G8631	PT NO ELG 4 ORDER ANTI BI GIVE	This is no longer a valid code.	N/A
G8632	DOC NO ANTI BI ORDER B/4 SURG	This is no longer a valid code.	N/A
G8634	PT NO ELG PHAR THER OSTEO	This is no longer a valid code.	N/A
G8645	ASTHMA MEASURES GRP	This is no longer a valid code.	N/A
G8646	ASTHMA MG QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8682	LVG TEST PERF	This is no longer a valid code.	N/A
G8683	PT NOT ELIG FOR LVF TEST	This is no longer a valid code.	N/A
G8685	LVF TEST NOT PERF	This is no longer a valid code.	N/A
G8696	ANTITHROMB THX PRESC	This is no longer a valid code.	N/A
G8697	ANTITHROMBOTIC TX NOT PRSC DOC RSN	This is no longer a valid code.	N/A
G8698	ANTITHROMB NO PRESC NO REAS	This is no longer a valid code.	N/A
G8699	REHAB ORDERED DISCH	This is no longer a valid code.	N/A
G8700	REHAB NOT INDICATED DISCH	This is no longer a valid code.	N/A
G8701	REHAB NOT ORDERED	This is no longer a valid code.	N/A
G8702	ANTIBIOTICS 4 HR PRIOR SURG	This is no longer a valid code.	N/A
G8703	ANTIBIOTICS NOT PRIOR SURG	This is no longer a valid code.	N/A
G8704	ECG PERFORMED	This is no longer a valid code.	N/A
G8705	MED REAS NO ECG	This is no longer a valid code.	N/A
G8706	PT REAS NO ECG	This is no longer a valid code.	N/A
G8707	ECG NOT PERFORMED	This is no longer a valid code.	N/A
G8713	SPKT/V GREAT 1.2 KT/V	This is no longer a valid code.	N/A
G8714	HEMODIALYSIS 3 TIMES WEEK	This is no longer a valid code.	N/A
G8717	LESS 1.2 KT/V	This is no longer a valid code.	N/A
G8718	GREAT 1.7 KT/V PER WEEK	This is no longer a valid code.	N/A
G8720	LESS 1.7 KT/V PER WEEK	This is no longer a valid code.	N/A
G8725	LIPID PROFILE PERF DOC	This is no longer a valid code.	N/A
G8726	DOC REAS NO LIPID PROFILE	This is no longer a valid code.	N/A
G8728	LIPID PROFILE NOT PERF	This is no longer a valid code.	N/A
G8736	LDL-C <100MG/DL	This is no longer a valid code.	N/A
G8737	LDL-C >=100MG/DL	This is no longer a valid code.	N/A
G8738	LVEF < 40 PERCENT	This is no longer a valid code.	N/A
G8739	LVEF >= 40 PERCENT	This is no longer a valid code.	N/A
G8740	LVEF NOT PERFRMD	This is no longer a valid code.	N/A
G8751	SMKG STATUS NOT ASSESS	This is no longer a valid code.	N/A
G8757	COPD MG QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8758	IBD MG QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8759	OSA MG QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8761	DEMENTIA MG QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8762	PD MG QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8763	HYPERTEN MG QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8764	CAR PREV MG QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8765	CATARACT MG QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8767	LIPID PANEL RES DOC REV	This is no longer a valid code.	N/A
G8768	DOC MED REAS NO LIPID PROFLE	This is no longer a valid code.	N/A
G8769	LIPID PROFILE NOT PERFORM	This is no longer a valid code.	N/A
G8770	URINE PROTEIN TEST DOC REV	This is no longer a valid code.	N/A
G8771	DOC DX CKD	This is no longer a valid code.	N/A
G8772	DOC MED REAS NO URINE PROTN	This is no longer a valid code.	N/A
G8773	NO URINE PROTEIN TEST	This is no longer a valid code.	N/A
G8774	SERUM CREATININE DOC REV	This is no longer a valid code.	N/A
G8775	DOC MED REAS NO SERUM CRTN	This is no longer a valid code.	N/A
G8776	S-CR TEST NOT PERF RSN NOT GIVEN	This is no longer a valid code.	N/A
G8777	DIABETES SCREEN	This is no longer a valid code.	N/A
G8778	DOC MED REAS NO DIABETE SCRIN	This is no longer a valid code.	N/A
G8779	NO DIABETES SCREEN	This is no longer a valid code.	N/A
G8780	COUNSEL DIET PHYS ACTIVITY	This is no longer a valid code.	N/A
G8781	DOC MED REAS NO COUNSEL DIET	This is no longer a valid code.	N/A
G8782	NO COUNSEL DIET PHYS ACT	This is no longer a valid code.	N/A
G8784	PT NO ELIG FOR BP ASSESS	This is no longer a valid code.	N/A
G8848	MILD OSA	This is no longer a valid code.	N/A
G8853	POS AIR PRESS NOT PRESCRIBE	This is no longer a valid code.	N/A
G8859	CORTICOSTEROIDS 10MG 60 DAYS	This is no longer a valid code.	N/A
G8860	CORTICOSTEROID 10 MG 60 DAYS	This is no longer a valid code.	N/A
G8862	NO CORTICOSTRD 10MG 60 DAYS	This is no longer a valid code.	N/A
G8868	1ST COURSE ANTIITNF	This is no longer a valid code.	N/A
G8870	HEPB ADMIN 1ST ANTIITNF	This is no longer a valid code.	N/A
G8871	NO 1ST ANTIITNF	This is no longer a valid code.	N/A
G8879	NODE NEG INV BRST CNCR	This is no longer a valid code.	N/A
G8886	BP UNDER CONTROL	This is no longer a valid code.	N/A
G8887	DOC MED REAS BP NOT CONTROL	This is no longer a valid code.	N/A
G8888	BP NOT UNDER CONTROL	This is no longer a valid code.	N/A
G8889	NO DOC BP	This is no longer a valid code.	N/A
G8890	LDL-C UNDER CONTROL	This is no longer a valid code.	N/A
G8891	DOC MED REAS NO LDL-C CONTRL	This is no longer a valid code.	N/A
G8892	DOC MED REAS NO LDL-C TEST	This is no longer a valid code.	N/A
G8893	LDL-C NOT UNDER CONTROL	This is no longer a valid code.	N/A
G8894	LDL-C NOT PERFORMED	This is no longer a valid code.	N/A
G8895	ANTROM PRESCRIBE	This is no longer a valid code.	N/A
G8896	DOC MED REAS NO ANTIHTROM	This is no longer a valid code.	N/A
G8897	ANTITHROM NOT PRESCRIBE	This is no longer a valid code.	N/A
G8898	COPD MEASURES GROUP	This is no longer a valid code.	N/A
G8899	INFLAMMATORY BOWEL DIS MG	This is no longer a valid code.	N/A
G8900	OBSTRUCTIVE SLEEP APNEA MG	This is no longer a valid code.	N/A
G8902	DEMENTIA MEASURES GROUP	This is no longer a valid code.	N/A
G8903	PARKINSON,S DISEASE MG	This is no longer a valid code.	N/A
G8904	HYPERTENSION MG	This is no longer a valid code.	N/A
G8905	CARDIOVASCULAR PREVENTION MG	This is no longer a valid code.	N/A

G8906	CATARACT MEASURES GROUP	This is no longer a valid code.	N/A
G8919	MST RCNT SYS BP <140MMHG	This is no longer a valid code.	N/A
G8920	MST RCNT SYS BP >=140MMHG	This is no longer a valid code.	N/A
G8921	MST RCNT DIA BP <90MMHG	This is no longer a valid code.	N/A
G8922	MST RCNT DIA BP >=90MMHG	This is no longer a valid code.	N/A
G8923	LVEF < 40% OR LVSD	This service is not covered by Superior HealthPlan.	N/A
G8924	SP TR FEV1 >= 60% FEV1/FVC >= 70%	This service is not covered by Superior HealthPlan.	N/A
G8925	SP TR FEV1 >= 60% FEV1/FVC >= 70%	This service is not covered by Superior HealthPlan.	N/A
G8926	SPIRO NO PERF OR DOC	This service is not covered by Superior HealthPlan.	N/A
G8927	ADJ CHEM PRES AJCC III	This is no longer a valid code.	N/A
G8928	ADJ CHEM NOT PRES RSN SPEC	This is no longer a valid code.	N/A
G8929	ADJ CMO NOT PRES RSN NOT GVN	This is no longer a valid code.	N/A
G8930	ASSESS OF DEP @ INITIAL EVAL	This is no longer a valid code.	N/A
G8931	ASSESS OF DEP NOT DOCUMENTED	This is no longer a valid code.	N/A
G8932	SUICD RSK ASSESSED INIT EVAL	This is no longer a valid code.	N/A
G8933	SUICIDE RISK NOT ASSESSED	This is no longer a valid code.	N/A
G8934	LVEF <40% OR DEP LV SYS FCN	This service is not covered by Superior HealthPlan.	N/A
G8935	RX ACE OR ARB THERAPY	This service is not covered by Superior HealthPlan.	N/A
G8936	PT NOT ELIGIBLE ACE/ARB	This service is not covered by Superior HealthPlan.	N/A
G8937	NO RX ACE/ARB THERAPY	This service is not covered by Superior HealthPlan.	N/A
G8938	BMI DOC ONL FUP NT DOC	This service is not covered by Superior HealthPlan.	N/A
G8939	PA D P FU PL NOT D D PT NOT ELG ENC	This service is not covered by Superior HealthPlan.	N/A
G8940	SRN CLIN DEP DOC NO F/U PLN	This is no longer a valid code.	N/A
G8941	ELD MAL SCR POS F/U NOT DOC NOT ELG	This service is not covered by Superior HealthPlan.	N/A
G8942	DOC FCN/CARE PLAN W/30 DAYS	This service is not covered by Superior HealthPlan.	N/A
G8943	LDLC NOT PRES W/ 12 MO PRIR	This is no longer a valid code.	N/A
G8944	AJCC MEL CNR STG 0 - IIC	This service is not covered by Superior HealthPlan.	N/A
G8945	ANEURYSM <=6 CM FOR MEN	This is no longer a valid code.	N/A
G8946	MIBM BUT NO DX OF BREAST CA	This service is not covered by Superior HealthPlan.	N/A
G8947	1 OR MORE NEUROPSYCH	This is no longer a valid code.	N/A
G8948	NO NEUROPSYCH SYMPTOMS	This is no longer a valid code.	N/A
G8949	DOC PT REAS ON COUNSEL DIET	This is no longer a valid code.	N/A
G8950	PRE-HTN OR HTN DOC, F/U INDC	This service is not covered by Superior HealthPlan.	N/A
G8951	PRE-HTN/HTN DOC, NO PT F/U	This is no longer a valid code.	N/A
G8952	PRE-HTN/HTN, NO F/U, NOT GVN	This service is not covered by Superior HealthPlan.	N/A
G8953	ONCOLOGY MG QUAL ACT PERFORM	This is no longer a valid code.	N/A
G8954	PT DATA RPT QUAL CLIN DB REG	This is no longer a valid code.	N/A
G8955	MOST RECENT ASSESS VOL MGMT	This service is not covered by Superior HealthPlan.	N/A
G8956	PT RCV HEDIA OUTPT DYLS FAC	This service is not covered by Superior HealthPlan.	N/A
G8957	PT NO HEDIA IN OUTPT FAC	This is no longer a valid code.	N/A
G8958	ASSESS VOL MGMT NOT DOC	This service is not covered by Superior HealthPlan.	N/A
G8959	CLIN TX MDD COMM TO TX CLIN	This service is not covered by Superior HealthPlan.	N/A
G8960	CLIN TX MDD NOT COMM	This service is not covered by Superior HealthPlan.	N/A
G8961	CSIT LOWRISK SURG PTS PREOP	This service is not covered by Superior HealthPlan.	N/A
G8962	CSIT ON PT ANY REAS 30 DAYS	This service is not covered by Superior HealthPlan.	N/A
G8963	CSI PER ASX PT W/PCI 2 YRS	This service is not covered by Superior HealthPlan.	N/A
G8964	CSI ANY OTHER THAN PCI 2 YR	This service is not covered by Superior HealthPlan.	N/A
G8965	CSIT PERF ON LOW CHD RSK	This service is not covered by Superior HealthPlan.	N/A
G8966	CSIT PERF SX OR HIGH CHD RSK	This service is not covered by Superior HealthPlan.	N/A
G8967	WARFARIN/ANR FDA APRV ORAL AC PRESC	This service is not covered by Superior HealthPlan.	N/A
G8968	DOC M RSN NOT RX WAR/ANR FDA-APV AC	This service is not covered by Superior HealthPlan.	N/A
G8969	DOC PT RSN NOT RX WAR/OTHER PREV TE	This service is not covered by Superior HealthPlan.	N/A
G8970	NO RSK FAC OR 1 MOD RISK TE	This service is not covered by Superior HealthPlan.	N/A
G8971	WARFRN OR OTHR ANTCDG NO RX	This is no longer a valid code.	N/A
G8972	1>=RISK OR>= MOD RISK FOR TE	This is no longer a valid code.	N/A
G8973	MST RCNT HBB < 10G/DL	This service is not covered by Superior HealthPlan.	N/A
G8974	HGB NOT DOC RNS NOT GVN	This service is not covered by Superior HealthPlan.	N/A
G8975	HGB <10G/DL, MED RSN	This service is not covered by Superior HealthPlan.	N/A
G8976	HGB >= 10 G/DL	This service is not covered by Superior HealthPlan.	N/A
G8977	ONCOLOGY MEASURES GRP	This is no longer a valid code.	N/A
G8978	MOBILITY CURRENT STATUS	This service is not covered by Superior HealthPlan.	N/A
G8979	MOBILITY GOAL STATUS	This service is not covered by Superior HealthPlan.	N/A
G8980	MOBILITY D/C STATUS	This service is not covered by Superior HealthPlan.	N/A
G8981	BODY POS CURRENT STATUS	This service is not covered by Superior HealthPlan.	N/A
G8982	BODY POS GOAL STATUS	This service is not covered by Superior HealthPlan.	N/A
G8983	BODY POS D/C STATUS	This service is not covered by Superior HealthPlan.	N/A
G8984	CARRY CURRENT STATUS	This service is not covered by Superior HealthPlan.	N/A
G8985	CARRY GOAL STATUS	This service is not covered by Superior HealthPlan.	N/A
G8986	CARRY D/C STATUS	This service is not covered by Superior HealthPlan.	N/A
G8987	SELF CARE CURRENT STATUS	This service is not covered by Superior HealthPlan.	N/A
G8988	SELF CARE GOAL STATUS	This service is not covered by Superior HealthPlan.	N/A
G8989	SELF CARE D/C STATUS	This service is not covered by Superior HealthPlan.	N/A
G8990	OTHER PT/OT CURRENT STATUS	This service is not covered by Superior HealthPlan.	N/A
G8991	OTHER PT/OT GOAL STATUS	This service is not covered by Superior HealthPlan.	N/A
G8992	OTHER PT/OT D/C STATUS	This service is not covered by Superior HealthPlan.	N/A
G8993	SUB PT/OT CURRENT STATUS	This service is not covered by Superior HealthPlan.	N/A
G8994	SUB PT/OT GOAL STATUS	This service is not covered by Superior HealthPlan.	N/A
G8995	SUB PT/OT D/C STATUS	This service is not covered by Superior HealthPlan.	N/A
G8996	SWALLOW CURRENT STATUS	This service is not covered by Superior HealthPlan.	N/A
G8997	SWALLOW GOAL STATUS	This service is not covered by Superior HealthPlan.	N/A
G8998	SWALLOW D/C STATUS	This service is not covered by Superior HealthPlan.	N/A
G8999	MOTOR SPEECH CURRENT STATUS	This service is not covered by Superior HealthPlan.	N/A
G9001	COORDINATED CARE FEE INITIAL RATE	This service is not covered by Superior HealthPlan.	N/A
G9002	COORDINATED CARE FEE MAINT RATE	This service is not covered by Superior HealthPlan.	N/A
G9003	COORD CARE FEE RISK ADJUSTD HI INIT	This service is not covered by Superior HealthPlan.	N/A
G9004	COORD CARE FEE RISK ADJUSTD LW INIT	This service is not covered by Superior HealthPlan.	N/A
G9005	COORD CARE FEE RISK ADJUSTED MAINT	This service is not covered by Superior HealthPlan.	N/A
G9006	COORD CARE FEE HOME MONITORING	This service is not covered by Superior HealthPlan.	N/A
G9007	COORD CARE FEE SCHEDULE TEAM CONF	This service is not covered by Superior HealthPlan.	N/A
G9008	COORD CARE FEE PHYS OVSIGHT SRVC	This service is not covered by Superior HealthPlan.	N/A
G9009	COORD CARE FEE RISK ADJ MAINT LVL 3	This service is not covered by Superior HealthPlan.	N/A
G9010	COORD CARE FEE RISK ADJ MAINT LVL 4	This service is not covered by Superior HealthPlan.	N/A
G9011	COORD CARE FEE RISK ADJ MAINT LVL 5	This service is not covered by Superior HealthPlan.	N/A
G9012	OTH SPEC CASE MGMT SERVICE NEC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9013	ESRD DEMO BASIC BUNDLE LEVEL I	This service is not covered by Superior HealthPlan.	N/A
G9014	ESRD DEMO EXPND BUNDLE INCL VENOUS ACSS&REL SRVC	This service is not covered by Superior HealthPlan.	N/A
G9016	SMOKNG CESS CNSLG-W/WO OTH E&M/SESS	This service is not covered by Superior HealthPlan.	N/A
G9017	AMANTADINE HYDROCHLORIDE ORAL PER 100 MG	This service is not covered by Superior HealthPlan.	N/A
G9018	ZANAMIVIR INHAL POWDR ADMIN THRU INHAL PER 10 MG	No pre-authorization is required for all providers.	N/A
G9019	OSELTAMIVIR PHOSPHATE ORAL PER 75 MG	No pre-authorization is required for all providers.	N/A
G9020	RIMANTADINE HYDROCHLORIDE ORAL PER 100 MG	This service is not covered by Superior HealthPlan.	N/A
G9021	CHEMO ASSESS NV AT TIME CHEMO LEVEL 1: NOT AT ALL	No pre-authorization is required for all providers.	N/A
G9022	CHEMO ASSESS NV AT TIME CHEMO LEVEL 2: LITTLE	No pre-authorization is required for all providers.	N/A
G9023	CHEMO ASSESS NV AT TIME CHEMO LEVEL 3: QUITE BIT	No pre-authorization is required for all providers.	N/A
G9024	CHEMO ASSESS NV AT TIME CHEMO LEVEL 4: VERY MUCH	This is no longer a valid code.	N/A
G9025	CHEMO ASSESS PAIN AT TIME CHEMO LVL 1:NOT AT ALL	No pre-authorization is required for all providers.	N/A
G9026	CHEMO ASSESS PAIN AT TIME CHEMO LVL 2: LITTLE	This is no longer a valid code.	N/A
G9027	CHEMO ASSESS PAIN AT TIME CHEMO LVL 3: QUITE BIT	No pre-authorization is required for all providers.	N/A
G9028	CHEMO ASSESS PAIN AT TIME CHEMO LVL 4: VERY MUCH	This is no longer a valid code.	N/A
G9029	CHEMO ASSESS FATIGUE TIME CHEMO LVL 1:NOT AT ALL	This is no longer a valid code.	N/A
G9030	CHEMO ASSESS FATIGUE TIME CHEMO LVL 2: LITTLE	This is no longer a valid code.	N/A

G9031	CHEMO ASSESS FATIGUE TIME CHEMO LVL 3: QUITE BIT	This is no longer a valid code.	N/A
G9032	CHEMO ASSESS FATIGUE TIME CHEMO LVL 4: VRY MUCH	No pre-authorization is required for all providers.	N/A
G9033	AMANTADINE HYDROCHLORIDE ORAL BRAND /100 MG	This service is not covered by Superior HealthPlan.	N/A
G9034	SERVICES PROVIDED BY OCCUPATIONAL THERAPIST	This service is not covered by Superior HealthPlan.	N/A
G9035	SRVC PROV BY ORIENTATION AND MOBILITY SPECIALIST	This service is not covered by Superior HealthPlan.	N/A
G9036	SERVICES PROVIDED BY LOW VISION THERAPIST	This service is not covered by Superior HealthPlan.	N/A
G9037	SERVICES PROVIDED BY REHABILITATION TEACHER	This is no longer a valid code.	N/A
G9050	ONCOLOGY VISIT WORK UP & EVAL OR STAGING AT TIME OF CANCER DX OR RECURRE	This service is not covered by Superior HealthPlan.	N/A
G9051	ONCOLOGY VISIT TREATMENT DECISION MAKING AFTER DISEASE IS STAGED OR REST	This service is not covered by Superior HealthPlan.	N/A
G9052	ONCOLOGY VISIT SURVEILLANCE FOR DISEASE RECURRENCE FOR PAT WHO HAS COMPL	This service is not covered by Superior HealthPlan.	N/A
G9053	ONCOLOGY VISIT EXPECTANT MGMT OF PAT W EVIDENCE OF CANCER FOR WHOM NO CA	This service is not covered by Superior HealthPlan.	N/A
G9054	ONCOLOGY VISIT SUPERVISION COORDINATING OR MANAGING OF CARE OF PAT W TER	This service is not covered by Superior HealthPlan.	N/A
G9055	ONCOLOGY VISIT OTHER UNSPECIFIED SERVICE NOT OTHERWISE LISTED	This service is not covered by Superior HealthPlan.	N/A
G9056	ONCOLOGY PRACT GUIDELINES MGMT ADHERES TO GUIDELINES	This service is not covered by Superior HealthPlan.	N/A
G9057	ONCOLOGY PRACT GUIDELINES MGMT DIFFERS FROM GUIDELINES AS RESULT OF PAT	This service is not covered by Superior HealthPlan.	N/A
G9058	ONCOLOGY PRACT GUIDELINES MGMT DIFFERS FROM GUIDELINES BECAUSE THE TREAT	This service is not covered by Superior HealthPlan.	N/A
G9059	ONCOLOGY PRACT GUIDELINES MGMT DIFFERS FROM GUIDELINES BECAUSE THE PATIE	This service is not covered by Superior HealthPlan.	N/A
G9060	ONCOLOGY PRACT GUIDELINES	This service is not covered by Superior HealthPlan.	N/A
G9061	ONCOLOGY PRACT GUIDELINES	This service is not covered by Superior HealthPlan.	N/A
G9062	ONCOLOGY PRACT GUIDELINES	This service is not covered by Superior HealthPlan.	N/A
G9063	ONCOLOGY DISEASE STATUS LIMITED TO NON SMALL CELL LUNG CANCER	This service is not covered by Superior HealthPlan.	N/A
G9064	ONCOLOGY DISEASE STATUS LIMITED TO NON SMALL CELL LUNG CANCER	This service is not covered by Superior HealthPlan.	N/A
G9065	ONCOLOGY DISEASE STATUS LIMITED TO NON SMALL CELL LUNG CANCER	This service is not covered by Superior HealthPlan.	N/A
G9066	ONCOLOGY DISEASE STATUS LIMITED TO NON SMALL CELL LUNG CANCER	This service is not covered by Superior HealthPlan.	N/A
G9067	ONCOL, DISEASE STAT, LIMITED TO NON SM CELL LUNG CANCER, STAGING IN PROGR	This service is not covered by Superior HealthPlan.	N/A
G9068	ONCOLOGY DISEASE STATUS LIMITED TO SMALL CELL & COMBINED SMALL/NON SMAL	This service is not covered by Superior HealthPlan.	N/A
G9070	ONCOL, DISEASE STAT, LIMITED TO NON SM CELL & COMBINED SM CELL LUNG CANCER	This service is not covered by Superior HealthPlan.	N/A
G9071	ONCOLOGY DISEASE STATUS INVASIVE FEMALE BREAST CANCER	This service is not covered by Superior HealthPlan.	N/A
G9072	ONCOLOGY DISEASE STATUS INVASIVE FEMALE BREAST CANCER	This service is not covered by Superior HealthPlan.	N/A
G9073	ONCOLOGY DISEASE STATUS INVASIVE FEMALE BREAST CANCER	This service is not covered by Superior HealthPlan.	N/A
G9074	ONCOLOGY DISEASE STATUS INVASIVE FEMALE BREAST CANCER	This service is not covered by Superior HealthPlan.	N/A
G9075	ONCOLOGY DISEASE STATUS INVASIVE FEMALE BREAST CANCER	This service is not covered by Superior HealthPlan.	N/A
G9076	ONCOLOGY DISEASE STATUS INVASIVE FEMALE BREAST CANCER	This is no longer a valid code.	N/A
G9077	ONCOLOGY DISEASE STATUS PROSTATE CANCER	This service is not covered by Superior HealthPlan.	N/A
G9078	ONCOLOGY DISEASE STATUS PROSTATE CANCER	This service is not covered by Superior HealthPlan.	N/A
G9079	ONCOLOGY DISEASE STATUS PROSTATE CANCER	This service is not covered by Superior HealthPlan.	N/A
G9081	ONCOLOGY DISEASE STATUS PROSTATE CANCER	No pre-authorization is required for all providers.	N/A
G9082	ONCOLOGY DISEASE STATUS PROSTATE CANCER	No pre-authorization is required for all providers.	N/A
G9083	ONCOL DISEASE STAT, PROSTATE CANCER, LIMITED TO ADENOCARCINOMA AFTER INIT	This service is not covered by Superior HealthPlan.	N/A
G9084	ONCOLOGY DISEASE STATUS COLON CANCER	This service is not covered by Superior HealthPlan.	N/A
G9085	ONCOLOGY DISEASE STATUS COLON CANCER	This service is not covered by Superior HealthPlan.	N/A
G9086	ONCOLOGY DISEASE STATUS COLON CANCER	This service is not covered by Superior HealthPlan.	N/A
G9087	ONCOLOGY DISEASE STATUS COLON CANCER	This service is not covered by Superior HealthPlan.	N/A
G9088	ONCOLOGY DISEASE STATUS COLON CANCER	This service is not covered by Superior HealthPlan.	N/A
G9089	ONCOL, DISEASE STAT, RECTAL CANCER, LIMITED TO INVASIVE CANCER, ADENOCARC	This service is not covered by Superior HealthPlan.	N/A
G9090	ONCOLOGY DISEASE STATUS RECTAL CANCER	This service is not covered by Superior HealthPlan.	N/A
G9091	ONCOLOGY DISEASE STATUS RECTAL CANCER	This service is not covered by Superior HealthPlan.	N/A
G9092	ONCOLOGY DISEASE STATUS RECTAL CANCER	This service is not covered by Superior HealthPlan.	N/A
G9093	ONCOLOGY DISEASE STATUS RECTAL CANCER	This service is not covered by Superior HealthPlan.	N/A
G9094	ONCOLOGY DISEASE STATUS RECTAL CANCER	This service is not covered by Superior HealthPlan.	N/A
G9095	ONCOL, DISEASE STAT, RECTAL CANCER, LIMITED TO INVASIVE, STAGING PROGRESS	This service is not covered by Superior HealthPlan.	N/A
G9096	ONCOLOGY DISEASE STATUS ESOPHAGEAL CANCER	This service is not covered by Superior HealthPlan.	N/A
G9097	ONCOLOGY DISEASE STATUS ESOPHAGEAL CANCER	This service is not covered by Superior HealthPlan.	N/A
G9098	ONCOLOGY DISEASE STATUS ESOPHAGEAL CANCER	This service is not covered by Superior HealthPlan.	N/A
G9099	ONCOL, DISEASE STAT, ESOPHAGEAL CANCER, LIMITED TO ADENOCARCINOMA	This service is not covered by Superior HealthPlan.	N/A
G9100	ONCOLOGY DISEASE STATUS GASTRIC CANCER	This service is not covered by Superior HealthPlan.	N/A
G9101	ONCOLOGY DISEASE STATUS GASTRIC CANCER	This service is not covered by Superior HealthPlan.	N/A
G9102	ONCOLOGY DISEASE STATUS GASTRIC CANCER	This service is not covered by Superior HealthPlan.	N/A
G9103	ONCOLOGY DISEASE STATUS GASTRIC CANCER	This service is not covered by Superior HealthPlan.	N/A
G9104	ONCOL, DISEASE STAT, GASTRIC CANCER, LIMITED TO ADENOCARCINOMA AS PREDOM	This service is not covered by Superior HealthPlan.	N/A
G9105	ONCOLOGY DISEASE STATUS PANCREATIC CANCER	This service is not covered by Superior HealthPlan.	N/A
G9106	ONCOLOGY DISEASE STATUS PANCREATIC CANCER	This service is not covered by Superior HealthPlan.	N/A
G9107	ONCOLOGY DISEASE STATUS PANCREATIC CANCER	This service is not covered by Superior HealthPlan.	N/A
G9108	ONCOL, DISEASE STAT, PANCREATIC CANCER, LIMITED TO ADENOCARCINOMA	This service is not covered by Superior HealthPlan.	N/A
G9109	ONCOLOGY DISEASE STATUS HEAD & NECK CANCER	This service is not covered by Superior HealthPlan.	N/A
G9110	ONCOLOGY DISEASE STATUS HEAD & NECK CANCER	This service is not covered by Superior HealthPlan.	N/A
G9111	ONCOLOGY DISEASE STATUS HEAD & NECK CANCER	This service is not covered by Superior HealthPlan.	N/A
G9112	ONCOL, DISEASE STAT, HEAD & NECK CANCER, LIMITED TO CANCERS OF ORAL CAVITY	This service is not covered by Superior HealthPlan.	N/A
G9113	ONCOLOGY DISEASE STATUS OVARIAN CANCER	This service is not covered by Superior HealthPlan.	N/A
G9114	ONCOLOGY DISEASE STATUS OVARIAN CANCER	This service is not covered by Superior HealthPlan.	N/A
G9115	ONCOLOGY DISEASE STATUS OVARIAN CANCER	This service is not covered by Superior HealthPlan.	N/A
G9116	ONCOLOGY DISEASE STATUS OVARIAN CANCER	This service is not covered by Superior HealthPlan.	N/A
G9117	ONCOL, DISEASE STAT, OVARIAN CANCER, LIMITED TO EPITHELIAL CANCER, EXTENT	This service is not covered by Superior HealthPlan.	N/A
G9118	ONCOLOGY DISEASE STATUS NON HODGKINS LYMPHOMA	This is no longer a valid code.	N/A
G9119	ONCOLOGY DISEASE STATUS NON HODGKINS LYMPHOMA	This is no longer a valid code.	N/A
G9120	ONCOLOGY DISEASE STATUS NON HODGKINS LYMPHOMA	No pre-authorization is required for all providers.	N/A
G9121	ONCOLOGY DISEASE STATUS NON HODGKINS LYMPHOMA	This is no longer a valid code.	N/A
G9122	ONCOLOGY DISEASE STATUS NON HODGKINS LYMPHOMA	This is no longer a valid code.	N/A
G9123	ONCOLOGY DISEASE STATUS NON HODGKINS LYMPHOMA	This service is not covered by Superior HealthPlan.	N/A
G9124	ONCOLOGY DISEASE STATUS NON HODGKINS LYMPHOMA	This service is not covered by Superior HealthPlan.	N/A
G9125	ONCOLOGY DISEASE STATUS NON HODGKINS LYMPHOMA	This service is not covered by Superior HealthPlan.	N/A
G9126	ONCOLOGY DISEASE STATUS OVARIAN CANCER	This service is not covered by Superior HealthPlan.	N/A
G9127	ONCOLOGY DISEASE STATUS LIMITED TO MULTIPLE MYELOMA	No pre-authorization is required for all providers.	N/A
G9128	ONCOLOGY DISEASE STATUS LIMITED TO MULTIPLE MYELOMA	This service is not covered by Superior HealthPlan.	N/A
G9129	ONCOLOGY DISEASE STATUS CHRONIC MYELOGENOUS LEUKEMIA	This service is not covered by Superior HealthPlan.	N/A
G9130	ONCOL, DISEASE STAT, INVASIVE FEMALE BREAST CANCER, ADENOCARCINOMA AS	This service is not covered by Superior HealthPlan.	N/A
G9131	ONCOL, DISEASE STAT, INVASIVE FEM BREAST CANCER, ADENOCARCINOMA	This service is not covered by Superior HealthPlan.	N/A
G9132	ONCOL, DISEASE STAT, PROSTATE CANCER, LIMIT TO ADENOCARCINOMA, ANDROGEN	This service is not covered by Superior HealthPlan.	N/A
G9133	ONCOL, DISEASE STAT, PROSTATE CANCER, LIMIT TO ADENOCARCINOMA, CL MESTAS	This service is not covered by Superior HealthPlan.	N/A
G9134	ONCOL, DISEASE STAT, NON-HODGKIN'S LYMPHOMA, ANY CELL CLASS, ST I & II	This service is not covered by Superior HealthPlan.	N/A
G9135	ONCOL, DISEASE STAT, NON-HODGKIN'S LYMPHOMA, ANY CELL CLASS, ST III & IV	This service is not covered by Superior HealthPlan.	N/A
G9136	ONCOL, DISEASE STAT, NON-HODGKIN'S LYMPHOMA, ANY CELL CLASS, 2ND CELL	This service is not covered by Superior HealthPlan.	N/A
G9137	ONCOL, DISEASE STAT, NON-HODGKIN'S LYMPHOMA, ANY CELL CLASS, RELAPSED	This service is not covered by Superior HealthPlan.	N/A
G9138	ONCOL, DISEASE STAT, NON-HODGKIN'S LYMPHOMA, ANY CELL CLASS, NON RESP	This service is not covered by Superior HealthPlan.	N/A
G9139	ONCOL, DISEASE STAT, CHRONIC MYELOGENOUS LEUKEMIA, STAGING IN PROGRESS	This service is not covered by Superior HealthPlan.	N/A
G9143	WARFARIN RESPON GENETIC TEST	This service is not covered by Superior HealthPlan.	N/A
G9147	OUTP IV INSULIN TX ANY MEAS	This service is not covered by Superior HealthPlan.	N/A
G9157	TRANSESOPH DOPPL CARDIAC MON	This service is not covered by Superior HealthPlan.	N/A
G9158	MOTOR SPEECH D/C STATUS	This service is not covered by Superior HealthPlan.	N/A
G9159	LANG COMP CURRENT STATUS	This service is not covered by Superior HealthPlan.	N/A
G9160	LANG COMP GOAL STATUS	This service is not covered by Superior HealthPlan.	N/A
G9161	LANG COMP D/C STATUS	This service is not covered by Superior HealthPlan.	N/A
G9162	LANG EXPRESS CURRENT STATUS	This service is not covered by Superior HealthPlan.	N/A
G9163	LANG EXPRESS GOAL STATUS	This service is not covered by Superior HealthPlan.	N/A
G9164	LANG EXPRESS D/C STATUS	This service is not covered by Superior HealthPlan.	N/A
G9165	#N/A	This service is not covered by Superior HealthPlan.	N/A
G9166	#N/A	This service is not covered by Superior HealthPlan.	N/A
G9167	#N/A	This service is not covered by Superior HealthPlan.	N/A
G9168	#N/A	This service is not covered by Superior HealthPlan.	N/A
G9169	MEMORY GOAL STATUS	This service is not covered by Superior HealthPlan.	N/A
G9170	MEMORY D/C STATUS	This service is not covered by Superior HealthPlan.	N/A

G9171	VOICE CURRENT STATUS	This service is not covered by Superior HealthPlan.	N/A
G9172	VOICE GOAL STATUS	This service is not covered by Superior HealthPlan.	N/A
G9173	VOICE D/C STATUS	This service is not covered by Superior HealthPlan.	N/A
G9174	SPEECH LANG CURRENT STATUS	This service is not covered by Superior HealthPlan.	N/A
G9175	SPEECH LANG GOAL STATUS	This service is not covered by Superior HealthPlan.	N/A
G9176	SPEECH LANG D/C STATUS	This service is not covered by Superior HealthPlan.	N/A
G9186	MOTOR SPEECH GOAL STATUS	This service is not covered by Superior HealthPlan.	N/A
G9187	BPCI HOME VISIT	This service is not covered by Superior HealthPlan.	N/A
G9193	DOC NOT ELIGIBLE FOR DEP MED	This is no longer a valid code.	N/A
G9194	MDD PT TREATED FOR 180D	This is no longer a valid code.	N/A
G9195	MDD PT NOT TREATED FOR 180D	This is no longer a valid code.	N/A
G9199	DOC REASON FOR NO VTE	This is no longer a valid code.	N/A
G9200	NO REASON FOR NO VTE	This is no longer a valid code.	N/A
G9201	VTE GIVEN UPON ADMISSION	This is no longer a valid code.	N/A
G9202	HEP C ABY POS	This is no longer a valid code.	N/A
G9203	HEP C RNA DONE PRIOR TO MED	This is no longer a valid code.	N/A
G9204	NO REASON FOR NO HEP C RNA	This is no longer a valid code.	N/A
G9205	HEP C ANTIVIRAL STARTED	This is no longer a valid code.	N/A
G9206	HEP C THERAPY STARTED	This is no longer a valid code.	N/A
G9207	HEP C GENOTYPE PRIOR TO MED	This is no longer a valid code.	N/A
G9208	NO REASON FOR NO HEP C GENO	This is no longer a valid code.	N/A
G9209	HEP C RNA 4TO12 WK AFTER MED	This is no longer a valid code.	N/A
G9210	NO HEPC RNA AFTER MED DOCRSN	This is no longer a valid code.	N/A
G9211	NO HEPC RNA AFTER MED NO RSN	This is no longer a valid code.	N/A
G9214	CD4 COUNT DOCUMENTED	This is no longer a valid code.	N/A
G9215	NO CD4 COUNT NO REASON	This is no longer a valid code.	N/A
G9216	NO PCP PROPH AT DX NO REASON	This is no longer a valid code.	N/A
G9217	NO PCP PROPH LOW CD4 NORSN	This is no longer a valid code.	N/A
G9218	NO PCP PROP LOW AT CD4 NORSN	This is no longer a valid code.	N/A
G9219	NO ODER PJP FOR MED REASON	This is no longer a valid code.	N/A
G9220	NO ORDER FOR PJP FOR MEDRSN	This is no longer a valid code.	N/A
G9221	PJP PROPH PRESCRIBED	This is no longer a valid code.	N/A
G9222	PJP PROPH ORDERED LOW CD4	This is no longer a valid code.	N/A
G9224	MEDRSN NO FOOT EXAM	This is no longer a valid code.	N/A
G9233	TKR COMPOSIT	This is no longer a valid code.	N/A
G9234	TKR INTEN	This is no longer a valid code.	N/A
G9235	GS MG COMPOSIT	This is no longer a valid code.	N/A
G9236	OP RAD MG COMPOSIT	This is no longer a valid code.	N/A
G9237	GS MG INTEN	This is no longer a valid code.	N/A
G9238	OP RAD MG INTEN	This is no longer a valid code.	N/A
G9244	ANTIVIRAL NOT ORDERE	This is no longer a valid code.	N/A
G9245	ANTIVIRAL ORDERE	This is no longer a valid code.	N/A
G9248	NO MED VISIT 6M	This is no longer a valid code.	N/A
G9249	MED VISIT W IN 6M	This is no longer a valid code.	N/A
G9252	NEO DETECT SCRIN COL	This is no longer a valid code.	N/A
G9253	NO NEO DETECT SCRIN COL	This is no longer a valid code.	N/A
G9271	LDL UNDER 10	This is no longer a valid code.	N/A
G9272	LDL 100 AND OVE	This is no longer a valid code.	N/A
G9320	MEDRSN NO STD NOMENCLATUR	This is no longer a valid code.	N/A
G9323	MDRSN NO DOC CNT OF C	This is no longer a valid code.	N/A
G9324	NOT ALL DATA NORS	This is no longer a valid code.	N/A
G9325	MEDRSN NO CT RPT TO RE	This is no longer a valid code.	N/A
G9328	MEDRSN NO DICOM FORMAT DO	This is no longer a valid code.	N/A
G9343	MEDRSN NO DICOM SRC	This is no longer a valid code.	N/A
G9346	NO FOLLOW UP PULM NO	This is no longer a valid code.	N/A
G9362	MAC OR PNB W/O GENANES >60M	This is no longer a valid code.	N/A
G9363	MAC OR PNB W/O GENANES <60M	This is no longer a valid code.	N/A
G9364	SINUS CAUS BAC INX	This service is not covered by Superior HealthPlan.	N/A
G9365	1HIGH RISK MED ORD	This service is not covered by Superior HealthPlan.	N/A
G9366	1HIGH RISK NO ORD	This service is not covered by Superior HealthPlan.	N/A
G9367	AT LEAST 2 ORD SAME HIGH-RISK MED	This service is not covered by Superior HealthPlan.	N/A
G9368	AT LEAST 2 ORD SAME HR MEDS NOT ORD	This service is not covered by Superior HealthPlan.	N/A
G9369	FILL 2 RX ANTIPSYCH	This is no longer a valid code.	N/A
G9370	NOT FILL 2 RX ANTIPSYCH	This is no longer a valid code.	N/A
G9376	CONTD RET ATTACH AT 6MTH F/U	This is no longer a valid code.	N/A
G9377	NO RET ATTACH AFTER 6MT	This is no longer a valid code.	N/A
G9378	CONTD RET ATTACH F/U VIS	This is no longer a valid code.	N/A
G9379	NO ACHEIVE FLAT RET 6MTH	This is no longer a valid code.	N/A
G9380	OFF ASSIS EOL ISS	This service is not covered by Superior HealthPlan.	N/A
G9381	DOC MED RSN NOT OFFR ASST EOL ISSUE	This is no longer a valid code.	N/A
G9382	NO OFF ASSIS EOL	This service is not covered by Superior HealthPlan.	N/A
G9383	RECD SCRIN HCV INFEC	This service is not covered by Superior HealthPlan.	N/A
G9384	DOC MED RSN NO HCV SCRIN	This service is not covered by Superior HealthPlan.	N/A
G9385	DOC PT REAS NOT REC HCV SRN	This service is not covered by Superior HealthPlan.	N/A
G9386	SCRIN HCV INFEC NOT RECD	This service is not covered by Superior HealthPlan.	N/A
G9389	UNPLN RUP POST CAP	This service is not covered by Superior HealthPlan.	N/A
G9390	NO UNPLN RUP POST CAP	This service is not covered by Superior HealthPlan.	N/A
G9391	ACHV REFRAC +1D	This is no longer a valid code.	N/A
G9392	NOT ACHV REFRAC +1D	This is no longer a valid code.	N/A
G9393	INI PHQ9 >9 REMISS <5	This service is not covered by Superior HealthPlan.	N/A
G9394	DX BIPOL, DEATH, NHRES, HOSP	This service is not covered by Superior HealthPlan.	N/A
G9395	INI PHQ9 >9 NO REMISS >=5	This service is not covered by Superior HealthPlan.	N/A
G9396	INI PHQ9 >9 NOT ASSESS	This service is not covered by Superior HealthPlan.	N/A
G9399	DOC DISC TX CHOICES	This service is not covered by Superior HealthPlan.	N/A
G9400	DOC REAS NO DISC TX OPT	This service is not covered by Superior HealthPlan.	N/A
G9401	NO DISC TX CHOICES	This service is not covered by Superior HealthPlan.	N/A
G9402	RECD F/U W/IN 30D DISCH	This service is not covered by Superior HealthPlan.	N/A
G9403	DOC REAS NO 30 DAY F/U	This service is not covered by Superior HealthPlan.	N/A
G9404	NO 30 DAY F/U	This service is not covered by Superior HealthPlan.	N/A
G9405	PATIENT RECEIVED F/U WITHIN 7 DAYS AFTER D/C	This service is not covered by Superior HealthPlan.	N/A
G9406	DOC REAS NO 7D F/U	This service is not covered by Superior HealthPlan.	N/A
G9407	NO 7D F/U	This service is not covered by Superior HealthPlan.	N/A
G9408	CARD TAMP W/IN 30D	This service is not covered by Superior HealthPlan.	N/A
G9409	NO CARD TAMP E/IN 30D	This service is not covered by Superior HealthPlan.	N/A
G9410	ADMIT W/IN 180D REQ REMOV	This service is not covered by Superior HealthPlan.	N/A
G9411	NO ADMIT W/IN 180D REQ REMOV	This service is not covered by Superior HealthPlan.	N/A
G9412	ADMIT W/IN 180D REQ SURG REV	This service is not covered by Superior HealthPlan.	N/A
G9413	NO ADMIT REQ SURG REV	This service is not covered by Superior HealthPlan.	N/A
G9414	PT HAD 1 DOSE MC VAC ON/BETWN PT 11TH AND 13TH BD	This service is not covered by Superior HealthPlan.	N/A
G9415	NO 1DOSE MENI VAC BTWN 11&13	This service is not covered by Superior HealthPlan.	N/A
G9416	PT 1 TET DT TDAP ON/BTW 10 & 13 BD	This service is not covered by Superior HealthPlan.	N/A
G9417	PT NO 1 TET DT TDAP ON/BTW 10&13 BD	This service is not covered by Superior HealthPlan.	N/A
G9418	LUNG CX BX RPT DOCS CLASS	This service is not covered by Superior HealthPlan.	N/A
G9419	MED REAS NOT INCL HISTO TYPE	This service is not covered by Superior HealthPlan.	N/A
G9420	SPEC SITE NO LUNG	This service is not covered by Superior HealthPlan.	N/A
G9421	LUNG CX BX RPT NO DOC CLASS	This service is not covered by Superior HealthPlan.	N/A
G9422	RPT DOC CLASS HISTO TYPE	This service is not covered by Superior HealthPlan.	N/A
G9423	DOC MED RSN NO RPRT H TYP/NSCLC-NOS	This service is not covered by Superior HealthPlan.	N/A
G9424	SPEC SITE OTH THAN LOC L NOT NSCLC	This service is not covered by Superior HealthPlan.	N/A
G9425	SPEC RPT NO DOC CLASS HISTO	This service is not covered by Superior HealthPlan.	N/A
G9426	IMPR MED TIME EDARR PAIN MED	This service is not covered by Superior HealthPlan.	N/A

G9427	NO IMPRO MED TIME PAIN MED	This service is not covered by Superior HealthPlan.	N/A
G9428	PATH RPRT PT CAT AND STM THK ULCER AND MITOTIC RATE	This service is not covered by Superior HealthPlan.	N/A
G9429	DOC MED RSN NOT INCL PT CAT AND STM THK ULCER AND MR	This service is not covered by Superior HealthPlan.	N/A
G9430	SPEC SITE NO CUTANEOUS	This service is not covered by Superior HealthPlan.	N/A
G9431	PATH RPRT NO PT CAT AND STM THK ULCER AND MITOTIC RA	This service is not covered by Superior HealthPlan.	N/A
G9432	ASTH CONTROLLED	This service is not covered by Superior HealthPlan.	N/A
G9433	DEATH, NHRES, HOSPICE	This is no longer a valid code.	N/A
G9434	ASTH NOT CONTROLLED	This service is not covered by Superior HealthPlan.	N/A
G9435	ASP PRESC DISCH	This is no longer a valid code.	N/A
G9436	ASP NOT PRESC DOC REAS	This is no longer a valid code.	N/A
G9437	ASP NOT PRESC DISCH	This is no longer a valid code.	N/A
G9438	P2Y INHIB PRESC	This is no longer a valid code.	N/A
G9439	P2Y INHIB NOT PRESC DOC REAS	This is no longer a valid code.	N/A
G9440	P2Y INHIB NOT PRESC	This is no longer a valid code.	N/A
G9441	STATIN PRESC DISCH	This is no longer a valid code.	N/A
G9442	STATIN NOT PRESC DOC REAS	This is no longer a valid code.	N/A
G9443	STATIN NOT PRESC DISCH	This is no longer a valid code.	N/A
G9448	BORN 1945-1965	This service is not covered by Superior HealthPlan.	N/A
G9449	HX BLD TRANSF B/F 1992	This service is not covered by Superior HealthPlan.	N/A
G9450	HX INJEC DRUG USE	This service is not covered by Superior HealthPlan.	N/A
G9451	1X SCRIN HCV INFECT	This service is not covered by Superior HealthPlan.	N/A
G9452	DOC MED REAS NO SCRIN HCV	This service is not covered by Superior HealthPlan.	N/A
G9453	PT REAS NO HCV INFECT	This service is not covered by Superior HealthPlan.	N/A
G9454	NO HCV INFECT SRN	This service is not covered by Superior HealthPlan.	N/A
G9455	ABD IMAG W/US, CT OR MRI	This service is not covered by Superior HealthPlan.	N/A
G9456	DOC MED PT REAS NO HCC SCRIN	This service is not covered by Superior HealthPlan.	N/A
G9457	PT NO ABD IMAG AND NOT DOC RSN NO ABD IMAG SBMS P	This service is not covered by Superior HealthPlan.	N/A
G9458	TOB USER RECD CESS INTERV	This service is not covered by Superior HealthPlan.	N/A
G9459	TOB NON-USER	This service is not covered by Superior HealthPlan.	N/A
G9460	NO TOB ASSESS OR CESS INTER	This service is not covered by Superior HealthPlan.	N/A
G9463	SINUSITIS INTENT	This is no longer a valid code.	N/A
G9464	SINUSITIS COMP	This is no longer a valid code.	N/A
G9465	AOE INTENT	This is no longer a valid code.	N/A
G9466	AOE COMP	This is no longer a valid code.	N/A
G9467	RECD CORTICO >=10MG/DAY >60D	This is no longer a valid code.	N/A
G9468	NO RECD CORTICO>=10MG/D >60D	This service is not covered by Superior HealthPlan.	N/A
G9469	PT RECV/RVNG CS >= 10 MG/D PDN EQ 90/GT CONS D	This service is not covered by Superior HealthPlan.	N/A
G9470	NO REC CORTICO>60D 1RX 600MG	This service is not covered by Superior HealthPlan.	N/A
G9471	W/IN 2YR DXA NOT ORDER	This service is not covered by Superior HealthPlan.	N/A
G9472	NO DXA NO MED HX NO RV SX	This service is not covered by Superior HealthPlan.	N/A
G9473	SRVC PERF CHAPLN HOSPICE EA 15 MIN	No pre-authorization is required for all providers.	N/A
G9474	SRVC PRF DIET CNSLR HOSPICE EA 15 M	No pre-authorization is required for all providers.	N/A
G9475	SRVC PERF OTH COUNS HSPICE EA 15 MIN	No pre-authorization is required for all providers.	N/A
G9476	SRVC PRF VOLUNTEER HOSPICE EA15 MIN	No pre-authorization is required for all providers.	N/A
G9477	SRVC PRF CARE COORD HOSPICE EA 15 M	No pre-authorization is required for all providers.	N/A
G9478	SRVC PRF OTH QUAL TH HOSPICE EA 15 M	No pre-authorization is required for all providers.	N/A
G9479	SRVC PRF QUAL PHARM HOSPICE EA 15 M	No pre-authorization is required for all providers.	N/A
G9480	ADMISSION TO MCCM PROGRAM	No pre-authorization is required for all providers.	N/A
G9481	REMOTE IN-HOME VST E/M NEW PT 10 M	No pre-authorization is required for all providers.	N/A
G9482	RMT IN-HOME VISIT E/M NEW PT 20 MIN	No pre-authorization is required for all providers.	N/A
G9483	REMOTE IN-HOME VST E/M NEW PT 30 M	No pre-authorization is required for all providers.	N/A
G9484	REMOTE IN-HOME VST E/M NEW PT 45 M	No pre-authorization is required for all providers.	N/A
G9485	REMOTE IN-HOME VST E/M NEW PT 60 M	No pre-authorization is required for all providers.	N/A
G9486	REMOTE IN-HOME VST E/M EST PT 10 M	No pre-authorization is required for all providers.	N/A
G9487	REMOTE IN-HOME VST E/M EST PT 15 M	No pre-authorization is required for all providers.	N/A
G9488	REMOTE IN-HOME VST E/M EST PT 25 M	No pre-authorization is required for all providers.	N/A
G9489	REMOTE IN-HOME VST E/M EST PT 40 M	No pre-authorization is required for all providers.	N/A
G9490	CMS IC MDL HV PA CLN - NOT BLL 30-D P	No pre-authorization is required for all providers.	N/A
G9496	DOC RSN NOT DETECT AD/OTH NEOPLASM	This is no longer a valid code.	N/A
G9497	RECV INSTR ANES/PRXY ABSTN SM DA SX	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9498	ANTIBIOTIC REGIMEN PRESCRIBED	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9499	PT NOT ST/RECV AV TX HEP C MSR PER	This is no longer a valid code.	N/A
G9500	RADIATION EXPOSURE INDICES DOC	No authorization required. Code is for informational purposes only.	N/A
G9501	RE INDCS/EXP TM&NO FL I N DOC N RSN	No authorization required. Code is for informational purposes only.	N/A
G9502	DOC MED RSN FOR NOT PERF FOOT EXAM	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9503	PT TAKING TAMSULOSIN HYDROCHLORIDE	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9504	DOC NOT ASSESS HBV PRI ANTI-TNF TX	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9505	ABX PRSC 10 D AFT ON SX DOC MED RSN	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9506	BIOLOGIC IMMUNE RESPONSE MOD PRSC	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9507	DOC PT ON STATN MED/DOC VALID CNTRA	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9508	DOC PT IS NOT ON STATIN MEDICATION	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9509	ADULT 18 YR/OLDER MD/DYSTHYMIA REMISS AT 12 MO	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9510	ADLT PT 18/>MD NO REM 12 MO DEM 12 MO PHQ-9 <5	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9511	IDX PHQ-9/PHQ-9M SC>9 DOC DUR 12 MO DNOMN ID PRD	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9512	INDIVIDUAL HAD A PDC OF 0.8/GREATER	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9513	INDIV DID NOT HAVE A PDC OF 0.8/>	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9514	PT RQR RTN TO OR W/I 90 D OF SURG	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9515	PT DID NOT RQR RTN OR W/I 90 D SURG	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9516	PT ACHVD IMPRV VA PREOP LVL 90 D SX	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9517	PT NO IMPRV VA PREOP LVL 90D S NO R	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9518	DOCUMENTATION OF ACTIVE INJ DRUG US	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9519	PT FINAL REFR +/- 1.0 D REFR W/I 90 DAYS SURG	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9520	PT NO F REFR +/- 1.0 DIO REFR W/I 90 D SURG	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9521	TOT # ED VSTS & IP HOSP>2 PAST 12 M	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9522	TOT #ED VST&IP=>2 12 M/NO SCR NO R	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9523	PT DXD HEMODIAL/PERITONEAL DIALYSIS	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9524	PATIENT WAS REF TO HOSPICE CARE	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9525	DOC PT RSN FOR NOT REF HOSPICE CARE	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9526	PT NOT REF HOSPICE CARE RSN NOT GVN	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9529	PT MIN BLNT HD TRMA APPROP INDCT CT	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9530	PT PRESNT W/MIN BLUNT HEAD TRAUMA CT ORD BY ECP	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9531	PT DOC VENT SHUNT MXSYS TR/CURR TAKING AP MED	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9532	DOCUMENTATION OF SYS RSN FOR OBTG IMAG OF HEAD	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9533	PT MIN BLNT HD TRMA NO INDCAT HD CT	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9534	ADVANCED BRAIN IMAG WAS NOT ORDRD	This is no longer a valid code.	N/A
G9535	PATIENTS W/NORMAL NEUROLOGICAL EXAM	This is no longer a valid code.	N/A
G9536	DOC MED RSN ORD ADV BRAIN IMAG STDY	This is no longer a valid code.	N/A
G9537	DOC SYS RSN ORD ADVANCE HEAD CT MRI	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9538	ADVANCED BRAIN IMAGING WAS ORDERED	This is no longer a valid code.	N/A
G9539	INTENT FOR PTNTL REMV TIME OF PLCMT	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9540	PATIENT ALIVE 3 MOS POST PROCEDURE	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9541	FILTER REM 3 MON PLMT	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9542	DOC RE-ASSESS APPROP FILTR RMVL 3 M	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9543	DOC AT LEAST TWO ATTEMPTS REACH PT	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9544	PT THAT DO NOT HAVE THE FILTER RMVD	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9547	CYST RNL LES/AD LES<=1.0 CM/>1.0 CM BUT<=4.0CM	No authorization required. Code is for informational purposes only.	N/A
G9548	FINAL REPORTS IMAG STDY STAT NO F/U IMAG RECOM	No authorization required. Code is for informational purposes only.	N/A
G9549	DOC MEDICAL REASON THAT F/U IMAGING IS INDICATED	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9550	FINAL REPORTS IMAG STUDIES F/U IMAGING RECOM	No authorization required. Code is for informational purposes only.	N/A
G9551	FINAL RPT IMAG STDY W/O INCIDENTAL FND LES NOTED	No authorization required. Code is for informational purposes only.	N/A
G9552	INCIDENTL THYRD NODUL <1.0 CM IN RPT	No authorization required. Code is for informational purposes only.	N/A

G9553	PRIOR THYROID DISEASE DIAGNOSIS	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9554	FR CT CTA MRI/MRA CH/N F/U I REC	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9555	DOC MED RSN RECOMMEND F/U IMAGING	No authorization required. Code is for informational purposes only.	N/A
G9556	F RPT CT CT MRI/MRA CH/N FU I N RCM	No authorization required. Code is for informational purposes only.	N/A
G9557	F RP CT/MRI CH/NCK NO THR NOD<1.0CM	No authorization required. Code is for informational purposes only.	N/A
G9558	PT TX W/BETA-LACTAM ABX DEFINITV TX	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9559	DOC MED RSN NOT PRSC BETA-LACTM ABX	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9560	PT NOT TX BETA-LCTM ABX RSN NOT GVN	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9561	PT PRSC OPIATES FOR LNGR THAN 6 WKS	No authorization required. Code is for informational purposes only.	N/A
G9562	PT F/U EVAL EV 3 MOS DUR OPIOID TX	No authorization required. Code is for informational purposes only.	N/A
G9563	PT NO F/U EVL EV 3 MOS DR OPIOID TX	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9572	IND D PHQ-SCR>9 DC 12M DNMNTR ID PR	This is no longer a valid code.	N/A
G9573	ADULT >18 YR MD/DYSTHYMIA REMISS AT 6 MO PHQ-9>5	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9574	18 YR/OLDER MD/DYSTHYMIA NO REMISS 6 MO PHQ-9>5	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9577	PT PRSC OPIATES FOR LNGR THAN 6 WKS	No authorization required. Code is for informational purposes only.	N/A
G9578	DOC SGND OPIOID TX AGRMNT 1 DUR TX	No authorization required. Code is for informational purposes only.	N/A
G9579	NO DOC SGND OPIOID TX AGRMNT DUR TX	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9580	DOOR TO PUNCTURE TIME OF < 2 HOURS	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9581	DOOR-PUNCT TIME >2 HRS RSN DOC CLIN	This is no longer a valid code.	N/A
G9582	DOOR TO PUNCT TIME>2 HRS NO RSN GVN	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9583	PT PRSC OPIATES FOR LNGR THAN 6 WKS	No authorization required. Code is for informational purposes only.	N/A
G9584	PT EVAL RISK MISUSE OPI VAL INSTRM	No authorization required. Code is for informational purposes only.	N/A
G9585	PT NOT EVL RSK MSUSE OPI VAL INSTRM	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9593	PED PT M BLNT HD TRMA LW RSK PECARN	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9594	PT PRES MIN BLUNT HEAD TR AND HEAD CT ORDER TR ECP	No authorization required. Code is for informational purposes only.	N/A
G9595	PT HAS DOC VENTRICULAR SHUNT BT/COAGULOPATHY	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9596	PED PT HEAD CT TRAUMA ORD OTH ECP OR REAS OTH TR	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9597	PED PT MI HD TRMA NOT LW RSK PECARN	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9598	AA 5.5-5.9 CM MX D CL CT/MI D AX CT	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9599	AA 6.0 CM>MX DIA CL CT/M DIA AX CT	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9600	SYM AAS THAT RQR URG/EMERGENT REPR	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9601	PT D/C HOME NO LTR THN POST-OP D #7	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9602	PT NOT D/C HOME BY POST-OP DAY #7	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9603	PT SURV SCRE IMPRV FROM BASE FLW TX	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9604	PATIENT SURVEY RSLT NOT AVAILABLE	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9605	PT SURV SCRE NO IMPRV BASE FLW TX	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9606	IORT CYSTSCPY PERF EVAL LW TRCT INJ	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9607	D M RSN NOT PRF IO CYSTO/CASE PT D	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9608	IORT CYSTSCPY NOT P EVL LW TRCT INJ	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9609	DOC ORDER FOR ANTIPLATELET AGENTS	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9610	DOC MED RSN PT REC NOT ORD AP AGT	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9611	ORD AP AG NOT DOC PT R RSN NOT GVN	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9612	PHOTODOCUM 2/MORE CECAL LANDMARK EST COMPL EXAM	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9613	DOCUMENTATION OF POST-SURG ANATOMY	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9614	PHOTODOCUMENTATION <2 CECAL LSMK EST COMPLETE EX	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9615	PREOPERATIVE ASSESSMENT DOCUMENTED	No authorization required. Code is for informational purposes only.	N/A
G9616	DOC RSN NOT DOC A PREOP ASSESSMENT	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9617	PREOP ASSESS NOT DOC RSN NOT GVN	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9618	DOC SCR UTEN MALIG/US&ENDOMET SAMP	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9619	DOC REASON NO SCR FOR UTERN MALIG	This is no longer a valid code.	N/A
G9620	PT NOT SCR UTERN MALG/NO U/S NO RSN	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9621	PT ID UNHLTHY ALC USR SCR&BRF COUNS	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9622	PT NOT ID UNHLTHY ALC USR SCR ALC U	No authorization required. Code is for informational purposes only.	N/A
G9623	DOC MED RSN NO SCR UNHLTHY AL USE	No authorization required. Code is for informational purposes only.	N/A
G9624	PT NOT SCR UHLTY AU USING SYS SCR M	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9625	PT SUSTAIN BLAD INJ SRG/DSCV SUBSQ UP 30 DAY P S	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9626	DOC MED RSN NOT REPORT BLADDER INJ	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9627	DID NOT SUST BLAD INJ SRG/NOR DSCV SUBSQ UP 30PS	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9628	PT SUSTN BOWEL INJ SURG/DISC SUBSEQ 30D PST SRG	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9629	DOC MED RSN NOT REPORT BOWEL INJ	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9630	PT NOT SUSTN BOWL INJ SRG/DISC TO 30 D POST SURG	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9631	PT SUSTAIN URETER INJ SURG/DISC 30 DAY POST SURG	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9632	PT NOT ELG E.G. GYN/OTH PLV MAL DOC	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9633	PT NOT SUSTN URETER INJ SX/DISC 30D POST SRG	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9634	H-REL QOL ASSESS 2 VST&QOL SME/MPR	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9635	HLTH-REL QOL NOT ASSESS TL DOC RSN	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9636	H-REL QOL NOT ASSES 2 VST&QOL DCLND	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9637	FINAL REPORT W/DOC 1/MORE DOSE REDUCTION TECH	No authorization required. Code is for informational purposes only.	N/A
G9638	FINAL REPORTS W/O DOC 1/MORE DOSE REDUCTION TECH	No authorization required. Code is for informational purposes only.	N/A
G9639	MAJOR AMP/OPEN SURG BYPS NOT RQR	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9640	DOC OF PLANNED HYBRID/STAGED PROC	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9641	MAJOR AMPUTATION/OPEN SURG BYPS RQR	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9642	CURRENT CIGARETTE SMOKERS	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9643	ELECTIVE SURGERY	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9644	PT ABST FROM SMOK PRI ANES D SX/PCR	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9645	PT NOT F ABST SMK PRI ANES D SX/PCR	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9646	PATIENTS W/90 DA MRS SCORE 0 TO 2	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9647	PT MRS SCORE NOT OBTAINED 90 DA F/U	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9648	PATIENTS WITH 90 DAY MRS SCORE >2	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9649	PSORIASIS ASSESS TOOL DOC ANY 1 BNCHMK BSA SEV	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9650	DOC THAT PATIENT DECLINED TX CHANGE	This is no longer a valid code.	N/A
G9651	PSO ASSESS TOOL DOC NOT MTG ANY 1 SPEC BNCHMRK	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9652	PT BEEN TX SYS/BIO MED PSO AL 6 MOS	This is no longer a valid code.	N/A
G9653	PT NOT TX SYS/BIO MED PSO AL 6 MOS	This is no longer a valid code.	N/A
G9654	MONITORED ANESTHESIA CARE	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9655	A TRAN OF CARE PROT/HO TL/CHKCLIST	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9656	PT TR D F AA LOC TO PACE/OTH N-ICU	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9657	TRNSF OF CARE DUR ANESTHETIC/TO ICU	This is no longer a valid code.	N/A
G9658	A TRAN CARE PROT/HO TOOL/CHECKLIST	No authorization required. Code is for informational purposes only.	N/A
G9659	PT>85 YRS NO HX CC/MED RSN COLO	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9660	DOC MED RSN COLONOSCOPY PT>85 YRS	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9661	PT>85 YRS RECV ROUTINE COLONOSCOPY	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9662	PREVIOUSLY DX/ACTIVE DX CLIN ASCVD	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9663	ANY FASTING/DIR LDL-C LAB TEST RSLT <= 190 MG/DL	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9664	PT CUR STATIN USR/RCDV ORD STATN TX	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9665	PT NO CUR STATN USR/NO ORD STATN TX	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9666	HI F/DIR LDL-C LB RSLT 70/189 MG/DL	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9667	DC MD R NO STATN TX U/RCV ORD STATN	This is no longer a valid code.	N/A
G9669	I INTND TO RPT MX CHRND CONND MSR GRP	This is no longer a valid code.	N/A
G9670	ALL QLTY ACT APP MSR MX CHRND MSR	This is no longer a valid code.	N/A
G9671	I INTEND TO RPT THE DIAB RP MSR GRP	This is no longer a valid code.	N/A
G9672	ALL QLTY ACT APPL MSR DIAB RP MSR	This is no longer a valid code.	N/A
G9673	I INTEND TO RPR THE CV PREV MSR GRP	This is no longer a valid code.	N/A
G9674	PATIENTS W/CLINICAL ASCVD DIAGNOSIS	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9675	PT HAD F/DR LB RSLT LDL-C=190 MG/DL	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9676	PT 40-75 YRS BEG MSR PRD T 1/2 DIAB	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
G9677	ALL QLTY ACT APPLIC MSR CV PREV MSR	This is no longer a valid code.	N/A
G9686	NURSING FACILITY CONFERENCE	This is no longer a valid code.	N/A
G9978	RMT IH VST E/M NP MCR-APVD BPCI ADV EOC TYP 10 M	This service is not covered by Superior HealthPlan.	N/A
G9979	RMT IH VST E/M NP MCR-APVD BPCI ADV EOC TYP 20 M	This service is not covered by Superior HealthPlan.	N/A
G9980	RMT IH VST E/M NP MCR-APVD BPCI ADV EOC TYP 30 M	This service is not covered by Superior HealthPlan.	N/A

G9981	RMT IH VST E/M NP MCR-APVD BPCI ADV EOC TYP 45 M	This service is not covered by Superior HealthPlan.	N/A
G9982	RMT IH VST E/M NP MCR-APVD BPCI ADV EOC TYP 60 M	This service is not covered by Superior HealthPlan.	N/A
G9983	RMT IH VST E/M EST PT MCR-APVD BPCI ADV TYP 10 M	This service is not covered by Superior HealthPlan.	N/A
G9984	RMT IH VST E/M EST PT MCR-APVD BPCI ADV TYP 15 M	This service is not covered by Superior HealthPlan.	N/A
G9985	RMT IH VST E/M EST PT MCR-APVD BPCI ADV TYP 25 M	This service is not covered by Superior HealthPlan.	N/A
G9986	RMT IH VST E/M EST PT MCR-APVD BPCI ADV TYP 40 M	This service is not covered by Superior HealthPlan.	N/A
G9987	BPCI ADV MOD HOME VISIT PT ASMT PERF CLIN STAFF	This service is not covered by Superior HealthPlan.	N/A
H0001	ALCOHOL AND/OR DRUG ASSESSMENT	Allow 1 visit every 6 months, then Pre-authorization is required.	Prior to 09/01/2019
H0002	BHVAL HLTH SCR DETRM ADMIS TX PROGM	This service is not covered by Superior HealthPlan.	N/A
H0003	AL &/OR DRG SCRNG;LAB ANALY	This service is not covered by Superior HealthPlan.	N/A
H0004	BEHAVIORAL HEALTH CNSL&TX-15 MIN	Allow 26 hours every calendar year, then Pre-authorization is required	Prior to 09/01/2019
H0005	AL &/OR DRG SRV;GRP CNSLG-CLINICIAN	Allow 135 hours every calendar year, then Pre-authorization is required.	Prior to 09/01/2019
H0006	AL &/OR DRG SRV;CASE MGMT	This service is not covered by Superior HealthPlan.	N/A
H0007	AL &/OR DRG SRV;CRISIS INT-OUTPT	This service is not covered by Superior HealthPlan.	N/A
H0008	AL &/OR DRG SRV;SUB-ACUTE DETOX-IP	This service is not covered by Superior HealthPlan.	N/A
H0009	AL &/OR DRG SRV;ACUTE DETOX-IP	This service is not covered by Superior HealthPlan.	N/A
H0010	AL &/OR DRG SRV;SUB-ACUTE DETOX-IP	This service is not covered by Superior HealthPlan.	N/A
H0011	AL &/OR DRG SRV;ACUTE DETOX-RAP/IP	This service is not covered by Superior HealthPlan.	N/A
H0012	AL &/OR DRG SRV;SUB-ACUTE DETX-OP	Pre-authorization is required for all providers.	Prior to 09/01/2019
H0013	AL &/OR DRG SERV;ACUTE DETOX-OP	This service is not covered by Superior HealthPlan.	N/A
H0014	ALCOHOL &/OR DRUG SRVS;AMB DETOX	This service is not covered by Superior HealthPlan.	N/A
H0015	IOP AL &/OR DRG SRV->=3HRS DA3DAWK	This service is not covered by Superior HealthPlan.	N/A
H0016	AL &/OR DRG SRV;MED/SOMATIC	Pre-authorization required for all providers.	Prior to 09/01/2019
H0017	BHVAL HEALTH; RES W/O ROOM&BD-DIEM	This service is not covered by Superior HealthPlan.	N/A
H0018	BHVAL HLTH; SHRT-TERM RES PER DIEM	This service is not covered by Superior HealthPlan.	N/A
H0019	BHVAL HLTH; LNG-TERM RES PER DIEM	This service is not covered by Superior HealthPlan.	N/A
H0020	AL &/OR DRG SRV;METHADONE ADMIN/SRV	No pre-authorization is required for all providers.	N/A
H0021	AL &/OR DRG TRAINING SERV	This service is not covered by Superior HealthPlan.	N/A
H0022	AL &/OR DRG INTERVEN SERV	This service is not covered by Superior HealthPlan.	N/A
H0023	BEHAVIORAL HEALTH OUTREACH SERVICE	This service is not covered by Superior HealthPlan.	N/A
H0024	BHVAL HLTH PRV INFORM DISSEMIN SRVC	This service is not covered by Superior HealthPlan.	N/A
H0025	BHVAL HEALTH PREV EDUCATION SERVICE	This service is not covered by Superior HealthPlan.	N/A
H0026	AL &/OR DRG PRV PROCESS SRV COM-BSD	This service is not covered by Superior HealthPlan.	N/A
H0027	AL &/OR DRG PREV ENVIRONMNTL SRV	This service is not covered by Superior HealthPlan.	N/A
H0028	AL &/OR DRG PRV PRB ID/EX ASSES	This service is not covered by Superior HealthPlan.	N/A
H0029	AL &/OR DRG PREV ALTERNATIVES SRV	This service is not covered by Superior HealthPlan.	N/A
H0030	BEHAVIORAL HEALTH HOTLINE SERVICE	This service is not covered by Superior HealthPlan.	N/A
H0031	MENTAL HEALTH ASSESS NON-PHYSICIAN	No pre-authorization is required for all providers.	N/A
H0032	MENTL HLTH SRVC PLAN DVLP NON-PHYS	No pre-authorization is required for all providers.	N/A
H0033	ORAL MEDADMIN DIR OBSERVATION	No pre-authorization is required for all providers.	N/A
H0034	MEDICATION TRN&SUPPORT PER 15 MIN	No pre-authorization is required for all providers.	N/A
H0035	MENTAL HEALTH PART HOSP TX < 24 HR	This service is not covered by Superior HealthPlan.	N/A
H0036	CMTY PSYC SUPP TX FCE-TO-FCE-15 MIN	This service is not covered by Superior HealthPlan.	N/A
H0037	CMTY PSYC SUPPORTIVE TX PROGM-DIEM	This service is not covered by Superior HealthPlan.	N/A
H0038	SELF-HELP/PEER SERVICES PER 15 MIN	Allow 104 units every 6 months, then Pre-authorization is required.	Prior to 09/01/2019
H0039	ASSERTIVE CMTY TX FCE-TO-FCE-15 MIN	This service is not covered by Superior HealthPlan.	N/A
H0040	ASSERTIVE CMTY TX PROGM PER DIEM	This service is not covered by Superior HealthPlan.	N/A
H0041	FOSTER CARE CHLD NON-TX-DIEM	This service is not covered by Superior HealthPlan.	N/A
H0042	FOSTER CARE CHLD NON-TX-MONTH	This service is not covered by Superior HealthPlan.	N/A
H0043	SUPPORTED HOUSING PER DIEM	This service is not covered by Superior HealthPlan.	N/A
H0044	SUPPORTED HOUSING PER MONTH	This service is not covered by Superior HealthPlan.	N/A
H0045	RESPIRE CARE SRVC NOT HOME PER DIEM	This service is not covered by Superior HealthPlan.	N/A
H0046	MENTAL HEALTH SERVICES NOS	This service is not covered by Superior HealthPlan.	N/A
H0047	ALCOHOL &/OR OTH DRUG ABS SRVC NOS	This service is not covered by Superior HealthPlan.	N/A
H0048	ALC &/OTH RX TST: CLCT&HNDL NOT BLD	This service is not covered by Superior HealthPlan.	N/A
H0049	ALCOHOL AND/OR DRUG SCREENING	This service is not covered by Superior HealthPlan.	N/A
H0050	ALCOHOL AND/OR DRUG SERVICES, BRIEF INTERVENTION, PER 15 MINUTES	No pre-authorization is required for all providers.	N/A
H1000	PRENATAL CARE, AT-RISK ASSESSMENT	This service is not covered by Superior HealthPlan.	N/A
H1001	PRENATAL CARE, AT-RISK ENHANCED SERVICE	This service is not covered by Superior HealthPlan.	N/A
H1002	PRENATAL CARE, AT RISK ENHANCED SERVICE	This service is not covered by Superior HealthPlan.	N/A
H1003	PRENATAL CARE, AT-RISK ENHANCED SERVICE	This service is not covered by Superior HealthPlan.	N/A
H1004	PRENATAL CARE, AT-RISK ENHANCED SERVICE	This service is not covered by Superior HealthPlan.	N/A
H1005	PRENATAL CARE, AT-RISK ENHANCED SERVICE PACKAGE (INCLUDES H1001-H1004)	This service is not covered by Superior HealthPlan.	N/A
H1010	NON-MEDICAL FAM PLANNING ED-SESSION	No pre-authorization is required for all providers.	N/A
H1011	FAM ASSESS LIC BHVAL HLTH STATE DEF	This service is not covered by Superior HealthPlan.	N/A
H2000	COMP MULTIDISCIPLINARY EVALUATION	This service is not covered by Superior HealthPlan.	N/A
H2001	REHABILITATION PROGRAM PER 1/2 DAY	This service is not covered by Superior HealthPlan.	N/A
H2010	COMPREHENSIVE MEDICATION SERVICES, PER 15 MINUTES	No pre-authorization is required for all providers.	N/A
H2011	CRISIS INTERVENTION SERVICE, PER 15 MINUTES	No pre-authorization is required for all providers.	N/A
H2012	BEHAVIORAL HEALTH DAY TREATMENT, PER HOUR	No pre-authorization is required for all providers.	N/A
H2013	PSYCHIATRIC HEALTH FACILITY SERVICE, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
H2014	SKILLS TRAINING AND DEVELOPMENT, PER 15 MINUTES	No pre-authorization is required for all providers.	N/A
H2015	COMPREHENSIVE COMMUNITY SUPPORT SERVICES, PER 15 MINUTES	Preauthorization required for all providers	Prior to 09/01/2019
H2016	COMPREHENSIVE COMMUNITY SUPPORT SERVICES, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
H2017	PSYCHOSOCIAL REHABILITATION SERVICES, PER 15 MINUTES	No pre-authorization is required for all providers.	N/A
H2018	PSYCHOSOCIAL REHABILITATION SERVICES, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
H2019	THERAPEUTIC BEHAVIORAL SERVICES, PER 15 MINUTES	This service is not covered by Superior HealthPlan.	N/A
H2020	THERAPEUTIC BEHAVIORAL SERVICES, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
H2021	COMMUNITY-BASED WRAP-AROUND SERVICES, PER 15 MINUTES	This service is not covered by Superior HealthPlan.	N/A
H2022	COMMUNITY-BASED WRAP-AROUND SERVICES, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
H2023	SUPPORTED EMPLOYMENT, PER 15 MINUTES	Preauthorization required for all providers	Prior to 09/01/2019
H2024	SUPPORTED EMPLOYMENT, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
H2025	ONGOING SUPPORT TO MAINTAIN EMPLOYMENT, PER 15 MINUTES	Preauthorization required for all providers	Prior to 09/01/2019
H2026	ONGOING SUPPORT TO MAINTAIN EMPLOYMENT, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
H2027	PSYCHOEDUCATIONAL SERVICE, PER 15 MINUTES	This service is not covered by Superior HealthPlan.	N/A
H2028	SEXUAL OFFENDER TREATMENT SERVICE, PER 15 MINUTES	This service is not covered by Superior HealthPlan.	N/A
H2029	SEXUAL OFFENDER TREATMENT SERVICE, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
H2030	MENTAL HEALTH CLUBHOUSE SERVICES, PER 15 MINUTES	This service is not covered by Superior HealthPlan.	N/A
H2031	MENTAL HEALTH CLUBHOUSE SERVICES, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
H2032	ACTIVITY THERAPY, PER 15 MINUTES	This service is not covered by Superior HealthPlan.	N/A
H2033	MULTISYSTEMIC THERAPY FOR JUVENILES, PER 15 MINUTES	This service is not covered by Superior HealthPlan.	N/A
H2034	ALCOHOL AND/OR DRUG ABUSE HALFWAY HOUSE SERVICES, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
H2035	ALCOHOL AND/OR OTHER DRUG TREATMENT PROGRAM, PER HOUR	Pre-authorization required for all providers.	Prior to 09/01/2019
H2036	ALCOHOL AND/OR OTHER DRUG TREATMENT PROGRAM, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
H2037	DVLP MNTL DELAY PRVNTN ACTIVITIES, DPNDNT CHILD OF CLIENT/15 MIN	This service is not covered by Superior HealthPlan.	N/A
H5300	OCCUPATIONAL THERAPY	This is no longer a valid code.	N/A
J0110	NON-ITEMIZED DRUGS	This is no longer a valid code.	N/A
J0120	INJ TETRACYCLINE TO 250 MG	This service is not covered by Superior HealthPlan.	N/A
J0121	INJECTION OMADACYCLINE 1 MG	No pre-authorization is required for all providers.	N/A
J0122	INJECTION ERAVACYCLINE 1 MG	No pre-authorization is required for all providers.	N/A
J0128	INJECTION ABARELIX 10 MG	This is no longer a valid code.	N/A
J0129	ABATACEPT INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0130	INJ ABCIXIMAB 10 MG	No pre-authorization is required for all providers.	N/A
J0131	ACETAMINOPHEN INJECTION	No pre-authorization is required for all providers.	N/A
J0132	INJECTION ACETYLCYSTEINE 100 MG	No pre-authorization is required for all providers.	N/A
J0133	INJECTION ACYCLOVIR 5 MG	No pre-authorization is required for all providers.	N/A
J0135	INJECTION ADALIMUMAB 20 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0150	INJ ADENOSINE 6 MG (FOR PHOS COMPND USE A9270)	This is no longer a valid code.	N/A
J0151	INJ ADENOSINE DIAG 1M	This is no longer a valid code.	N/A
J0152	INJ, ADENOSINE, 30 MG	This is no longer a valid code.	N/A
J0153	ADENOSINE INJ 1MG	This service is not covered by Superior HealthPlan.	N/A

J0170	INJ ADRENALINE EPINEPHRINE TO 1 ML AMPULE	This is no longer a valid code.	N/A
J0171	ADRENALIN EPINEPHRINE INJECT	No pre-authorization is required for all providers.	N/A
J0178	AFLIBERCEPT INJECTION	No pre-authorization is required for all providers.	N/A
J0179	INJECTION BROLCICIZUMAB-DBLL 1 MG	This service is not covered by Superior HealthPlan.	N/A
J0180	INJECTION AGALSIDASE BETA 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0185	INJECTION APREPITANT 1 MG	No pre-authorization is required for all providers.	N/A
J0190	INJ BIPERIDEN LACTATE, PER 5 MG	No pre-authorization is required for all providers.	N/A
J0200	INJECTION, ALATROFLOXACIN MESYLATE, 100 MG	This service is not covered by Superior HealthPlan.	N/A
J0202	INJECTION ALEMTUZUMAB 1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J0205	INJ ALGLUCERASE PER 10 UNITS (CEREDASE)	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0207	INJ AMIFOSTINE 500 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0210	INJ METHYLDOPATE HCL TO 250 MG	No pre-authorization is required for all providers.	N/A
J0215	INJECTION, ALEFACEPT, 0.5 MG	This service is not covered by Superior HealthPlan.	N/A
J0220	ALGLUCOSIDASE ALFA INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0221	LUMIZYME INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0222	INJECTION PATISIRAN 0.1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0223	INJECTION GIVOSIRAN 0.5 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J0256	ALPHA 1 PROTEINASE INHIBITOR	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0257	GLASSIA INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0270	INJ ALPROSTADIL 1.25 MCG ADMIN DIR PHYS SUPERVS	This service is not covered by Superior HealthPlan.	N/A
J0275	ALPROSTADIL URETHRAL SUPP ADMIN MD NOT BY SELF	This service is not covered by Superior HealthPlan.	N/A
J0278	INJECTION AMIKACIN SULFATE 100 MG	No pre-authorization is required for all providers.	N/A
J0280	INJ AMINOPHYLLIN TO 250 MG	No pre-authorization is required for all providers.	N/A
J0282	INJ AMIODARONE HYDROCHLORIDE 30 MG	No pre-authorization is required for all providers.	N/A
J0285	INJ AMPHOTERICIN B 50 MG	No pre-authorization is required for all providers.	N/A
J0287	INJ AMPHOTERICIN B LIPID CMLPX 10 MG	No pre-authorization is required for all providers.	N/A
J0288	INJ AMPHOTERICIN B CHOLESTRYL 10 MG	No pre-authorization is required for all providers.	N/A
J0289	INJ AMPHOTERICIN B LIPOSOME 10 MG	No pre-authorization is required for all providers.	N/A
J0290	INJ AMPICILLIN TO 500 MG	No pre-authorization is required for all providers.	N/A
J0291	INJECTION PLAZOMICIN 5 MG	No pre-authorization is required for all providers.	N/A
J0295	INJ AMPICILLIN SODIUM/SULBACTAM SODIUM 1.5 GM	No pre-authorization is required for all providers.	N/A
J0300	INJ AMOBARBITAL TO 125 MG	No pre-authorization is required for all providers.	N/A
J0330	INJ SUCCINYLCHOLINE CHLORIDE TO 20 MG	No pre-authorization is required for all providers.	N/A
J0348	ANIDULAFUNGIN INJECTION	No pre-authorization is required for all providers.	N/A
J0350	INJ ANISTREPLASE PER 30 UNITS	This service is not covered by Superior HealthPlan.	N/A
J0360	INJ HYDRALAZINE HCL TO 20 MG	No pre-authorization is required for all providers.	N/A
J0364	INJECTION, APOMORPHINE HYDROCHLORIDE, 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0365	INJECTION APROTONIN 10000 KIU	This service is not covered by Superior HealthPlan.	N/A
J0370	INJ AQUMEPHYTON VIT K UP TO 10	No pre-authorization is required for all providers.	N/A
J0380	INJ METARAMINOL BITARTRATE, PER 10 MG	No pre-authorization is required for all providers.	N/A
J0390	INJ CHLOROQUINE HCL TO 250 MG	No pre-authorization is required for all providers.	N/A
J0395	INJ ARBUTAMINE HCL 1 MG	No pre-authorization is required for all providers.	N/A
J0400	INJ TRIMETHAPHAN CAMSYLATE UP TO 500 MG	No pre-authorization is required for all providers.	N/A
J0401	INJ ARIPIPAZOLE EXT REL 1M	No pre-authorization is required for all providers.	N/A
J0456	INJECTION, AZITHROMYCIN, 500 MG	No pre-authorization is required for all providers.	N/A
J0460	INJ ATROPINE SULFATE TO 0.3 MG	This is no longer a valid code.	N/A
J0461	ATROPINE SULFATE INJECTION	No pre-authorization is required for all providers.	N/A
J0470	INJ DIMECAPROL PER 100 MG	No pre-authorization is required for all providers.	N/A
J0475	INJ BACLOFEN 10 MG	No pre-authorization is required for all providers.	N/A
J0476	INJ BACLOFEN 50 MCG INTRATHECAL TRIAL	No pre-authorization is required for all providers.	N/A
J0480	INJECTION BASILIXIMAB 20 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0485	BELATACEPT INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0490	BELIMUMAB INJECTION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
J0500	INJ DICYCLIMINE TO 20MG	No pre-authorization is required for all providers.	N/A
J0515	INJ BENZTROPINE MESYLATE, PER 1 MG	No pre-authorization is required for all providers.	N/A
J0517	INJECTION BENRALIZUMAB 1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J0520	INJ BETHANECHOL CHL/MYOTONACHOL/URECHOLINE 5 MG	No pre-authorization is required for all providers.	N/A
J0530	INJ PEN G BENZATHINE/PROCAINE TO 600,000 UNITS	This is no longer a valid code.	N/A
J0540	INJ PEN G BENZATHINE/PROCAINE TO 1,200,000 UNITS	This is no longer a valid code.	N/A
J0550	INJ PEN G BENZATHINE/PROCAINE TO 2,400,000 UNITS	This is no longer a valid code.	N/A
J0558	PENG BENZATHINE/PROCAINE INJ	No pre-authorization is required for all providers.	N/A
J0559	PENG BENZATHINE/PROCAINE INJ	This is no longer a valid code.	N/A
J0560	INJ PEN G BENZATHINE TO 600,000 UNITS	This is no longer a valid code.	N/A
J0561	PENICILLIN G BENZATHINE INJ	No pre-authorization is required for all providers.	N/A
J0565	INJECTION BEZLOTOXUMAB 10 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0567	INJECTION CERLIPONASE ALFA 1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J0570	INJ PEN G BENZATHINE TO 1,200,000 UNITS	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0571	BUPRENORPHINE ORAL 1MG	This service is not covered by Superior HealthPlan.	N/A
J0572	BUPREN/NAL UP TO 3MG BUPRENO	This service is not covered by Superior HealthPlan.	N/A
J0573	BPN/NLX ORAL >3 MG BUT <=6 MG BPN	This service is not covered by Superior HealthPlan.	N/A
J0574	BUPREN/NAL 6.1 TO 10MG BUPRE	This service is not covered by Superior HealthPlan.	N/A
J0575	BUPREN/NAL OVER 10MG BUPRENO	This service is not covered by Superior HealthPlan.	N/A
J0580	INJ PEN G BENZATHINE TO 2,400,000 UNITS	This is no longer a valid code.	N/A
J0583	INJECTION, BIVALIRUDIN, 1 MG	No pre-authorization is required for all providers.	N/A
J0584	INJECTION BUROSUMAB-TWZA 1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J0585	INJECTION,ONABOTULINUMTOXINA	Prior authorization required for all providers except when services are rendered by an ophthalmologist.	Prior to 09/01/2019
J0586	ABOBOTULINUMTOXINA	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0587	INJ, RIMABOTULINUMTOXINB	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0588	INCOBOTULINUMTOXIN A	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0591	INJECTION DEOXYCHOLIC ACID 1 MG	This service is not covered by Superior HealthPlan.	N/A
J0592	INJ BUPRENORPHINE HYDROCHLOR 0.1 MG	No pre-authorization is required for all providers.	N/A
J0593	INJECTION LANADELUMAB-FLYO 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0594	INJECTION, BUSULFAN, 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0595	INJECTION, BUTORPHANOL TARTRATE, 1 MG	No pre-authorization is required for all providers.	N/A
J0596	INJ C1 ESTERASE INHIB RUCONEST 10 U	Pre-authorization required for all providers.	Prior to 09/01/2019
J0597	C-1 ESTERASE, BERINERT	This service is not covered by Superior HealthPlan.	N/A
J0598	C-1 ESTERASE, CINRYZE	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0599	INJECTION C-1 ESTERASE INHIBITOR 10 UNITS	Pre-authorization required for all providers.	Prior to 09/01/2019
J0600	INJ EDETATE CALCIUM DISODIUM UP TO 1000 MG	No pre-authorization is required for all providers.	N/A
J0604	CINACALCET ORAL 1 MG	This service is not covered by Superior HealthPlan.	N/A
J0606	INJECTION ETELCALCETIDE 0.1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J0610	INJ CALCIUM GLUCONATE PER 10 ML	No pre-authorization is required for all providers.	N/A
J0620	INJ CALCIUM GLYCEROPHOSPHATE/LACTATE PER 10 ML	This service is not covered by Superior HealthPlan.	N/A
J0630	INJ CALCITONIN SALMON TO 400 UNITS	No pre-authorization is required for all providers.	N/A
J0636	INJECTION CALCITRIOL 0.1 MCG	No pre-authorization is required for all providers.	N/A
J0637	INJECTION CASPOFUNGIN ACETATE 5 MG	No pre-authorization is required for all providers.	N/A
J0638	CANAKINUMAB INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0640	INJ LEUCOVORIN CALCIUM PER 50 MG	No pre-authorization is required for all providers.	N/A
J0641	INJECTION LEVOLEUCOVORIN NOS 0.5 MG	No pre-authorization is required for all providers.	N/A
J0642	INJECTION LEVOLEUCOVORIN (KHAPZORY), 0.5 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0670	INJ MEPIVACAINE HCL, PER 10 ML	No pre-authorization is required for all providers.	N/A
J0690	INJ CEFZOLIN SODIUM TO 500 MG	No pre-authorization is required for all providers.	N/A
J0691	INJECTION LEFAMULIN 1 MG	No pre-authorization is required for all providers.	N/A
J0692	INJECTION, CEFEPIME HYDROCHLORIDE, 500 MG	No pre-authorization is required for all providers.	N/A
J0694	INJ CEFOXITIN SODIUM 1 GM	No pre-authorization is required for all providers.	N/A
J0695	INJ CEFTOLOZANE 50 MG & TAZ 25 MG	No pre-authorization is required for all providers.	N/A
J0696	INJ CEFTRIAZONE SODIUM PER 250 MG	No pre-authorization is required for all providers.	N/A
J0697	INJ STERILE CEFUROXIME SODIUM PER 750 MG	No pre-authorization is required for all providers.	N/A
J0698	CEFOTAXIME SODIUM PER GM	No pre-authorization is required for all providers.	N/A
J0702	BETAMETHASONE ACET&SOD PHOSP	No pre-authorization is required for all providers.	N/A
J0704	INJ BETAMETHASONE SODIUM PHOSPHATE PER 4 MG	This is no longer a valid code.	N/A

J0706	INJECTION, CAFFEINE CITRATE, 5MG	No pre-authorization is required for all providers.	N/A
J0710	INJ CEPHAPIRIN SODIUM TO 1 GM	This service is not covered by Superior HealthPlan.	N/A
J0712	CEFTAROLINE FOSAMIL INJ	This service is not covered by Superior HealthPlan.	N/A
J0713	INJECTION, CEFTAZIDIME, PER 500 MG	No pre-authorization is required for all providers.	N/A
J0714	INJ CFTAZDM & AVIBCTM 0.5 G/0.125 G	No pre-authorization is required for all providers.	N/A
J0715	INJ CEFTIZOXIME SODIUM PER 500 MG	No pre-authorization is required for all providers.	N/A
J0716	CENTRUROIDES IMMUNE F(AB)	No pre-authorization is required for all providers.	N/A
J0717	CERTOLIZUMAB PEGOL INJ 1M	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0718	CERTOLIZUMAB PEGOL INJ	This is no longer a valid code.	N/A
J0720	INJ CHLORAMPHENICOL SODIUM SUCCINATE TO 1 GM	No pre-authorization is required for all providers.	N/A
J0725	INJ CHORIONIC GONADOTROPIN PER 1000 USP UNITS	No pre-authorization is required for all providers.	N/A
J0735	INS CLONIDINE HYDROCHLORIDE 1 MG	No pre-authorization is required for all providers.	N/A
J0740	INJ CIDOFOVIR 375 MG	No pre-authorization is required for all providers.	N/A
J0742	INJ IMP 4 MG CILASTATIN 4 MG AND RELEBACTAM 2 MG	This service is not covered by Superior HealthPlan.	N/A
J0743	INJ CILASTATIN SODIUM; IMPENEM PER 250MG	No pre-authorization is required for all providers.	N/A
J0744	INJECTION, CIPROFLOXACIN FOR INTRAVENOUS INFUSION, 200 MG	No pre-authorization is required for all providers.	N/A
J0745	INJ CODEINE PHOSPHATE PER 30 MG	No pre-authorization is required for all providers.	N/A
J0760	INJ COLCHICINE PER 1 MG	This is no longer a valid code.	N/A
J0770	INJ COLISTIMETHATE SODIUM TO 150 MG	No pre-authorization is required for all providers.	N/A
J0775	COLLAGENASE, CLOST HIST INJ	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0780	INJ PROCHLORPERAZINE TO 10 MG	No pre-authorization is required for all providers.	N/A
J0791	INJECTION CRIZANLIZUMAB-TMCA 5 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J0795	INJECTION CORTICORELIN OVINE TRIFLUTATE 1 MICROGRAM	No pre-authorization is required for all providers.	N/A
J0800	INJ CORTICOTROPIN TO 40 UNITS	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0833	COSYNTROPIN INJECTION NOS	This is no longer a valid code.	N/A
J0834	INJECTION COSYNTROPIN 0.25 MG	No pre-authorization is required for all providers.	N/A
J0840	CROTALIDAE POLY IMMUNE FAB	No pre-authorization is required for all providers.	N/A
J0841	INJECTION CROTALIDAE IMMUNE F120 MG	This service is not covered by Superior HealthPlan.	N/A
J0850	INJ CYTOMEGALOVIRUS IMMUNE GLOBULIN IV PER VIAL	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0875	INJECTION DALBAVANCIN 5MG	No pre-authorization is required for all providers.	N/A
J0878	INJECTION DAPTOMYCIN 1 MG	No pre-authorization is required for all providers.	N/A
J0880	INJECTION, DARBEPOETIN ALFA, 5 MCG	This is no longer a valid code.	N/A
J0881	INJECTION DARBEPOETIN ALFA 1 MICROGRAM NON-ESRD USE	Pre-authorization required for all providers.	Prior to 09/01/2019
J0882	INJECTION DARBEPOETIN ALFA 1 MICROGRAM FOR ESRD ON DIALYSIS	Pre-authorization required for all providers.	Prior to 09/01/2019
J0883	ARGATROBAN NONESRD USE 1MG	No pre-authorization is required for all providers.	N/A
J0884	ARGATROBAN ESRD DIALYSIS 1MG	No pre-authorization is required for all providers.	N/A
J0885	INJECTION EPOETIN ALFA FOR NON-ESRD USE 1000 UNITS	Pre-authorization required for all providers.	Prior to 09/01/2019
J0886	INJECTION EPOETIN ALFA 1000 UNITS FOR ESRD ON DIALYSIS	This is no longer a valid code.	N/A
J0887	EPOETIN BETA ESRD USE	This service is not covered by Superior HealthPlan.	N/A
J0888	EPOETIN BETA NON ESRD	This service is not covered by Superior HealthPlan.	N/A
J0890	PEGINESATIDE INJECTION	This service is not covered by Superior HealthPlan.	N/A
J0894	INJECTION, DECITABINE, 1 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J0895	INJ DEFEROXAMINE MESYLATE 500 MG PER 5 CC	No pre-authorization is required for all providers.	N/A
J0896	INJECTION LUSPATERCEPT-AAAMT 0.25 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J0897	DENOSUMAB INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J0900	INJ TESTOSTERONE ENANTHATE/ESTRADIOL VALERATE 1C	This is no longer a valid code.	N/A
J0945	INJ BROMPHENIRAMINE MALEATE PER 10 MG	This service is not covered by Superior HealthPlan.	N/A
J0950	INJ DELALUTIN TO 250MG	No pre-authorization is required for all providers.	N/A
J0970	INJ ESTRADIOL VALERATE TO 40 MG	This is no longer a valid code.	N/A
J1000	INJ DEPO-ESTRADIOL CYPIONATE TO 5 MG	No pre-authorization is required for all providers.	N/A
J1020	INJ METHYLPREDNISOLONE ACETATE 20 MG	No pre-authorization is required for all providers.	N/A
J1030	INJ METHYLPREDNISOLONE ACETATE 40 MG	No pre-authorization is required for all providers.	N/A
J1040	INJ METHYLPREDNISOLONE ACETATE 80 MG	No pre-authorization is required for all providers.	N/A
J1050	MEDROXYPROGESTERONE ACETATE	No pre-authorization is required for all providers.	N/A
J1060	INJ TESTOSTERONE/ESTRADIOL CYPIONATE TO 1 ML	This is no longer a valid code.	N/A
J1070	INJ TESTOSTERONE CYPIONATE TO 100 MG	This is no longer a valid code.	N/A
J1071	INJ TESTOSTERONE CYPIONATE	No pre-authorization is required for all providers.	N/A
J1080	INJ TESTOSTERONE CYPIONATE 1 CC 200 MG	This is no longer a valid code.	N/A
J1094	INJECTION DEXAMETHASONE ACTAT 1 MG	This service is not covered by Superior HealthPlan.	N/A
J1095	INJECTION DEXAMETHASONE 9 PERCENT	This service is not covered by Superior HealthPlan.	N/A
J1096	DEXAMETHASONE LACRIMAL OPHTHALMIC INSERT 0.1 MG	No pre-authorization is required for all providers.	N/A
J1097	PHEN 10.16 AND KET 2.88 MG/ML OPHI IRR SOL 1 ML	This service is not covered by Superior HealthPlan.	N/A
J1100	INJ DEXMETHOSON SODIM PHOSHATE 1 MG	No pre-authorization is required for all providers.	N/A
J1110	INJ DIHYDROERGOTAMINE MESYLATE PER 1 MG	No pre-authorization is required for all providers.	N/A
J1120	INJ ACETAZOLAMIDE SODIUM TO 500 MG	No pre-authorization is required for all providers.	N/A
J1130	INJ DICLOFENAC SODIUM 0.5MG	No pre-authorization is required for all providers.	N/A
J1160	INJ DIGOXIN TO 0.5 MG	No pre-authorization is required for all providers.	N/A
J1162	INJECTION DIGOXIN IMMUNE FAB OVINE /VIAL	No pre-authorization is required for all providers.	N/A
J1165	INJ PHENYTOIN SODIUM, PER 50 MG	No pre-authorization is required for all providers.	N/A
J1170	INJ HYDROMORPHONE TO 4 MG	No pre-authorization is required for all providers.	N/A
J1180	INJ DYPHYLLINE TO 500 MG	This service is not covered by Superior HealthPlan.	N/A
J1190	INJ DEXRAZOXANE HYDROCHLORIDE PER 250 MG	No pre-authorization is required for all providers.	N/A
J1200	INJ DIPHENHYDRAMINE HCL TO 50 MG	No pre-authorization is required for all providers.	N/A
J1201	INJECTION CETIRIZINE HYDROCHLORIDE 0.5 MG	This service is not covered by Superior HealthPlan.	N/A
J1205	INJ CHLOROTHIAZIDE SODIUM, PER 500 MG	No pre-authorization is required for all providers.	N/A
J1212	INJ DMSO DIMETHYL SULFOXIDE 50% 50 ML	No pre-authorization is required for all providers.	N/A
J1230	INJ METHADONE HCL TO 20 MG	No pre-authorization is required for all providers.	N/A
J1240	INJ DIMENHYDRINATE TO 50 MG	No pre-authorization is required for all providers.	N/A
J1245	INJ DIPYRIDAMOLE PER 10MG	No pre-authorization is required for all providers.	N/A
J1250	INJECTION, DOBUTAMINE HYDROCHLORIDE, PER 250 MG	No pre-authorization is required for all providers.	N/A
J1260	INJ DOLASETRON MESYLATE 1 MG	No pre-authorization is required for all providers.	N/A
J1265	INJECTION PHENYTOIN SODIUM /50 MG	No pre-authorization is required for all providers.	N/A
J1267	DORIPENEM INJECTION	No pre-authorization is required for all providers.	N/A
J1270	INJECTION, DOXERCALCIFEROL, 1 MCG	No pre-authorization is required for all providers.	N/A
J1290	ECALLANTIDE INJECTION	This service is not covered by Superior HealthPlan.	N/A
J1300	ECULIZUMAB INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1301	INJECTION EDARAVONE 1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J1303	INJECTION RAVULIZUMAB-CWVZ 10 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1320	INJ AMITRIPTYLINE HCL TO 20 MG	This service is not covered by Superior HealthPlan.	N/A
J1322	ELOSULFASE ALFA, INJECTION	Pre-authorization required for all providers.	Prior to 09/01/2019
J1324	INJECTION, ENFUVIRTIDE, 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1325	INJ EPOPROSTENOL 0.5 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1327	INJECTION, EPTIFIBATIDE 5MG	No pre-authorization is required for all providers.	N/A
J1330	INJ ERGONOVINE MALEATE TO 0.2 MG	No pre-authorization is required for all providers.	N/A
J1335	INJECTION, ERTAPENEM SODIUM, 500 MG	No pre-authorization is required for all providers.	N/A
J1364	INJ ERYTHROMYCIN LACTOBIONATE PER 500 MG	No pre-authorization is required for all providers.	N/A
J1380	INJ ESTRADIOL VALERATE TO 10 MG	No pre-authorization is required for all providers.	N/A
J1390	INJ ESTRADIOL VALERATE TO 20 MG	This is no longer a valid code.	N/A
J1405	INJECTION ESTRADURIN	This is no longer a valid code.	N/A
J1410	INJ ESTROGEN CONJUGATED PER 25 MG	No pre-authorization is required for all providers.	N/A
J1428	INJECTION ETEPLIRSEN 10 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1429	INJECTION GOLODIRSEN 10 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J1430	INJECTION ETHANOLAMINE OLEATE 100 MG	This service is not covered by Superior HealthPlan.	N/A
J1435	INJ ESTRONE PER 1 MG	No pre-authorization is required for all providers.	N/A
J1436	INJ ETIDRONATE DISODIUM TO 300 MG	No pre-authorization is required for all providers.	N/A
J1438	INJECTION ETANERCEPT 25 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1439	INJ FERRIC CARBOXYMALTOS 1MG	No pre-authorization is required for all providers.	N/A
J1440	INJ FILGRASTIM 300 MCG	This is no longer a valid code.	N/A
J1441	INJ FILGRASTIM 480 MCG	This is no longer a valid code.	N/A
J1442	INJ FILGRASTIM EXCL BIOSIMIL	Pre-authorization required for all providers.	Prior to 09/01/2019
J1443	INJ FERRIC PRPP CIT SOL 0.1 MG IRON	This service is not covered by Superior HealthPlan.	N/A

J1444	INJ FERRIC PYROPHOSPHATE CITRATE PWD 0.1 MG IRON	No pre-authorization is required for all providers.	N/A
J1446	INJ, TBO-FILGRASTIM, 5 MC	This is no longer a valid code.	N/A
J1447	INJECTION TBO-FILGRASTIM 1 MICROG	No pre-authorization is required for all providers.	N/A
J1450	INJECTION, FLUCONAZOLE, 200 MG	No pre-authorization is required for all providers.	N/A
J1451	INJECTION FOMEPIZOLE 15 MG	No pre-authorization is required for all providers.	N/A
J1452	INJ FOMIVIRSEN SODIUM IO 1.65MG	This service is not covered by Superior HealthPlan.	N/A
J1453	FOSAPREPITANT INJECTION	No pre-authorization is required for all providers.	N/A
J1454	INJ FOSNETUPITANT 235 MG AND PALONOSETRON 0.25 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J1455	INJ FOSCARNET SODIUM PER 1000MG	This service is not covered by Superior HealthPlan.	N/A
J1457	INJECTION GALLIUM NITRATE 1 MG	No pre-authorization is required for all providers.	N/A
J1458	INJECTION, GALSULFASE, 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1459	INJ IVIG PRIVIGEN 500 MG	No pre-authorization is required for all providers.	N/A
J1460	INJ GAMMA GLOBULIN IM 1 CC	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1470	INJ GAMMA GLOBULIN IM 2 CC	This is no longer a valid code.	N/A
J1480	INJ GAMMA GLOBULIN IM 3 CC	This is no longer a valid code.	N/A
J1490	INJ GAMMA GLOBULIN IM 4 CC	This is no longer a valid code.	N/A
J1500	INJ GAMMA GLOBULIN IM 5 CC	This is no longer a valid code.	N/A
J1510	INJ GAMMA GLOBULIN IM 6 CC	This is no longer a valid code.	N/A
J1520	INJ GAMMA GLOBULIN IM 7 CC	This is no longer a valid code.	N/A
J1530	INJ GAMMA GLOBULIN IM 8 CC	This is no longer a valid code.	N/A
J1540	INJ GAMMA GLOBULIN IM 9 CC	This is no longer a valid code.	N/A
J1550	INJ GAMMA GLOBULIN IM 10 CC	This is no longer a valid code.	N/A
J1555	INJECTION IMMUNE GLOBULIN 100 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1556	INJ, IMM GLOB BIVIGAM, 500M	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1557	GAMMAPLEX INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1558	INJECTION IMMUNE GLOBULIN XEMBIFY 100 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J1559	HIZENTRA INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1560	INJ GAMMA GLOBULIN IM OVER 10 CC	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1561	GAMUNEX-C/GAMMAKED	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1562	VIVAGLOBIN, INJ	This service is not covered by Superior HealthPlan.	N/A
J1563	INJ IMMUNE GLOB IV 1G	This is no longer a valid code.	N/A
J1564	INJECTION IMMUNE GLOBULIN 10 MG	This is no longer a valid code.	N/A
J1566	IMMUNE GLOBULIN, POWDER	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1568	OCTAGAM INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1569	GAMMAGARD LIQUID INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1570	INJ GANCICLOVIR SODIUM 500 MG	No pre-authorization is required for all providers.	N/A
J1571	HEPAGAM B IM INJECTION	No pre-authorization is required for all providers.	N/A
J1572	FLEBOGAMMA INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1573	HEPAGAM B INTRAVENOUS INJ	No pre-authorization is required for all providers.	N/A
J1575	INJ IG/HYALURONIDASE 100 MG IG	Pre-authorization required for all providers.	Prior to 09/01/2019
J1580	INJ GARAMYCIN GENTAMICIN TO 80 MG	No pre-authorization is required for all providers.	N/A
J1590	INJECTION, GATIFLOXACIN, 10MG	This is no longer a valid code.	N/A
J1595	INJECTION, GLATIRAMER ACETATE, 20 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1599	IVIG NON-LYOPHILIZED, NOS	Authorization is required for all non-participating providers. Authorization is required for participating providers if billed amount is greater than or equal to \$500.	Prior to 09/01/2019
J1600	INJ GOLD SODIUM THIOAMLEATE TO 50 MG	No pre-authorization is required for all providers.	N/A
J1602	GOLIMUMAB FOR IV USE 1M	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1610	INJ GLUCAGON HYDROCHLORIDE PER 1 MG	No pre-authorization is required for all providers.	N/A
J1620	INJ GONADORELIN HYDROCHLORIDE PER 100 MCG	No pre-authorization is required for all providers.	N/A
J1625	INJECTION GRANISETRON HYDROCHLORIDE PER 1 MG	This is no longer a valid code.	N/A
J1626	INJ GRANISETRON HYDROCHLORIDE 100 MCG	No pre-authorization is required for all providers.	N/A
J1627	INJ GRANISETRON EXT-RLSE 0.1 MG	No pre-authorization is required for all providers.	N/A
J1628	INJECTION GUSELKUMAB 1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J1630	INJ HALOPERIDOL TO 5 MG	No pre-authorization is required for all providers.	N/A
J1631	INJ HALOPERIDOL DECANOATE PER 50 MG	No pre-authorization is required for all providers.	N/A
J1640	INJECTION HEMIN 1 MG	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
J1642	INJ HEPARIN SODIUM-HEP LOCK FLUSH-PER 10 UNITS	No pre-authorization is required for all providers.	N/A
J1644	INJ HEPARIN SODIUM PER 1000 UNITS	No pre-authorization is required for all providers.	N/A
J1645	INJ DALTEPARIN SODIUM PER 2500 IU	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1650	INJECTION, ENOXAPARIN SODIUM, 10 MG	No pre-authorization is required for all providers.	N/A
J1652	INJ FONDAPARINUX SODIUM 0.5 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1655	INJECTION, TINZAPARIN SODIUM, 1000 IU	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
J1670	INJ TETANUS IMMUNE GLOBULIN HUMAN TO 250 UNITS	No pre-authorization is required for all providers.	N/A
J1680	HUMAN FIBRINOGEN CONC INJ	This is no longer a valid code.	N/A
J1700	INJ HYDROCORTISONE ACETATE TO 25 MG	This service is not covered by Superior HealthPlan.	N/A
J1710	INJ HYDROCORTISONE SODIUM PHOSPHATE TO 50 MG	This service is not covered by Superior HealthPlan.	N/A
J1720	INJ HYDROCORTISONE SODIUM SUCCINATE TO 100 MG	No pre-authorization is required for all providers.	N/A
J1725	HYDROXYPROGESTERONE CAPROATE	This is no longer a valid code.	N/A
J1726	INJECTION HPC 10 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1729	INJECTION HPC NOS 10 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1730	INJ DIAZOXIDE TO 300 MG	This service is not covered by Superior HealthPlan.	N/A
J1740	INJECTION, IBANDRONATE SODIUM, 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1742	INJ IBUTILIDE FUMARATE 1 MG	No pre-authorization is required for all providers.	N/A
J1743	IDURSULFASE INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1744	INJECTION, ICATIBANT, 1 MG	This service is not covered by Superior HealthPlan.	N/A
J1745	INJ INFLIXIMAB EXCL BIOSIMILR 10 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1746	INJECTION IBALIZUMAB-UIYK 10 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J1750	INJ IRON DEXTRAN	No pre-authorization is required for all providers.	N/A
J1751	IRON DEXTRAN 165 INJECTION	This is no longer a valid code.	N/A
J1752	IRON DEXTRAN 267 INJECTION	This is no longer a valid code.	N/A
J1756	INJECTION IRON SUCROSE 1 MG	No pre-authorization is required for all providers.	N/A
J1785	INJ IMIGLUCERASE PER UNIT	This is no longer a valid code.	N/A
J1786	IMUGLUCERASE INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1790	INJ DROPERIDOL TO 5 MG	No pre-authorization is required for all providers.	N/A
J1800	INJ PROPRANOLOL HCL TO 1 MG	No pre-authorization is required for all providers.	N/A
J1810	INJ DROPERIDOL & FENTANYL CITRATE TO 2 ML AMP	This service is not covered by Superior HealthPlan.	N/A
J1815	INJECTION INSULIN PER 5 UNITS	This service is not covered by Superior HealthPlan.	N/A
J1817	INSULIN ADMIN THRU DME PER 50 UNITS	This service is not covered by Superior HealthPlan.	N/A
J1825	INJECTION INTERFERON BETA-1A 33 MCG	This is no longer a valid code.	N/A
J1826	INTERFERON BETA-1A INJ	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1830	INTERFERON BETA-1B PER 0.25 MG ADMIN PHYS SUPERV	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1833	INJECTION ISAVUONAZONIUM 1 MG	No pre-authorization is required for all providers.	N/A
J1835	INJECTION, ITRACONAZOLE, 50 MG	This service is not covered by Superior HealthPlan.	N/A
J1840	INJ KANAMYCIN SULFATE TO 500 MG	No pre-authorization is required for all providers.	N/A
J1850	INJ KANAMYCIN TO 75 MG	No pre-authorization is required for all providers.	N/A
J1885	INJ KETOROLAC TROMETHAMINE PER 15MG	No pre-authorization is required for all providers.	N/A
J1890	INJ CEPHALOTHIN SODIUM TO 1 GM	This service is not covered by Superior HealthPlan.	N/A
J1930	LANREOTIDE INJECTION	Pre-authorization required for all providers.	Prior to 09/01/2019
J1931	INJECTION LARONIDASE 0.1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1940	INJ FUROSEMIDE TO 20 MG	No pre-authorization is required for all providers.	N/A
J1942	ARIPRAZOLE LAUROXIL 1MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J1943	INJECTION ARIPIRAZOLE LAUROXIL 1 MG	No pre-authorization is required for all providers.	N/A
J1944	INJECTION ARIPIRAZOLE LAUROXIL 1 MG	No pre-authorization is required for all providers.	N/A
J1945	INJECTION LEPIRUDIN 50 MG	No pre-authorization is required for all providers.	N/A
J1950	INJ LEUPROLIDE ACETATE PER 3.75 MG	No pre-authorization is required for all providers.	N/A
J1953	LEVETIRACETAM INJECTION	No pre-authorization is required for all providers.	N/A
J1955	INJECTION, LEVOCARNITINE, PER 1 GMI	No pre-authorization is required for all providers.	N/A
J1956	INJ LEVOFLOXACIN 250 MG	No pre-authorization is required for all providers.	N/A
J1960	INJ LEVORPHANOL TARTRATE TO 2 MG	No pre-authorization is required for all providers.	N/A
J1980	INJ HYOSCYAMINE SULFATE TO .25 MG	No pre-authorization is required for all providers.	N/A
J1990	INJ CHLORDIAZEPOXIDE HCL TO 100 MG	This service is not covered by Superior HealthPlan.	N/A
J2001	INJECTION, LIDOCAINE HCl FOR INTRAVENOUS INFUSION, 10 MG	This service is not covered by Superior HealthPlan.	N/A

J2010	INJ LINCOMYCIN HCL TO 300 MG	No pre-authorization is required for all providers.	N/A
J2020	INJECTION, LINEZOLID, 200MG	This service is not covered by Superior HealthPlan.	N/A
J2060	INJ LORAZEPAM 2MG	No pre-authorization is required for all providers.	N/A
J2062	LOXAPINE FOR INHALATION 1 MG	No pre-authorization is required for all providers.	N/A
J2150	INJ MANNITOL 25% IN 50 ML	No pre-authorization is required for all providers.	N/A
J2170	INJECTION, MECASERMIN, 1 MG	This service is not covered by Superior HealthPlan.	N/A
J2175	INJ MEPERIDINE HYDROCHLORIDE PER 100 MG	No pre-authorization is required for all providers.	N/A
J2180	INJ MEPERIDINE & PROMETHAZINE HCL TO 50 MG	This service is not covered by Superior HealthPlan.	N/A
J2182	INJECTION MEPOLIZUMAB 1MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2185	INJECTION, MEROPENEM, 100 MG	No pre-authorization is required for all providers.	N/A
J2186	INJECTION MEROPENEM VABORBACTAM	No pre-authorization is required for all providers.	N/A
J2210	INJ METHYLERGONOVINE MALEATE TO 0.2 MG	No pre-authorization is required for all providers.	N/A
J2212	INJECTION, METHYLNALTREXONE, 0.1 MG	This service is not covered by Superior HealthPlan.	N/A
J2248	INJECTION, MICAFLUNGIN SODIUM, 1 MG	No pre-authorization is required for all providers.	N/A
J2250	INJECTION, MIDAZOLAM HYDROCHLORIDE, PER 1 MG	No pre-authorization is required for all providers.	N/A
J2260	MILRINONE LACTATE PER 5 ML	No pre-authorization is required for all providers.	N/A
J2265	MINOCYCLINE HYDROCHLORIDE	This service is not covered by Superior HealthPlan.	N/A
J2270	INJ MORPHINE SULFATE TO 10 MG	No pre-authorization is required for all providers.	N/A
J2271	MORPHINE SO4 INJECTION 100MG	This is no longer a valid code.	N/A
J2274	INJ MORPHINE PF EPID ITHC	This service is not covered by Superior HealthPlan.	N/A
J2275	MORPHINE SULFATE INJECTION	This is no longer a valid code.	N/A
J2278	INJECTION ZICONOTIDE 1 MICROGRAM	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2280	INJECTION, MOXIFLOXACIN, 100 MG	No pre-authorization is required for all providers.	N/A
J2300	INJECTION, NALBUPHINE HYDROCHLORIDE, PER 10 MG	No pre-authorization is required for all providers.	N/A
J2310	INJECTION, NALOXONE HYDROCHLORIDE, PER 1 MG	No pre-authorization is required for all providers.	N/A
J2315	INJECTION, NALTREXONE, DEPOT FORM, 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2320	INJ NANDROLONE DECANOATE TO 50 MG	No pre-authorization is required for all providers.	N/A
J2323	NATALIZUMAB INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2324	INJECTION NESIRITIDE 0.5 MG	No pre-authorization is required for all providers.	N/A
J2325	INJECTION NESIRITIDE 0.1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2326	INJECTION NUSINERSEN 0.1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2350	INJECTION OCRELIZUMAB 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2353	INJECTION, OCTREOTIDE, DEPOT FORM FOR INTRAMUSCULAR INJECTION, 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2354	INJ OCTREOTIDE, NON-DEPOT FORM FOR SUBCNIS OR INTRVNS INJ 25 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2355	INJ OPRELVEKIN 5 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2357	INJECTION OMALIZUMAB 5 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2358	OLANZAPINE LONG-ACTING INJ	No pre-authorization is required for all providers.	N/A
J2360	INJ ORPHENADRINE TO 60 MG	No pre-authorization is required for all providers.	N/A
J2370	INJ PHENYLEPHRINE HCL TO 1 ML	No pre-authorization is required for all providers.	N/A
J2400	INJ CHLOROPROCAINE HCL, PER 30 ML	No pre-authorization is required for all providers.	N/A
J2405	INJ ONDANSETRON HCL PER 1 MG	No pre-authorization is required for all providers.	N/A
J2407	INJECTION ORITAVANCIN 10 MG	No pre-authorization is required for all providers.	N/A
J2410	INJ OXYMORPHONE HCL TO 1 MG	No pre-authorization is required for all providers.	N/A
J2425	INJECTION PALIFERMIN 50 MICROGRAMS	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2426	PALIPERIDONE PALMITATE INJ	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2430	INJ PAMIDRONATE DISODIUM PER 30 MG	No pre-authorization is required for all providers.	N/A
J2440	INJ PAPAVERINE HCL TO 60 MG	No pre-authorization is required for all providers.	N/A
J2460	INJ OXYTETRACYCLINE HCL TO 50 MG	This service is not covered by Superior HealthPlan.	N/A
J2469	INJECTION PALONOSETRON HCL 25 MCG	No pre-authorization is required for all providers.	N/A
J2501	INJECTION PARICALCITOL 1 MCG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2502	INJ PASIREOTIDE LONG ACTING 1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J2503	INJECTION PEGAPTANIB SODIUM 0.3 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2504	INJECTION PEGADEMASE BOVINE 25 IU	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2505	INJECTION, PEGFILGRASTIM, 6 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J2507	PEGLICASE INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2510	INJ PENICILLIN G PROCAIN AQUEOUS TO 600,000 UNIT	No pre-authorization is required for all providers.	N/A
J2513	INJECTION PENTASTARCH 10% SOLUTION 100 ML	No pre-authorization is required for all providers.	N/A
J2515	INJ PENTOBARBITAL SODIUM, PER 50 MG.	No pre-authorization is required for all providers.	N/A
J2540	INJ PENICILLIN G POTASSIUM TO 600,000 UNITS	No pre-authorization is required for all providers.	N/A
J2543	INJECTION, PIPERACILLIN SODIUM TAZOBACTAM SODIUM 1.125 GRAMS	No pre-authorization is required for all providers.	N/A
J2545	PENTAMIDINE NON-COMP UNIT	No pre-authorization is required for all providers.	N/A
J2547	INJECTION PERAMIVIR 1 MG	No pre-authorization is required for all providers.	N/A
J2550	INJ PROMETHAZINE HCL TO 50 MG	No pre-authorization is required for all providers.	N/A
J2560	INJ PHENOBARBITAL SODIUM TO 120 MG	No pre-authorization is required for all providers.	N/A
J2562	PLERIXAFOR INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2590	INJ OXYTOCIN TO 10 UNITS	No pre-authorization is required for all providers.	N/A
J2597	INJECTION, DESMOPRESSIN ACETATE/PER 1MCG (DDAVP)	No pre-authorization is required for all providers.	N/A
J2650	INJ PREDNISOLONE ACETATE TO 1 ML	This service is not covered by Superior HealthPlan.	N/A
J2670	INJ TOLAZOLINE HCL TO 25 MG	No pre-authorization is required for all providers.	N/A
J2675	INJECTION, PROGESTERONE, PER 50 MG	No pre-authorization is required for all providers.	N/A
J2680	INJ FLUPHENAZINE DECANOATE TO 25 MG	No pre-authorization is required for all providers.	N/A
J2690	INJ PROCAINAMIDE HCL TO 1 GM	No pre-authorization is required for all providers.	N/A
J2700	INJ OXACILLIN SODIUM TO 250 MG	No pre-authorization is required for all providers.	N/A
J2704	INJ, PROPOFOL, 10 MG	This service is not covered by Superior HealthPlan.	N/A
J2710	INJ NEOSTIGMINE METHYLSULFATE TO 0.5 MG	No pre-authorization is required for all providers.	N/A
J2720	INJ PROTAMINE SULFATE PER 10 MG	No pre-authorization is required for all providers.	N/A
J2724	PROTEIN C CONCENTRATE	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2725	INJ PROTIRELIN PER 250 MCG	This service is not covered by Superior HealthPlan.	N/A
J2730	INJ PRALIDOXIME CHLORIDE TO 1 GM	No pre-authorization is required for all providers.	N/A
J2760	INJ PHENTOLAMINE MESYLATE TO 5 MG	No pre-authorization is required for all providers.	N/A
J2765	INJ METOCLOPRAMIDE HCL TO 10 MG	No pre-authorization is required for all providers.	N/A
J2770	INJ QUINUPRISTIN/DALFOPRISTIN 500MG	No pre-authorization is required for all providers.	N/A
J2778	RANIBIZUMAB INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2780	INJECTION, RANITIDINE HYDROCHLORIDE 25 MG	No pre-authorization is required for all providers.	N/A
J2783	INJECTION, RASBURICASE, 0.5 MG	This service is not covered by Superior HealthPlan.	N/A
J2785	REGADENOSON INJECTION	No pre-authorization is required for all providers.	N/A
J2786	INJECTION RESLIZUMAB 1MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2787	RIBOFLAVIN 5'-PHOSPHATE OPHTHALMIC SOL TO 3 ML	This service is not covered by Superior HealthPlan.	N/A
J2788	RHO D IMMUNE GLOBULIN 50 MCG	No pre-authorization is required for all providers.	N/A
J2790	RHO D IMMUNE GLOBULIN INJ	No pre-authorization is required for all providers.	N/A
J2791	RHOPHYLAC INJECTION	No pre-authorization is required for all providers.	N/A
J2792	INJ RHO D IMMUNE GLOBULIN IV HUMAN 100 IU	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2793	RILONACEPT INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2794	INJECTION RISPERIDONE 0.5 MG	No pre-authorization is required for all providers.	N/A
J2795	INJ ROPIVACAINE HYDROCHLORIDE 1 MG	No pre-authorization is required for all providers.	N/A
J2796	ROMPLOSTIM INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2797	INJECTION ROLAPITANT 0.5 MG	This service is not covered by Superior HealthPlan.	N/A
J2798	INJECTION RISPERIDONE 0.5 MG	No pre-authorization is required for all providers.	N/A
J2800	INJ METHOCARBAMOL TO 10 ML	No pre-authorization is required for all providers.	N/A
J2805	INJECTION SINCALIDE 5 MICROGRAMS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
J2810	INJ THEOPHYLLINE PER 40 MG	No pre-authorization is required for all providers.	N/A
J2820	INJ SARGRAMOSTIN (GM-CSF)/50MCG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2840	INJ SEBELIPASE ALFA 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J2850	INJECTION SECRETIN SYNTHETIC HUMAN 1 MICROGRAM	No pre-authorization is required for all providers.	N/A
J2860	INJECTION SILTUXIMAB 10 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J2910	INJ AUROTHIOGLUCOSE TO 50 MG	This service is not covered by Superior HealthPlan.	N/A
J2912	INJ SODIUM CHLORIDE, 0.9 % PER 2 ML	No pre-authorization is required for all providers.	N/A
J2916	INJ SODIM FERRIC GLUCONATE 12.5 MG	No pre-authorization is required for all providers.	N/A
J2920	INJ METHYLPREDNISOLONE SODIUM SUCCINATE TO 40 MG	No pre-authorization is required for all providers.	N/A
J2930	INJ METHYLPREDNISOLONE SODIUM SUCCINATE TO 125MG	No pre-authorization is required for all providers.	N/A
J2940	INJECTION, SOMATREM, 1 MG	This service is not covered by Superior HealthPlan.	N/A

J2941	INJECTION SOMATROPIN, 1MG	This service is not covered by Superior HealthPlan.	N/A
J2950	INJ PROMAZINE HCL TO 25 MG	No pre-authorization is required for all providers.	N/A
J2993	INJ RETEPLASE 18.8 MG	No pre-authorization is required for all providers.	N/A
J2995	INJ STREPTOKINASE PER 250,000 IU	This service is not covered by Superior HealthPlan.	N/A
J2996	INJ ALTEPLASE RECOMBINANT PER 10MG	This is no longer a valid code.	N/A
J2997	INJ ALTEPLASE RECOMBINANT 1 MG	No pre-authorization is required for all providers.	N/A
J3000	INJ STREPTOMYCIN TO 1 GM	No pre-authorization is required for all providers.	N/A
J3005	INJECTION STRONTIUM-89 CHLORIDE PER 10PL	This is no longer a valid code.	N/A
J3010	INJ FENTANYL CITRATE TO 2 ML	No pre-authorization is required for all providers.	N/A
J3030	INJ SUMATRIPTAN SUCCINATE 6 MG ADMIN PHYS SUPERV	No pre-authorization is required for all providers.	N/A
J3031	INJECTION FREMANEZUMAB-VFRM 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J3060	INJ, TALIGLUCERACE ALFA 10	Pre-authorization is required for all providers.	Prior to 09/01/2019
J3070	INJECTION PENTAZOCINE 30 MG	No pre-authorization is required for all providers.	N/A
J3090	INJECTION TEDIZOLID PHOSPHATE 1 MG	No pre-authorization is required for all providers.	N/A
J3095	TELEVANCIN INJECTION	This service is not covered by Superior HealthPlan.	N/A
J3101	TENECTEPLASE INJECTION	No pre-authorization is required for all providers.	N/A
J3105	INJ TERBUTALINE SULFATE TO 1 MG	No pre-authorization is required for all providers.	N/A
J3110	INJ TESLAC UP TO 100 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J3111	INJECTION ROMOSUZUMAB-AQQG 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J3120	INJ TESTOSTERONE ENANTHATE TO 100 MG	This is no longer a valid code.	N/A
J3121	INJ TESTOSTERO ENANTHATE 1MG	No pre-authorization is required for all providers.	N/A
J3130	INJ TESTOSTERONE ENANTHATE TO 200 MG	This is no longer a valid code.	N/A
J3140	INJ TESTOSTERONE SUSPENSION TO 50 MG	This is no longer a valid code.	N/A
J3145	TESTOSTERONE UNDECANOATE 1MG	No pre-authorization is required for all providers.	N/A
J3150	INJ TESTOSTERONE PROPIONATE TO 100 MG	This is no longer a valid code.	N/A
J3230	INJ CHLORPROMAZINE HCL TO 50 MG	No pre-authorization is required for all providers.	N/A
J3240	INJ THYROTROPIN .9 MG PROV 1.1 VIAL	No pre-authorization is required for all providers.	N/A
J3243	INJECTION, TIGECYCLINE, 1 MG	No pre-authorization is required for all providers.	N/A
J3245	INJECTION TILDRAKIZUMAB 1 MG	No pre-authorization is required for all providers.	N/A
J3246	INJECTION TIROFIBAN HCL 0.25MG	No pre-authorization is required for all providers.	N/A
J3250	INJ TRIMETHOBENZAMIDE HCL TO 200 MG	No pre-authorization is required for all providers.	N/A
J3260	INJ TOBRAMYCIN SULFATE TO 80 MG	No pre-authorization is required for all providers.	N/A
J3262	TOCILIZUMAB INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J3265	INJECTION, TORSEMIDE, 10 MG/ML	No pre-authorization is required for all providers.	N/A
J3280	INJ THIETHYLPERAZINE MALEATE TO 10 MG	No pre-authorization is required for all providers.	N/A
J3285	INJECTION TREPROSTINIL 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J3300	TRIAMCINOLONE A INJ PRS-FREE	No pre-authorization is required for all providers.	N/A
J3301	TRIAMCINOLONE ACET INJ NOS	No pre-authorization is required for all providers.	N/A
J3302	INJ TRIAMCINOLONE DIACETATE PER 5 MG	This service is not covered by Superior HealthPlan.	N/A
J3303	INJ TRIAMCINOLONE HEXACETONIDE PER 5 MG	No pre-authorization is required for all providers.	N/A
J3304	INJECT TRIAMCINOLONE ACETONIDE PF ER MS F 1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J3305	INJECTION, TRIMETREXATE GLUCORONATE, PER 25 MG	No pre-authorization is required for all providers.	N/A
J3310	INJ PERPHENAZINE TO 5 MG	This service is not covered by Superior HealthPlan.	N/A
J3315	INJ TRIPTORELIN PAMOATE 3.75 MG	No pre-authorization is required for all providers.	N/A
J3316	INJECTION TRIPTORELIN EXTENDED-RELEASE 3.75 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J3320	INJ SPECTINOMYCIN HCL, 2GM	This service is not covered by Superior HealthPlan.	N/A
J3350	INJ UREA TO 40 GM	No pre-authorization is required for all providers.	N/A
J3355	INJECTION UROFOLLITROPIN 75 IU	No pre-authorization is required for all providers.	N/A
J3357	USTEKINUMAB FOR SUBQ INJECTION 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J3358	USTEKINUMAB INTRAVENOUS INJ 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J3360	INJ DIAZEPAM TO 5 MG	No pre-authorization is required for all providers.	N/A
J3364	INJ UROKINASE 5000 IU VIAL	No pre-authorization is required for all providers.	N/A
J3365	INJ IV UROKINASE 250,000 IU VIAL	No pre-authorization is required for all providers.	N/A
J3370	INJ VANCOMYCIN HCL TO 500 MG	No pre-authorization is required for all providers.	N/A
J3380	INJECTION VEDOLIZUMAB 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J3385	VELAGLUCERASE ALFA	Pre-authorization is required for all providers.	Prior to 09/01/2019
J3396	INJECTION VERTEPORFIN 0.1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J3397	INJECT VESTRONIDASE ALFA-VJBK 1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J3398	INJECTION VORETIGENE NEPARVOVEC-RZYL 1 B VEC G	Pre-authorization required for all providers.	Prior to 09/01/2019
J3399	INJ AVSX-101-XIOI P-TX TO 5X10^15 VCTR GNOMS	Pre-authorization required for all providers.	Prior to 09/01/2019
J3400	INJ TRIFLUPROMAZINE HCL TO 20 MG	No pre-authorization is required for all providers.	N/A
J3410	INJ HYDROXYZINE HCL TO 25 MG	No pre-authorization is required for all providers.	N/A
J3411	INJECTION, THIAMINE HCl, 100 MG	No pre-authorization is required for all providers.	N/A
J3415	INJECTION, PYRIDOXINE HCl, 100 MG	No pre-authorization is required for all providers.	N/A
J3420	INJ VITAMIN B-12 CYANOCOBALAMIN TO 1000 MCG	No pre-authorization is required for all providers.	N/A
J3430	INJ PHYTONADIONE (VIT K) PER 1 MG	No pre-authorization is required for all providers.	N/A
J3465	INJECTION VORICONAZOLE, 10 MG	No pre-authorization is required for all providers.	N/A
J3470	INJ HYALURONIDASE TO 150 UNITS	No pre-authorization is required for all providers.	N/A
J3471	INJECTION HYALURONIDASE OVINE PRESERVATIVE FREE /1 USP UNIT UP TO 999	No pre-authorization is required for all providers.	N/A
J3472	INJECTION HYALURONIDASE OVINE PRESERVATIVE FREE /1000 USP UNITS	No pre-authorization is required for all providers.	N/A
J3473	INJECTION, HYALURONIDASE, RECOMBINANT, 1 USP UNIT	No pre-authorization is required for all providers.	N/A
J3475	INJECTION, MAGNESIUM SULFATE, PER 500 MG	No pre-authorization is required for all providers.	N/A
J3480	INJECTION, POTASSIUM CHLORIDE, PER 2 MEQ	No pre-authorization is required for all providers.	N/A
J3485	INJ ZIDOVUDINE 10 MG	No pre-authorization is required for all providers.	N/A
J3486	INJECTION, ZIPRASIDONE MESYLATE, 10 MG	No pre-authorization is required for all providers.	N/A
J3487	ZOLEDRONIC ACID-ZOMETA, 1 MG	This is no longer a valid code.	N/A
J3488	RECLAST INJECTION, 1 MG	This is no longer a valid code.	N/A
J3489	ZOLEDRONIC ACID 1M	No pre-authorization is required for all providers.	N/A
J3490	UNCLASSIFIED DRUGS	Authorization is required for all non-participating providers. Authorization is required for participating providers if billed amount is greater than or equal to \$500.	Prior to 09/01/2019
J3520	EDEATE DISODIUM PER 150 MG	This service is not covered by Superior HealthPlan.	N/A
J3530	NASAL VACCINE INHALATION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
J3535	DRUG ADMIN THRU METERED DOSE INHALER	No pre-authorization is required for all providers.	N/A
J3570	LAETRILE AMYGDALIN VITAMIN B17	No pre-authorization is required for all providers.	N/A
J3590	UNCLASSIFIED BIOLOGICS	Authorization is required for all non-participating providers. Authorization is required for participating providers if billed amount is greater than or equal to \$500.	Prior to 09/01/2019
J3591	UNCLASS RX/BIOLOGICAL USED FOR ESRD ON DIALYSIS	This service is not covered by Superior HealthPlan.	N/A
J6000	TETANUS TOXOID	No pre-authorization is required for all providers.	N/A
J6005	POLIO	This is no longer a valid code.	N/A
J6030	MEASLES	No pre-authorization is required for all providers.	N/A
J6035	MUMPS	No pre-authorization is required for all providers.	N/A
J6040	RUBELLA	This is no longer a valid code.	N/A
J6065	PNEUMOCOCCAL VACCINE	No pre-authorization is required for all providers.	N/A
J7030	INFUSION NORMAL SALINE SOLUTION 1000 CC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
J7040	INFUSION NORMAL SALINE SOLUTION STERILE 500 ML	No pre-authorization is required for all providers.	N/A
J7042	5% DEXTROSE/NORMAL SALINE 500 ML = 1 UNIT	No pre-authorization is required for all providers.	N/A
J7044	INJECTION	No pre-authorization is required for all providers.	N/A
J7050	INFUSION NORMAL SALINE SOLUTION 250 CC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
J7051	STERILE SALINE/WATER UP TO 5 CC	This is no longer a valid code.	N/A
J7060	5% DEXTROSE/WATER 500 ML = 1 UNIT	No pre-authorization is required for all providers.	N/A
J7070	INFUSION D5W 1000 CC	No pre-authorization is required for all providers.	N/A
J7100	INFUSION DEXTRAN 40, 500 ML	This service is not covered by Superior HealthPlan.	N/A
J7110	INFUSION DEXTRAN 75, 500 ML	This service is not covered by Superior HealthPlan.	N/A
J7120	RINGERS LACTATE INFUSION TO 1000 CC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
J7121	5% DEXTROSE LR INFUSION TO 1000 CC	This service is not covered by Superior HealthPlan.	N/A
J7131	HYPERTONIC SALINE SOL	This service is not covered by Superior HealthPlan.	N/A
J7169	INJ COAGULATION FACTOR XA INACTIVATED-ZHZO 10 MG	This service is not covered by Superior HealthPlan.	N/A
J7170	INJECTION EMICIZUMAB-KXWH 0.5 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J7175	INJ FACTOR X (HUMAN) 1IU	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7177	INJECTION HUMAN FIBRINOGEN CONCENTRATE 1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J7178	INJECTION HUMAN FIBRINOGEN CONC NOS 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7179	VONVENDI INJ 1 IU VWF:RCO	Pre-authorization is required for all providers.	Prior to 09/01/2019

J7180	FACTOR XIII ANTI-HEM FACTOR	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7181	FACTOR XIII RECOMB A-SUBUNIT	Pre-authorization required for all providers.	Prior to 09/01/2019
J7182	FACTOR VIII RECOMB NOVOEIGHT	This service is not covered by Superior HealthPlan.	N/A
J7183	WILATE INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7185	XYNTHA INJ	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7186	ANTIHEMOPHILIC VIII VWF COMP	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7187	HUMATE-P, INJ	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7188	INJECTION FACTOR VIII PER I.U.	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7189	FACTOR VIIA ANTIHEMOPHILIC FACTOR RECOMBINANT /1 MICROGRAM	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7190	FACTOR VIII (ANTI-HEMOPHILIC FACTOR HUMAN)PER IU	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7191	FACTOR VIII (ANTIHEMOPHILIC FACTOR (PORCINE)), P	This service is not covered by Superior HealthPlan.	N/A
J7192	FACTOR VIII RECOMBINANT NOS	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7193	FACTOR IX (ANTIHEMOPHILIC FACTOR, PURIFIED, NON-RECOMBINANT) PER I.U.	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7194	FACTOR IX COMPLX PER IU	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7195	FACTOR IX RECOMBINANT NOS	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7196	ANTITHROMBIN RECOMBINANT	This service is not covered by Superior HealthPlan.	N/A
J7197	ANTITHROMBIN III (HUMAN) PER IU	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7198	ANTI INHIBITOR, PER IU	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7199	HEMOPHILIA CLOTTING FACTOR, NOT OTHERWISE CLASSIFIED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
J7200	FACTOR IX RECOMBINAN RIXUBIS	Pre-authorization required for all providers.	Prior to 09/01/2019
J7201	INJ FACTOR IX FC FUS PROTEIN PER IU	Pre-authorization required for all providers.	Prior to 09/01/2019
J7202	FACTOR IX IDELVION INJ	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7203	INJECTION FACTOR IX GLYCOPEGYLATED 1 IU	Pre-authorization required for all providers.	Prior to 09/01/2019
J7204	INJ FAC VIII ANTIHEM FAC GLYCOPEGYLATD-EXEI P-IU	This service is not covered by Superior HealthPlan.	N/A
J7205	INJ FACTOR VIII FC FUSION PER IU	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7207	FACTOR VIII PEGYLATED RECOMB	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7208	INJECTION FACTOR VIII PEGYLATED-AUCL 1 IU	Pre-authorization required for all providers.	Prior to 09/01/2019
J7209	FACTOR VIII NUWIO RECOMB 1IU	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7210	INJ FACTOR VIII AFSTYLA 1 I.U.	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7211	INJ FACTOR VIII KOVALTRY 1 I.U.	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7296	LNG-RELEASING IU COC SYS 19.5 MG	No pre-authorization is required for all providers.	N/A
J7297	LNG-RLS INTRAUTERINE COC SYS 52 MG	No pre-authorization is required for all providers.	N/A
J7298	LNG-RLS INTRAUTERINE COC SYS 52 MG	No pre-authorization is required for all providers.	N/A
J7300	INTRAUTERINE COPPER CONTRACEPTIVE	No pre-authorization is required for all providers.	N/A
J7301	LNG-RLS INTRAUTERNE COC SYS 13.5 MG	No pre-authorization is required for all providers.	N/A
J7302	LEVONORGESTREL IU 52 MG	This is no longer a valid code.	N/A
J7303	CONTRACEPTIVE SUPPLY, HORMONE CONTAINING VAGINAL RING, EACH	This service is not covered by Superior HealthPlan.	N/A
J7304	CONTRACEPTIVE SUPPLY HORMONE CONTAINING PATCH EA	No pre-authorization is required for all providers.	N/A
J7306	LEVONORGESTREL CONTRACEPTIVE IMPLANT SYSTEM INCL IMPLANTS & SUPPLIES	This service is not covered by Superior HealthPlan.	N/A
J7307	ETONOGESTREL IMPLANT SYSTEM	No pre-authorization is required for all providers.	N/A
J7308	AMINOLEVULINIC ACID HCI FOR TICL ADMIN, 20%/1UNIT DOSAGE FORM (354MG)	No pre-authorization is required for all providers.	N/A
J7309	METHYL AMINOLEVULINATE, TOP	This service is not covered by Superior HealthPlan.	N/A
J7310	IMPLANT GANCICLOVIR 4.5 MG LONG-ACTING	No pre-authorization is required for all providers.	N/A
J7311	INJECTION FA INTRAVITREAL IMPL 0.01 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J7312	DEXAMETHASONE INTRA IMPLANT	Prior authorization required for all providers except when services are rendered by an ophthalmologist.	Prior to 09/01/2019
J7313	INJECTION FA INTRAVITREAL IMPL 0.01 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J7314	INJECTION FA INTRAVITREAL IMPL 0.01 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7315	OPHTHALMIC MITOMYCIN	This service is not covered by Superior HealthPlan.	N/A
J7316	INJ. OCRIPLASMIN, 0.125 M	No pre-authorization is required for all providers.	N/A
J7317	SODIM HYALURONATE 20-25 MG ARTICLR	This is no longer a valid code.	N/A
J7318	HYALURONAN/DERIVATIVE DUROLANE FOR IA INJ 1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J7320	HYALURONAN/DERIVATIVE GENVISC 850 IA INJ 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7321	HYALURONAN/DERIV HYALGAN/SUPARTZ IA INJ PER DOSE	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7322	HYALURONAN/DRIV HYMOVIS IA INJ 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7323	EUFLEXXA INJ PER DOSE	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7324	ORTHOVISC INJ PER DOSE	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7325	SYNVISC OR SYNVISC-ONE	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7326	GEL-ONE	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7327	MONOVISC INJ PER DOSE	This service is not covered by Superior HealthPlan.	N/A
J7328	HYAL/DERIV GELSYN-3 IA INJ 0.1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7329	HYALURONAN/DERIVATIVE TRIVISC FOR IA INJ 1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J7330	AUTOL CULTURD CHONDROCYTES IMP	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	Prior to 09/01/2019
J7331	HYALURONAN/DERIVATIVE SYNOJOYNT IA INJ 1 MG	This service is not covered by Superior HealthPlan.	N/A
J7332	HYALURONAN/DERIVATIVE TRILURON IA INJ 1 MG	This service is not covered by Superior HealthPlan.	N/A
J7333	HYALURONAN/DERIVATIVE VISCO-3 IA INJ PER DOSE	This service is not covered by Superior HealthPlan.	N/A
J7335	CAPSAICIN 8% PATCH	This is no longer a valid code.	N/A
J7336	CAPSAICIN 8% PATCH	This service is not covered by Superior HealthPlan.	N/A
J7340	CRBDPA 5 MG/LVDP 20 MG EN SU 100 ML	No pre-authorization is required for all providers.	N/A
J7341	DERMAL SUBSTITUTE TISSUE OF NON-HUMAN ORIGIN W OR W/O OTHER	No pre-authorization is required for all providers.	N/A
J7342	INSTILLATION CIPROFLOXACIN OTIC SUSPENSION 6 MG	No pre-authorization is required for all providers.	N/A
J7343	DERM&EPID TISS NONHUMN W/O METAB ACTV ELEM SQ CM	No pre-authorization is required for all providers.	N/A
J7344	DERM TISS HUMN W/O METAB ACTV ELEMS PER SQ CM	No pre-authorization is required for all providers.	N/A
J7345	ALA HCL TOP ADMIN 10% GEL 10 MG	This service is not covered by Superior HealthPlan.	N/A
J7350	DERM TISS INJ W/O METAB ELEM-10 MG	This is no longer a valid code.	N/A
J7401	MOMETASONE FUROATE SINUS IMPLANT 10 MCG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7500	AZATHIOPRINE ORAL TAB 50 MG 100 EA	This service is not covered by Superior HealthPlan.	N/A
J7501	AZATHIOPRINE PARENTERAL VIAL 100 MG 20 ML EA	No pre-authorization is required for all providers.	N/A
J7502	CYCLOSPORINE, ORAL 100 MG	This service is not covered by Superior HealthPlan.	N/A
J7503	TACROLIMUS EXT RELEASE ORAL 0.25 MG	This service is not covered by Superior HealthPlan.	N/A
J7504	LYMPHOCYTE IMMUNE/ANTITHYMOCYTE GLOBULIN 5ML EA	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7505	MONOCLONAL ANTIBODIES PARENTERAL/5MG	This service is not covered by Superior HealthPlan.	N/A
J7506	PREDNISONE/ORAL/PER 5 MG	This is no longer a valid code.	N/A
J7507	TACROLIMUS ORAL PER 1 MG	This service is not covered by Superior HealthPlan.	N/A
J7508	TACROL ASTAGRAF EX REL ORAL	This service is not covered by Superior HealthPlan.	N/A
J7509	METHYLPREDNISOLONE ORAL, PER 4 MG	This service is not covered by Superior HealthPlan.	N/A
J7510	PREDNISOLONE ORAL, PER 5 MG	This service is not covered by Superior HealthPlan.	N/A
J7511	LYMPHOCYTE IMMUNE GLOBULIN	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7512	PDN IMMED RLSE/DELAY RLSE ORAL 1 MG	This service is not covered by Superior HealthPlan.	N/A
J7513	DACLIZUMAB PARENTERAL 25 MG	This service is not covered by Superior HealthPlan.	N/A
J7515	CYCLOSPORINE, ORAL 25 MG	This service is not covered by Superior HealthPlan.	N/A
J7516	CYCLOSPORINE, PARENTERAL, PER 50 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7517	MYCOPHENOLATE MOFETIL ORAL 250 MG	This service is not covered by Superior HealthPlan.	N/A
J7518	MYCOPHENOLIC ACID ORAL 180 MG	This service is not covered by Superior HealthPlan.	N/A
J7520	SIROLIMUS ORAL 1 MG	This service is not covered by Superior HealthPlan.	N/A
J7525	TACROLIMUS PARENTERAL 5 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7527	EVEROLIMUS, ORAL, 0.25 MG	This service is not covered by Superior HealthPlan.	N/A
J7599	IMMUNOSUPPRESSIVE DRUG, NOT OTHERWISE CLASSIFIED	Authorization is required for all non-participating providers. Authorization is required for participating providers if billed amount is greater than or equal to \$500.	Prior to 09/01/2019
J7604	ACETYLCYSTEINE COMP UNIT	This service is not covered by Superior HealthPlan.	N/A
J7605	ARFORMOTEROL NON-COMP UNIT	No pre-authorization is required for all providers.	N/A
J7606	FORMOTEROL FUMARATE INH	This service is not covered by Superior HealthPlan.	N/A
J7607	LEVALBUTEROL INHAL SOL COMP PROD ADMIN THRU DME CONC FORM 0.5 MG	This service is not covered by Superior HealthPlan.	N/A
J7608	ACETYLCYSTEINE NON-COMP UNIT	No pre-authorization is required for all providers.	N/A
J7609	ALBUTEROL INHAL SOL COMP PROD ADMIN THRU DME UNIT DOSE 1 MG	This service is not covered by Superior HealthPlan.	N/A
J7610	ALBUTEROL, INHAL SOL, COMPOUNDED, ADMIN THROUGH DME, CONCENTR FORM 1 MG	No pre-authorization is required for all providers.	N/A
J7611	ALBUTEROL NON-COMP CON	No pre-authorization is required for all providers.	N/A
J7612	LEVALBUTEROL NON-COMP CON	No pre-authorization is required for all providers.	N/A
J7613	ALBUTEROL NON-COMP UNIT	No pre-authorization is required for all providers.	N/A
J7614	LEVALBUTEROL NON-COMP UNIT	No pre-authorization is required for all providers.	N/A
J7615	LEVALBUTEROL, INHAL SOL, COMPOUNDED, ADMIN THROUGH DME, UNIT DOES 0.5 MG	No pre-authorization is required for all providers.	N/A
J7616	ALBUTEROL TO 5 MG&IPRATROPIUM BROMIDE TO 1 MG	This is no longer a valid code.	N/A
J7617	LEVALBUTROL TO 2.5 MG&IPRATROPIUM BROMID TO 1 MG	No pre-authorization is required for all providers.	N/A

J7620	ALBUTEROL,UP TO 2.5 MG&IPRATROPIUM BROMIDE,UP TO 0.5 MG,FDA APPROVED	No pre-authorization is required for all providers.	N/A
J7622	BECLOMETHASONE, INHAL SOL, COMPOUNDED, ADMIN THRU DME, UNIT DOSE /MG	No pre-authorization is required for all providers.	N/A
J7624	BETAMETHASONE, INHAL SOL, COMPOUNDED, ADMIN THRU DME, UNIT DOSE /MG	This service is not covered by Superior HealthPlan.	N/A
J7626	BUDESONIDE, INHAL SOL, NON COMPOUND, ADMIN THRU DME, UNIT DOSE UP TO 0.5 MG	No pre-authorization is required for all providers.	N/A
J7627	BUDESONIDE, INHAL SOL, COMPOUNDED, ADMIN THRU DME, UNIT DOSE UP TO 0.5 MG	No pre-authorization is required for all providers.	N/A
J7628	BITOLTEROL MESYLATE, INHAL SOL, COMPOUNDED, ADMIN THRU DME, CONC DOSE /MG	This service is not covered by Superior HealthPlan.	N/A
J7629	BITOLTEROL MESYLATE, INHAL SOL, COMPOUNDED, ADMIN THRU DME, UNIT DOSE /MG	This service is not covered by Superior HealthPlan.	N/A
J7631	CROMOLYN SODIUM NONCOMP UNIT	No pre-authorization is required for all providers.	N/A
J7632	CROMOLYN SODIUM COMP UNIT	This service is not covered by Superior HealthPlan.	N/A
J7633	BUDESONIDE, INHAL SOL, FDA APPROV, NONCOMP, ADMIN THRU DME, CONC 0.25 MG	No pre-authorization is required for all providers.	N/A
J7634	BUDESONIDE, INHAL SOL, COMP PR, ADMIN THRU DME, CONC FORM, PER 0.25 MG	This service is not covered by Superior HealthPlan.	N/A
J7635	ATROPINE, INHAL SOL, COMPOUNDED, ADMIN THRU DME, CONCENTRATED /MG	This service is not covered by Superior HealthPlan.	N/A
J7636	ATROPINE, INHAL SOL, COMPOUNDED, ADMIN THRU DME, CONCENTRATED /MG	This service is not covered by Superior HealthPlan.	N/A
J7637	ATROPINE, INHAL SOL, COMPOUNDED, ADMIN THROUGH DME, PER MG	This service is not covered by Superior HealthPlan.	N/A
J7638	DEXAMETHASONE, INHAL SOL, COMP, ADMIN THRU DME, CONC FORM, PER MG	This service is not covered by Superior HealthPlan.	N/A
J7639	DORNASE ALFA NON-COMP UNIT	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7640	FORMOTEROL, INHAL SOL, COMP, ADMIN THRU DME, UNIT DOSE, 12 MICROGRAMS	No pre-authorization is required for all providers.	N/A
J7641	FLUNISOLIDE, INHAL SOL, COMP, ADMIN THROUGH DME, UNIT DOSE, PER MG	This service is not covered by Superior HealthPlan.	N/A
J7642	GLYCOPYRROLATE, INHAL SOL, COMP, ADMIN THROUGH DME, CONC, PER MG	This service is not covered by Superior HealthPlan.	N/A
J7643	GLYCOPYRROLATE, INHAL SOL, COMPOUND, ADMIN THROUGH DME, PER MG	This service is not covered by Superior HealthPlan.	N/A
J7644	IPRATROPIUM BROMIDE, INHAL SOL, FDA APPR, NON COMP, ADM THRU DME, PER MG	No pre-authorization is required for all providers.	N/A
J7645	IPRATROPIUM BROMIDE, INHAL SOL, COMPOUND, ADMIN THROUGH DME, UNIT DOSE /MG	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
J7647	ISOETHARINE HCL INH SOL COMP PR ADMIN THR DME CONC FRM PER MG+B358	This service is not covered by Superior HealthPlan.	N/A
J7648	ISOETHARINE HCL, INHAL SOL, NONCOMP, ADM THRU DME, CONC, UNIT PER MG	This service is not covered by Superior HealthPlan.	N/A
J7649	ISOETHARINE HCL, INHAL SOL, FDA APPR, NONCOMP, ADM THRU DME, UNIT PER MG	This service is not covered by Superior HealthPlan.	N/A
J7650	ISOETHARINE HCL, INHAL SOL, COMPOUNDED, ADMIN THROUGH DME, CONC FORM /MG	No pre-authorization is required for all providers.	N/A
J7657	ISOPROTERENOL HCL, INH SOL, COMP PR, ADMIN TH DME, CONC FORM, PER MG	This service is not covered by Superior HealthPlan.	N/A
J7658	ISOPROTERENOL HCL, INHAL SOL, FDA APPR, NONCOMP, ADM THR DME, CONC, PER MG	This service is not covered by Superior HealthPlan.	N/A
J7659	ISOPROTERENOL HCL, INHAL SOL, FDA APPR, NONCOMP, ADM THR DME, PER MG	This service is not covered by Superior HealthPlan.	N/A
J7660	ISOPROTERENOL HCL, INHAL SOL, COMPOUND, ADMIN THROUGH DME, CONC FORM /MG	No pre-authorization is required for all providers.	N/A
J7665	MANNITOL FOR INHALER	No pre-authorization is required for all providers.	N/A
J7667	METAPROTERENOL SULFATE INH SOL COMP PR CONC FORM PER 10 MG	This service is not covered by Superior HealthPlan.	N/A
J7668	METAPROTERENOL SULFATE, INHAL SOL, NONCOMP, ADM THR DME, CONC, PER 10 MG	This service is not covered by Superior HealthPlan.	N/A
J7669	METAPROTERENOL SULFATE, INHAL SOL, FDA AP, NONCOMP, ADM THR DME, PER 10 MG	This service is not covered by Superior HealthPlan.	N/A
J7674	METHACHOLINE CHLORID INHAL SOL THRU NEB PER 1 MG	This service is not covered by Superior HealthPlan.	N/A
J7676	PENTAMIDINE COMP UNIT DOSE	This service is not covered by Superior HealthPlan.	N/A
J7677	REVEFENACIN INHAL SOL NONCOMPND ADM DME 1 MCG	No pre-authorization is required for all providers.	N/A
J7680	TERBUTALINE SULFATE, INHAL SOL, COMP, ADM THRU DME, CONC FORM, PER MG	This service is not covered by Superior HealthPlan.	N/A
J7681	TERBUTALINE SULFATE, INHAL SOLUTION, COMPOUNDED, ADM THRU DME, PER MG	This service is not covered by Superior HealthPlan.	N/A
J7682	TOBRAMYCIN, INHAL SOL, FDA APPR, NONCOMP, UNIT DOSE, ADM THR DME, PER MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J7683	TRIAMCINOLONE, INHAL SOL, COMPOUND, ADM THRU DME, CONC FORM, PER 300 MG	This service is not covered by Superior HealthPlan.	N/A
J7684	TRIAMCINOLONE, INHAL SOLUTION, COMPOUND, ADM THROUGH DME, PER 300 MG	This service is not covered by Superior HealthPlan.	N/A
J7685	TOBRAMYCIN, INH SOL COMP PR ADMIN TH DME UNIT DOSE FORM PER 300 MG	This service is not covered by Superior HealthPlan.	N/A
J7686	TREPROSTINIL, NON-COMP UNIT	This service is not covered by Superior HealthPlan.	N/A
J7699	NOC DRUGS, INHALATION SOLUTION ADMIN THRU DME	Authorization is required for all non-participating providers. Authorization is required for participating providers if billed amount is greater than or equal to \$500.	Prior to 09/01/2019
J7799	NOC DRUGS, OTHER THAN INHALATION, ADMIN THRU DME	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
J7999	COMPOUNDED DRUG NOC	This service is not covered by Superior HealthPlan.	N/A
J8498	ANTIEMETIC DRUG RECTAL/SUPPOSITORY NOT OTHERWISE SPECIFIED	This service is not covered by Superior HealthPlan.	N/A
J8499	PRESCRIPTION DRUG-ORAL-NON-CHEMOTHERAPEUTIC-NOS	Authorization is required for all non-participating providers. Authorization is required for participating providers if billed amount is greater than or equal to \$500.	Prior to 09/01/2019
J8501	APREPITANT ORAL 5 MG	This service is not covered by Superior HealthPlan.	N/A
J8510	BULSUFAN ORAL 2 MG	This service is not covered by Superior HealthPlan.	N/A
J8515	CABERGOLINE ORAL 0.25 MG	This service is not covered by Superior HealthPlan.	N/A
J8520	CAPECITABINE ORAL 150 MB	This service is not covered by Superior HealthPlan.	N/A
J8521	CAPECITABINE ORAL 500 MG	This service is not covered by Superior HealthPlan.	N/A
J8530	CYCLOPHOSPHAMIDE ORAL 25 MG	This service is not covered by Superior HealthPlan.	N/A
J8540	DEXAMETHASONE ORAL 0.25 MG	This service is not covered by Superior HealthPlan.	N/A
J8560	ETOPOSIDE ORAL 50 MG	This service is not covered by Superior HealthPlan.	N/A
J8561	ORAL EVEROLIMUS	This is no longer a valid code.	N/A
J8562	ORAL FLUDARABINE PHOSPHATE	This service is not covered by Superior HealthPlan.	N/A
J8565	GEFITINIB ORAL 250 MG	This service is not covered by Superior HealthPlan.	N/A
J8597	ANTIEMETIC DRUG ORAL NOT OTHERWISE SPECIFIED	This service is not covered by Superior HealthPlan.	N/A
J8600	MELPHALEN ORAL 2 MG	This service is not covered by Superior HealthPlan.	N/A
J8610	METHOTREXATE ORAL 2.5 MG	This service is not covered by Superior HealthPlan.	N/A
J8650	NABILONE, ORAL, 1 MG	This service is not covered by Superior HealthPlan.	N/A
J8655	NETUPITANT 300 MG AND PALONOSETRON 0.5 MG ORAL	This service is not covered by Superior HealthPlan.	N/A
J8670	ROLAPITANT ORAL 1MG	This service is not covered by Superior HealthPlan.	N/A
J8700	TEMOZOLOMIDE ORAL 5 MG	This service is not covered by Superior HealthPlan.	N/A
J8705	TOPOTECAN ORAL	This service is not covered by Superior HealthPlan.	N/A
J8999	PRESCRIPTION DRUG-ORAL-CHEMOTHERAPEUTIC-NOS	Authorization is required for all non-participating providers. Authorization is required for participating providers if billed amount is greater than or equal to \$500.	Prior to 09/01/2019
J9000	DOXORUBICIN HCL INJECTION	No pre-authorization is required for all providers.	N/A
J9001	DOXORUBICIN HCL LIPOSOME INJ	This is no longer a valid code.	N/A
J9002	DOXIL INJECTION	This is no longer a valid code.	N/A
J9010	ALEMTUZUMAB INJECTION	This is no longer a valid code.	N/A
J9015	ALDESLEUKIN INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9017	ARSENIC TRIOXIDE INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9019	ERWINAZE INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9020	ASPARAGINASE, NOS	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9022	INJECTION ATEZOLIZUMAB 10 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9023	INJECTION AVELUMAB 10 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9025	INJECTION AZACITIDINE 1 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9027	INJECTION CLOFARABINE 1 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9030	BCG LIVE INTRAVESICAL INSTALLATION 1 MG	No pre-authorization is required for all providers.	N/A
J9031	BCG (INTRAVESICAL) PER INSTALLATION	This is no longer a valid code.	N/A
J9032	INJECTION BELINOSTAT 10 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9033	INJ BENDAMUSTINE HCL TREANDA 1 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9034	INJ. BENDEKA 1 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9035	INJECTION BEVACIZUMAB 10 MG	Pre- authorization required for all providers except ophthalmologists.	Prior to 09/01/2019
J9036	INJECTION BENDAMUSTINE HYDROCHLORIDE 1 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9039	INJECTION BLINATUMOMAB 1 MICROGRAM	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9040	BLEOMYCIN SULFATE INJECTION	No pre-authorization is required for all providers.	N/A
J9041	INJECTION BORTEZOMIB 0.1 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9042	INJECTION, BRENTUXIMAB VEDOTIN, 1 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9043	CABAZITAXEL INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9044	INJECTION BORTEZOMIB NOS 0.1 MG	Pre-authorization is required for all providers except when services are rendered by a, internal medicine provider, hematologist, or oncologist.	Prior to 09/01/2019
J9045	CARBOPLATIN INJECTION	No pre-authorization is required for all providers.	N/A
J9047	INJECTION, CARFILZOMIB, 1 M	No pre-authorization is required for all providers.	N/A
J9050	CARMUSTINE INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019

J9055	INJECTION CETUXIMAB 10 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9057	INJECTION COPANLISIB 1 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9060	CISPLATIN 10 MG INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9062	CISPLATIN 50 MG	This is no longer a valid code.	N/A
J9065	INJ CLADRIBINE PER 1 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9070	CYCLOPHOSPHAMIDE 100MG	No pre-authorization is required for all providers.	N/A
J9080	CYCLOPHOSPHAMIDE 200 MG	This is no longer a valid code.	N/A
J9090	CYCLOPHOSPHAMIDE 500 MG	This is no longer a valid code.	N/A
J9091	CYCLOPHOSPHAMIDE 1 G	This is no longer a valid code.	N/A
J9092	CYCLOPHOSPHAMIDE 2 G	This is no longer a valid code.	N/A
J9093	CYCLOPHOSPHAMIDE LYOPHILIZED 100 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9094	CYCLOPHOSPHAMIDE LYOPHILIZED 200 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9095	CYCLOPHOSPHAMIDE LYOPHILIZED 500 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9096	CYCLOPHOSPHAMIDE LYOPHILIZED 1 G	This is no longer a valid code.	N/A
J9097	CYCLOPHOSPHAMIDE LYOPHILIZED 2 G	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9098	CYTARABINE LIPOSOME INJ	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9100	CYTARABINE HCL 100 MG INJ	No pre-authorization is required for all providers.	N/A
J9110	CYTARABINE HCL 500 MG INJ	This is no longer a valid code.	N/A
J9118	INJECTION CALASPARGASE PEGOL-MKNL 10 UNITS	Pre-authorization required for all providers.	Prior to 09/01/2019
J9119	INJECTION CEMIPILIMAB-RWLC 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J9120	DACTINOMYCIN INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9130	DACARBAZINE 100 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9140	DACARBAZINE 200 MG	This is no longer a valid code.	N/A
J9145	INJECTION DARATUMUMAB 10 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9150	DAUNORUBICIN INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9151	DAUNORUBICIN CITRATE INJ	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9153	INJECTION LIPOSOMAL 1 MG DNR AND 2.27 MG CA	Pre-authorization is required for all providers except when services are rendered by a, internal medicine provider, hematologist, or oncologist.	Prior to 09/01/2019
J9155	DEGARELIX INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9160	DENILEUKIN DIFTITOX INJ	This service is not covered by Superior HealthPlan.	N/A
J9165	DIETHYLSTILBESTROL INJECTION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
J9170	DOCETAXEL INJECTION	This is no longer a valid code.	N/A
J9171	DOCETAXEL INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9173	INJECTION DURVALUMAB 10 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9175	INJECTION ELLIOTT'S B SOLUTION 1 ML	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
J9176	INJECTION ELOTUZUMAB 1MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9177	INJECTION ENFORTUMAB VEDOTIN-EJFV 0.25 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J9178	INJECTION, EPIRUBICIN HCl, 2 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9179	ERIBULIN MESYLATE INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9181	ETOPOSIDE INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9182	ETOPOSIDE 100 MG	This is no longer a valid code.	N/A
J9185	FLUDARABINE PHOSPHATE INJ	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9190	FLUOROURACIL INJECTION	No pre-authorization is required for all providers.	N/A
J9198	INJ GEMCITABINE HYDROCHLORIDE INFUGEM 100 MG	This service is not covered by Superior HealthPlan.	N/A
J9199	INJECTION GEMCITABINE HCL INFUGEM 200 MG	This is no longer a valid code.	N/A
J9200	FLOXURIDINE INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9201	INJECTION GEMCITABINE HCL NOS 200 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9202	GOSERELIN ACETATE IMPLANT PER 3.6 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9203	INJ GEMTUZUMAB OZOGAMICIN 0.1 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9204	INJECTION MOGAMULIZUMAB-KPKC 1 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9205	INJ IRINOTECAN LIPOSOME 1 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9206	IRINOTECAN INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9207	IXABEPILONE INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9208	IFOSFAMIDE INJECTION	No pre-authorization is required for all providers.	N/A
J9209	MESNA INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9210	INJECTION EMAPALUMAB-LZSG 1 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J9211	IDARUBICIN HCL INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9212	INTERFERON ALFA-1 INJ	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9213	INTERFERON ALFA-2A INJ	This service is not covered by Superior HealthPlan.	N/A
J9214	INTERFERON ALFA-2B INJ	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9215	INTERFERON ALFA-N3 INJ	This service is not covered by Superior HealthPlan.	N/A
J9216	INTERFERON GAMMA 1-B INJ	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9217	LEUPROLIDE ACETATE FOR DEPOT SUSPENSION 7.5 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9218	LEUPROLIDE ACETATE PER 1 MG	No pre-authorization is required for all providers.	N/A
J9219	LEUPROLIDE ACETATE IMPLNT 65 MG	This service is not covered by Superior HealthPlan.	N/A
J9225	VANTAS IMPLANT	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9226	SUPPRELIN LA IMPLANT	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9228	IPILIMUMAB INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9229	INJECTION INOTUZUMAB OZOGAMICIN 0.1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J9230	MECHLORETHAMINE HCL INJ	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9240	MEDROXYPROGESTERONE ACETATE	This is no longer a valid code.	N/A
J9245	INJECTION MELPHALAN HCL NOS 50 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9246	INJECTION MELPHALAN EVOMELA 1 MG	This service is not covered by Superior HealthPlan.	N/A
J9250	METHOTREXATE SODIUM 5 MG	No pre-authorization is required for all providers.	N/A
J9260	METHOTREXATE SODIUM 50 MG	No pre-authorization is required for all providers.	N/A
J9261	INJECTION, NELARABINE, 50 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9262	INJ, OMACETAXINE MEP, 0.01M	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9263	INJECTION, OXALIPLATIN, 0.5 MG	No pre-authorization is required for all providers.	N/A
J9264	INJECTION PACLITAXEL PROTEIN-BOUND PARTICLES 1 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9265	PACLITAXEL INJECTION	This is no longer a valid code.	N/A
J9266	PEGASPARGASE INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019

J9267	PACLITAXEL INJECTION	No pre-authorization is required for all providers.	N/A
J9268	PENTOSTATIN INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9269	INJECTION TAGRAXOFUSP-ERZS 10 MCG	Pre-authorization is required for all providers.	Prior to 09/01/2019
J9270	PLICAMYCIN (MITHRAMYCIN) INJ	This service is not covered by Superior HealthPlan.	N/A
J9271	INJECTION PEMBROLIZUMAB 1 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9280	MITOMYCIN INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9285	INJECTION OLARATUMAB 10 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9290	MITOMYCIN 20 MG	This is no longer a valid code.	N/A
J9291	MITOMYCIN 40 MG	This is no longer a valid code.	N/A
J9293	INJ MITOXANTRONE HYDROCHLORIDE PER 5 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9295	INJECTION NECITUMUMAB 1 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9299	INJECTION NIVOLUMAB 1 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9300	GEMTUZUMAB OZOGAMICIN INJ	This is no longer a valid code.	N/A
J9301	OBINUTUZUMAB INJ	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9302	OFATUMUMAB INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9303	PANITUMUMAB INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9305	INJECTION PEMETREXED 10 MG	No pre-authorization is required for all providers.	N/A
J9306	INJECTION, PERTUZUMAB, 1 M	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9307	PRALATREXATE INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9308	INJECTION RAMUCIRUMAB 5 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9309	INJECTION POLATUZUMAB VEDOTIN-PIQ 1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J9310	RITUXIMAB INJECTION	This is no longer a valid code.	N/A
J9311	INJECTION RITUXIMAB 10 MG AND HYALURONIDASE	Pre-authorization is required for all providers except when services are rendered by a, internal medicine provider, hematologist, or oncologist.	Prior to 09/01/2019
J9312	INJECTION RITUXIMAB 10 MG	Pre-authorization is required for all providers for diagnosis Rheumatoid Arthritis. For all other diagnoses, pre-authorization is required for all providers except when services are rendered by an internal medicine provider, hematologist, or oncologist.	Prior to 09/01/2019
J9313	INJECTION MOXETUMOMAB PASUDOTOX-TDFK 0.01 MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9315	ROMIDEPSIN INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9320	STREPTOZOCIN INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9325	INJ TALIMOGENE LAHERPAREPVEC	This service is not covered by Superior HealthPlan.	N/A
J9328	TEMOZOLOMIDE INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9330	TEMSIROLIMUS INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9340	THIOTEPA INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9350	TOPOTECAN INJECTION	This is no longer a valid code.	N/A
J9351	TOPOTECAN INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9352	INJECTION TRABECTEDIN 0.1MG	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9354	INJ, ADO-TRASTUZUMAB EMT 1M	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9355	INJECTION TRASTUZUMAB EXCLUDES BIOSIMILAR 10 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J9356	INJECTION TRASTUZUMAB 10 MG AND HYALURONIDASE-OYSK	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9357	VALRUBICIN INJECTION	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9358	INJECTION FAM-TRASTUZUMAB DERUXTECAN-NXKI 1 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
J9360	VINBLASTINE SULFATE INJ	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9370	VINCRISTINE SULFATE 1 MG	No pre-authorization is required for all providers.	N/A
J9371	INJ, VINCRISTINE SUL LIP 1M	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9375	VINCRISTINE SULFATE 2 MG	This is no longer a valid code.	N/A
J9380	VINCRISTINE SULFATE 5 MG	This is no longer a valid code.	N/A
J9390	VINORELBINE TARTRATE INJ	Pre-authorization is required for all providers except when services are rendered by a hospital, internal medicine provider, hematologist or oncologist.	Prior to 09/01/2019
J9395	INJECTION, FULVESTRANT, 25 MG	No pre-authorization is required for all providers.	N/A
J9600	PORFIMER SODIUM INJECTION	This service is not covered by Superior HealthPlan.	N/A
J9999	NOT OTHERWISE CLASSIFIED ANTINEOPLASTIC DRUGS	Authorization is required for all non-participating providers. Authorization is required for participating providers if billed amount is greater than or equal to \$500.	Prior to 09/01/2019
K0001	STANDARD WHEELCHAIR	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0002	STANDARD HEMI (LOW SEAT) WHEELCHAIR	Pre-authorization required for all providers.	Prior to 09/01/2019
K0003	LIGHTWEIGHT WHEELCHAIR	Pre-authorization required for all providers.	Prior to 09/01/2019
K0004	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR	Pre-authorization required for all providers.	Prior to 09/01/2019
K0005	ULTRALIGHTWEIGHT WHEELCHAIR	Pre-authorization required for all providers.	Prior to 09/01/2019
K0006	HEAVY-DUTY WHEELCHAIR	Pre-authorization is required for all providers.	Prior to 09/01/2019
K0007	EXTRA HEAVY-DUTY WHEELCHAIR	Pre-authorization required for all providers.	Prior to 09/01/2019
K0008	CSTM MANUAL WHEELCHAIR/BASE	Pre-authorization required for all providers.	Prior to 09/01/2019
K0009	OTHER MANUAL WHEELCHAIR/BASE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0010	STANDARD-WEIGHT FRAME MOTORIZED/POWER WHEELCHAIR	Pre-authorization required for all providers.	Prior to 09/01/2019
K0011	STANDARD-WEIGHT FRAME POWER WHEELCHAIR W/CONTRL	Pre-authorization required for all providers.	Prior to 09/01/2019
K0012	LIGHTWEIGHT PORTABLE MOTORIZED/POWER WHEELCHAIR	No pre-authorization is required for all providers.	N/A
K0013	CUSTOM POWER WHLCHR BASE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0014	OTHER MOTORIZED/POWER WHEELCHAIR BASE	This service is not covered by Superior HealthPlan.	N/A
K0015	DETACHABLE NONADJUSTABLE HEIGHT ARMREST EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0017	DETACH ADJUST ARMREST BASE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0018	DETACH ADJUST ARMREST UPPER	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0019	ARM PAD REPLACEMENT ONLY EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0020	FIXED ADJUSTABLE HEIGHT ARMREST PAIR	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0021	ANTITIPPING DEVICE EA	No pre-authorization is required for all providers.	N/A
K0022	REINFORCED BACK UPHOLSTERY	No pre-authorization is required for all providers.	N/A
K0027	BACK UPHOLSTERY-NOT ULTRALIGHTWEIGHT WHEELCHAIR	No pre-authorization is required for all providers.	N/A
K0032	SEAT UPHOLSTERY-ULTRALIGHTWEIGHT WHEELCHAIR	No pre-authorization is required for all providers.	N/A
K0037	HIGH MOUNT FLIP-UP FOOTREST EACH	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0038	LEG STRAP EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0039	LEG STRAP H STYLE EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0040	ADJUSTABLE ANGLE FOOTPLATE EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0041	LG SIZE FOOTPLATE EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0042	STANDARD SIZE FOOTPLTE REPL ONLY EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0043	FOOTREST LWR EXT TUBE REPL ONLY EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0044	FOOTREST UPR HGR BRKT REPL ONLY EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0045	FOOTREST CMPL ASSEMBLY REPL ONLY EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0046	ELEVAT LEGRST L EXT TUBE RPL ONLY E	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0047	ELEVAT LEGRST UP HGR BRKT RPL ONLY E	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0050	RATCHET ASSEMBLY REPLACEMENT ONLY	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0051	CAM RLS ASSM FTRST/LGRST RPL ONLY E	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0052	SWNGAWAY DTACHBLE FTRSTS RPL ONLY E	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0053	ELEVATING FOOTRESTS ARTICULATING EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0055	SEAT DEPTH FOR HIGH STRENGTH/LIGHTWT WHEELCHAIR	No pre-authorization is required for all providers.	N/A
K0056	SEAT HT <17 IN=> 21 IN LT WT/ULTRA LT WT W/C	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0061	ALUMINUM HANDRIM EA	No pre-authorization is required for all providers.	N/A
K0064	ZERO PRESSURE TUBE ANY SIZE EA	This is no longer a valid code.	N/A

K0065	SPOKE PROTECTORS	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0066	SOLID TIRE ANY SIZE EA	This is no longer a valid code.	N/A
K0067	PNEUMATIC TIRE ANY SIZE EA	This is no longer a valid code.	N/A
K0068	PNEUMATIC TIRE TUBE EA	No pre-authorization is required for all providers.	N/A
K0069	RW ASM CMLP SOLID T SPKE/MLD RPL EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0070	RW ASM CMP PN T SPKS/MLD RPL ONLY E	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0071	FRT C ASM CMLP PN TIRE REPL ONLY E	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0072	FRT C ASM CMLP SEMIPN T RPL ONLY E	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0073	CASTER PIN LOCK EA	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0074	PNEUMATIC CASTER TIRE ANY SIZE EA	This is no longer a valid code.	N/A
K0075	SEMIPNEUMATIC CASTER TIRE ANY SIZE EA	No pre-authorization is required for all providers.	N/A
K0076	SOLID CASTER TIRE ANY SIZE EA	This is no longer a valid code.	N/A
K0077	FRT C ASM CMLP SLD TIRE REPL ONLY E	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0078	PNEUMATIC CASTER TIRE TUBE EA	This is no longer a valid code.	N/A
K0081	WHEEL LOCK ASSEMBLY COMPLT EA	No pre-authorization is required for all providers.	N/A
K0085	GROUP 24 SEALED LEAD ACID BATTERY EA	No pre-authorization is required for all providers.	N/A
K0086	U-1 NON-SEALED LEAD ACID BATTERY EA	No pre-authorization is required for all providers.	N/A
K0090	REAR WHEEL TIRE POWER WHEELCHAIR ANY SIZE EA	This is no longer a valid code.	N/A
K0091	REAR WHEEL TIRE TUBE NOT ZERO PRESSURE ANY SIZE	No pre-authorization is required for all providers.	N/A
K0092	REAR WHEEL ASSEMBLY FOR POWER W/C COMPLT EA	This is no longer a valid code.	N/A
K0093	REAR WHEEL ZERO PRESSURE TIRE TUBE FOR W/C EA	This is no longer a valid code.	N/A
K0094	WHEEL TIRE-POWER BASE ANY SIZE EA	No pre-authorization is required for all providers.	N/A
K0095	WHEEL TIRE TUBE NOT ZERO PRESSURE ANY SIZE EA	This is no longer a valid code.	N/A
K0096	WHEEL ASSEMBLY-POWER BASE COMPLT EA	This is no longer a valid code.	N/A
K0097	WHEEL ZERO PRESSURE TIRE TUBE-POWER BASE EA	No pre-authorization is required for all providers.	N/A
K0098	DRIVE BELT FOR POWER WC REPL ONLY	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0099	FRONT CASTER-POWER WHEELCHAIR	This is no longer a valid code.	N/A
K0100	AMPUTE ADAPTER PARI	No pre-authorization is required for all providers.	N/A
K0102	CRUTCH & CANE HOLDER	No pre-authorization is required for all providers.	N/A
K0104	CYLINDER TANK CARRIER	This is no longer a valid code.	N/A
K0105	IV HANGER	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0106	ARM TROUGH EA	This is no longer a valid code.	N/A
K0107	WHEELCHAIR TRAY	This is no longer a valid code.	N/A
K0108	OTHER ACCESSORY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0109	CUSTOMIZATION-WHEELCHAIR BASE FRAME	No pre-authorization is required for all providers.	N/A
K0112	TRUNK SUPPORT DEVICE-VEST-W/INNER FRAME PREFAB	No pre-authorization is required for all providers.	N/A
K0114	BACK SUPPORT SYST W/WHEELCHAIR W/INNER FRAME	No pre-authorization is required for all providers.	N/A
K0115	SEAT SYST BACK MOD W/WO SUPPRT CUST FAB ATT W/C	No pre-authorization is required for all providers.	N/A
K0125	PREDNISONE 100 TABS ANY DOSAGE	No pre-authorization is required for all providers.	N/A
K0137	SKIN BARRIER; LIQUID PER OZ	No pre-authorization is required for all providers.	N/A
K0169	SM VOL NONFILTERED PNEUMATIC NEBULIZER-DISP	No pre-authorization is required for all providers.	N/A
K0170	ADMIN SET-SM VOL NONFILT PNEU NEBULIZER-NON-DISP	No pre-authorization is required for all providers.	N/A
K0175	CORRUGAT TUBING-DISP-USE W/LG VOL NEBULIZ-100 FT	No pre-authorization is required for all providers.	N/A
K0176	CORRUGAT TUBING-NON DISP-USE W/LG VOL NEB-10 FT	No pre-authorization is required for all providers.	N/A
K0179	FILTER-NON DISP-USE W/AEROSOL COMPRSR/US GENER	No pre-authorization is required for all providers.	N/A
K0183	NASAL APPLIC DEVICE USE W/POS AIRWAY PRESS DEVIC	No pre-authorization is required for all providers.	N/A
K0184	NASAL PILLOWS/SEALS-REPLACE NAS APPL DEVICE-PAIR	No pre-authorization is required for all providers.	N/A
K0185	HEADGEAR USED W/POS PRESS AIRWAY DEVICE	No pre-authorization is required for all providers.	N/A
K0192	TUBING USED W/SUCTION PUMP	No pre-authorization is required for all providers.	N/A
K0195	ELEVATING LEG REST-PAIR-USED W/RENTED WC BASE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0268	HUMIDIFIER NON-HEATED USE W/PAP DEVICE	No pre-authorization is required for all providers.	N/A
K0269	AERO COMPRES ADJ PRESS LIGHT DUTY INTRMT USE	No pre-authorization is required for all providers.	N/A
K0270	ULTRASONIC GENERATOR W/SM VOL ULTRASONIC NEBULIZ	No pre-authorization is required for all providers.	N/A
K0278	SKIN BARRIER W/FLANGE/BUILT-IN CONVEX-ANY SIZE	No pre-authorization is required for all providers.	N/A
K0283	SAL SOLN/10 ML-METER DOSE DISP-USE W/INHAL DRUGS	No pre-authorization is required for all providers.	N/A
K0408	URIN CATH ANCHORING DEVICE, LEG STRAP	No pre-authorization is required for all providers.	N/A
K0411	MALE EXTERNAL CATH, W/ADHES STRIP, EACH	No pre-authorization is required for all providers.	N/A
K0413	NON-POWERED ADJUSTABLE ZONE PRESSURE-REDUCING AIR MATTRESS OVERLAY	No pre-authorization is required for all providers.	N/A
K0414	POEWRED AIR OVERLAY FOR MATTRESS	This is no longer a valid code.	N/A
K0415	RX ANTIEMETIC 1MG PO W/PO ANTI-CANCER DRUG NOS	No pre-authorization is required for all providers.	N/A
K0416	RX ANTIEMET-1MG RECTAL W/PO ANTI-CANCER DRUG NOS	No pre-authorization is required for all providers.	N/A
K0418	CYCLOSPORIN-ORAL PER 100 MG	No pre-authorization is required for all providers.	N/A
K0419	POUCH DRAINABLE W/FACEPLATE ATT PLSTC-EA	No pre-authorization is required for all providers.	N/A
K0421	POUCH DRAINABLE FOR USE ON FACEPLATE PLASTIC-EA	No pre-authorization is required for all providers.	N/A
K0422	POUCH DRAINABLE-FOR USE ON FACEPLATE RUBBER-EA	No pre-authorization is required for all providers.	N/A
K0424	POUCH URIN-W/FACEPLATE ATT RUBBER-EA	No pre-authorization is required for all providers.	N/A
K0427	POUCH URIN-FOR USE ON FACEPLATE RUBBER-EA	No pre-authorization is required for all providers.	N/A
K0428	OSTOMY FACEPLATE EQUIV SILICONE RING-EA	No pre-authorization is required for all providers.	N/A
K0429	SKIN BARR SOL 4X4 EQUIV EXTEN WEAR W/O CONVEX-EA	No pre-authorization is required for all providers.	N/A
K0431	POUCH CLOSED W/STAN WEAR BARR W/BLT-IN CONVEX-EA	No pre-authorization is required for all providers.	N/A
K0434	POUCH W/DRAIN EXT WEAR BARR ATT W/CONVEX-EA	No pre-authorization is required for all providers.	N/A
K0435	POUCH URIN-W/EXT WEAR BARR WO BLT-IN CONVEX-EA	No pre-authorization is required for all providers.	N/A
K0437	POUCH URIN EXT WEAR BARR ATT W/BLT-IN CONVEX-EA	No pre-authorization is required for all providers.	N/A
K0439	OSTOMY POUCH DEODORANT-PER SOL TAB	No pre-authorization is required for all providers.	N/A
K0440	NASAL PROSTHESIS PROVIDED BY NON-PHYS	No pre-authorization is required for all providers.	N/A
K0441	MIDFACIAL PROSTHESIS PROVIDED BY NON-PHYS	No pre-authorization is required for all providers.	N/A
K0442	ORBITAL PROSTHESIS PROVIDED BY NON-PHYS	No pre-authorization is required for all providers.	N/A
K0443	UPPER FACIAL PROSTHESIS PROVIDED BY NON-PHYS	No pre-authorization is required for all providers.	N/A
K0444	HEMI-FACIAL PROSTHESIS PROVIDED BY NON-PHYS	No pre-authorization is required for all providers.	N/A
K0445	AURICULAR PROSTHESIS PROVIDED BY NON-PHYS	No pre-authorization is required for all providers.	N/A
K0446	PARTIAL FACIAL PROSTHESIS PROVIDED BY NON-PHYS	No pre-authorization is required for all providers.	N/A
K0447	NASAL SEPTAL PROSTHESIS PROVIDED BY NON-PHYS	No pre-authorization is required for all providers.	N/A
K0448	UNSPEC MAXIL'FACIAL PROSTH-BR-PROVID BY NON-PHYS	No pre-authorization is required for all providers.	N/A
K0449	REPR/MOD MAXIL'FACIL PROSTH-15MIN LABOR NON-PHYS	No pre-authorization is required for all providers.	N/A
K0450	ADHES LIQUID USED W/FACIAL PROSTH ONLY-PER OUNCE	No pre-authorization is required for all providers.	N/A
K0451	ADHESIVE REMOVER WIPES PER BOX OF 50	No pre-authorization is required for all providers.	N/A
K0452	WHEELCHAIR BEARINGS-ANY TYPE	No pre-authorization is required for all providers.	N/A
K0455	INFUS PUMP USED FOR UNINTERRUPTED PARENTERAL ADMIN OF MEDI	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0456	HOSP BED HD EXTRA WIDE W/ANY SIDE RAILS W/MATRS	No pre-authorization is required for all providers.	N/A
K0457	EXTRA WIDE/HD COMMODE CHAIR EA	No pre-authorization is required for all providers.	N/A
K0458	HD WALKER WO WHEELS EA	No pre-authorization is required for all providers.	N/A
K0459	HD WHEELED WALKER EA	No pre-authorization is required for all providers.	N/A
K0460	PWR CONVRT MANUAL TO MOTOR WC JOYSTICK CNTRL	No pre-authorization is required for all providers.	N/A
K0461	PWR CONVRT MAN WC PWR OPER VEHICLE TILLER CNTRL	No pre-authorization is required for all providers.	N/A
K0462	TMP REPLC PT EQUIP/REPR/ANY TYPE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0501	AEROSOL COMPRES BATT PWR USE W/SM VOL NEB	No pre-authorization is required for all providers.	N/A
K0503	ACETYLCYSTEINE INHAL SOL ADMIN BY DME/U DOSE/GM	No pre-authorization is required for all providers.	N/A
K0506	ATRO INHAL SOL ADMIN THRU DME CONCEN FORM/PER MG	No pre-authorization is required for all providers.	N/A
K0507	ATRO INHAL SOL ADMIN THRU DME/U DOSE FORM/PER MG	No pre-authorization is required for all providers.	N/A
K0511	CROMOLYN SODIUM INHAL SOL VIA DME U DOSE/10 MG	No pre-authorization is required for all providers.	N/A
K0512	DEX INHAL SOL ADMIN THRU DME CONCEN FORM/PER MG	No pre-authorization is required for all providers.	N/A
K0513	DEX INHAL SOL ADMIN THRU DME U DOSE FORM/PER MG	No pre-authorization is required for all providers.	N/A
K0514	DORNASE ALPHA INHAL SOL VIA DME U DOSE/PER MG	No pre-authorization is required for all providers.	N/A
K0515	GLYCOPYRRROLATE INHAL SOL VIA DME CONCEN/PER MG	No pre-authorization is required for all providers.	N/A
K0516	GLYCOPYRRROLATE INHAL SOL VIA DME U DOSE/PER MG	No pre-authorization is required for all providers.	N/A
K0518	IPRATROPIUM BROMIDE INHAL SOL VIA DME U DOSE/ML	No pre-authorization is required for all providers.	N/A
K0519	ISOE HCL INHAL SOL VIA DME/CONCEN FORM/ PER ML	No pre-authorization is required for all providers.	N/A
K0520	ISOE HCL INHAL SOL ADMIN THRU DME/U DOSE FORM/MG	No pre-authorization is required for all providers.	N/A
K0521	ISO HCL INHAL SOL ADMIN THRU DME CONCEN FORM/MG	No pre-authorization is required for all providers.	N/A
K0522	ISO HCL INHAL SOL ADMIN THRU DME U DOSE FORM/MG	No pre-authorization is required for all providers.	N/A
K0523	METAPROTERENOL SO4 INHAL SOL VIA DME CONCEN/10MG	No pre-authorization is required for all providers.	N/A

K0524	METAPROTERENOL SO4 INHAL SOL VIA DME U DOSE/10MG	No pre-authorization is required for all providers.	N/A
K0525	TERB SO4 INHAL SOL VIA DME CONCEN FORM/PER MG	No pre-authorization is required for all providers.	N/A
K0526	TERB SO4 INHAL SOL ADMIN THRU DME/U DOSE FORM/MG	No pre-authorization is required for all providers.	N/A
K0527	TRIAMCINOLONE INHAL SOL ADMIN THRU DME/CONCEN/MG	No pre-authorization is required for all providers.	N/A
K0528	TRIAMCINOLONE INHAL SOL VIA DME U DOSE FORM/MG	No pre-authorization is required for all providers.	N/A
K0529	STER H2O/SAL/1000ML/USED W/LG VOL NEB	No pre-authorization is required for all providers.	N/A
K0530	NEB DUR/GLASS/AUTOCLAV PLSTC BTL NOT O2 THERAP	No pre-authorization is required for all providers.	N/A
K0531	HUM HEATED USE W/PAP DEVICE	No pre-authorization is required for all providers.	N/A
K0532	RAD BI-LVL PRESS W/O BACKUP W/NON	No pre-authorization is required for all providers.	N/A
K0533	RAD BI-LVL PRESS W/BACKUP W/NON-INV	No pre-authorization is required for all providers.	N/A
K0534	RAD BI-LVL PRESS W/BACKUP W/INVASIV	No pre-authorization is required for all providers.	N/A
K0538	NEG PRESS WND THER ELEC PMP STAT/PT	No pre-authorization is required for all providers.	N/A
K0539	DSG SET NEG PRESS WND THER ELEC PMP	No pre-authorization is required for all providers.	N/A
K0540	CAN SET NEG PRESS WND THER ELEC PMP	No pre-authorization is required for all providers.	N/A
K0541	DIG SPCH GEN DEV </= 8 MIN REC TIME	No pre-authorization is required for all providers.	N/A
K0542	DIG SPEECH GEN DEV > 8 MIN REC TIME	No pre-authorization is required for all providers.	N/A
K0543	SYN SPCH GEN DEV REQ PHY CNTCT W/DV	No pre-authorization is required for all providers.	N/A
K0544	SYN SPCH GEN DEV MX METHD MESS FRM	No pre-authorization is required for all providers.	N/A
K0545	SPCH GEN SOFTWARE PROG COMPTN	No pre-authorization is required for all providers.	N/A
K0546	ACCESS SPEECH GEN DEV MNTG SYS	No pre-authorization is required for all providers.	N/A
K0547	ACCESS FOR SPCH GEN DEV NOS	No pre-authorization is required for all providers.	N/A
K0548	INJECTION, INSULIN LISPRO, UP TO 50 MINUTES	No pre-authorization is required for all providers.	N/A
K0549	HOSPITAL BED	No pre-authorization is required for all providers.	N/A
K0550	HOSPITAL BED	No pre-authorization is required for all providers.	N/A
K0551	RESIDUAL LIMB SUPPORT	No pre-authorization is required for all providers.	N/A
K0552	SPL EX N-INS RX INF PMP SYR CRT S E	No pre-authorization is required for all providers.	N/A
K0553	THER CGM SUPPLY ALLOWANCE	Pre-authorization is required for all providers for STAR, STAR+PLUS and Chip members, for all other members, pre-authorization is required for non participating providers.	Prior to 09/01/2019
K0554	THER CGM RECEIVER/MONITOR	Pre-authorization is required for all providers for STAR, STAR+PLUS and Chip members, for all other members, pre-authorization is required for non participating providers.	Prior to 09/01/2019
K0556	ADD LW EXT BK/AK W/LOCK MECH	No pre-authorization is required for all providers.	N/A
K0557	ADD LW EXT BK/AK NOT W/LOCK MECH	No pre-authorization is required for all providers.	N/A
K0558	ADD LW EXT INSRT CONGN/TRM AMP INIT	No pre-authorization is required for all providers.	N/A
K0559	ADD LW EXT INSRT NOT CONGN/TRMA AMP	No pre-authorization is required for all providers.	N/A
K0560	METACARP PHAL JOINT REPLACEMENT/2PCS	No pre-authorization is required for all providers.	N/A
K0561	OSTOMY SKIN BARRIER NON PECTIN	No pre-authorization is required for all providers.	N/A
K0562	OSTOMY SKIN BARRIER PECTIN BASED	No pre-authorization is required for all providers.	N/A
K0563	OSTOMY SKIN BARRIER	No pre-authorization is required for all providers.	N/A
K0564	OSTOMY SKIN BARRIER / EXTENDED WEAR/ BUILT IN CONVEX	No pre-authorization is required for all providers.	N/A
K0565	OSTOMY SKIN BARRIER	No pre-authorization is required for all providers.	N/A
K0566	OSTOMY SKIN BARRIER/ FLANGE EXTENDED	No pre-authorization is required for all providers.	N/A
K0567	OSTOMY POUCH DRAINABLE/KARAYA BASED BARRIER	No pre-authorization is required for all providers.	N/A
K0568	OSTOMY POUCH DRAINABLE/ STANDARD	No pre-authorization is required for all providers.	N/A
K0569	OSTOMY POUCH / DRAINABLE	No pre-authorization is required for all providers.	N/A
K0570	OSTOMY SKIN BARRIER/ FLANGE	No pre-authorization is required for all providers.	N/A
K0571	OSTOMY SKIN BARRIER W/FLANGE	No pre-authorization is required for all providers.	N/A
K0572	TAPE NON WATER PROOF	No pre-authorization is required for all providers.	N/A
K0573	TAPE WATERPROOF	No pre-authorization is required for all providers.	N/A
K0574	ADDITION TO OSTOMY POUCH	No pre-authorization is required for all providers.	N/A
K0575	ADDITION TO OSTOMY POUCH / RUSTLE FREE	No pre-authorization is required for all providers.	N/A
K0576	ADD TO OSTOMY POUCH/FRICTION AND IRRITANT REDUCING	No pre-authorization is required for all providers.	N/A
K0577	ADD TO OSTOMY POUCH / ODER BARRIER	No pre-authorization is required for all providers.	N/A
K0578	ADD TO OSTOMY POUCH/ FAUCET TYPE	No pre-authorization is required for all providers.	N/A
K0579	ADD TO OSTOMY POUCH/ABSORBENT	No pre-authorization is required for all providers.	N/A
K0580	ADD TO OSTOMY POUCH/ FLANGE LOCKING	No pre-authorization is required for all providers.	N/A
K0581	OST POUCH CLOS W/BARRIER W/FLTR EA	No pre-authorization is required for all providers.	N/A
K0582	OST POUCH CLO W/BARR BUILT-IN CONVX	No pre-authorization is required for all providers.	N/A
K0583	OST POUCH CLOS; W/O BARRIER W/FLTR	No pre-authorization is required for all providers.	N/A
K0584	OST POUCH CLOS; BARRIER FLNGE FLTR	No pre-authorization is required for all providers.	N/A
K0585	OST POUCH CLOS; BARRIER LOCK FLNGE	No pre-authorization is required for all providers.	N/A
K0586	OST POUCH CLO; BARR LOCK FLNGE FLTR	No pre-authorization is required for all providers.	N/A
K0587	OST POUCH DRNABLE W/BARRIER FLTR EA	No pre-authorization is required for all providers.	N/A
K0588	OST POUCH DRNABL;BARRIER FLNGE FLTR	No pre-authorization is required for all providers.	N/A
K0589	OST POUCH DRNABLE; BARR LOCK FLNGE	No pre-authorization is required for all providers.	N/A
K0590	OST POUCH DRN; BARR LOCK FLNGE FLTR	No pre-authorization is required for all providers.	N/A
K0591	OST POUCH URIN W/EXT WEAR BARR TAP	No pre-authorization is required for all providers.	N/A
K0592	OST POUCH URIN BARR BUILT-IN CONVX	No pre-authorization is required for all providers.	N/A
K0593	OST POUCH URIN EXT WR BUILT-IN CNVX	No pre-authorization is required for all providers.	N/A
K0594	OST POUCH URIN; BARR FAUCET TAP EA	No pre-authorization is required for all providers.	N/A
K0595	OST POUCH URIN; BARR FLNGE FAUCET	No pre-authorization is required for all providers.	N/A
K0596	OSTOMY POUCH URIN; BARR LOCK FLNGE	No pre-authorization is required for all providers.	N/A
K0597	OST POUCH URIN; BARR LOCK FLNGE TAP	No pre-authorization is required for all providers.	N/A
K0600	FUNCTIONAL NEUROMUSCULAR STIMULATOR	No pre-authorization is required for all providers.	N/A
K0601	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0602	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP, SILVER OXIDE, 3 VOLT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0603	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP ALKALINE, 1.5 VOLT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0604	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP LITHIUM, 3.6 VOLT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0605	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMPLITHIUM, 4.5 VOLT	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0606	AUTOMATIC EXTRNL DFBRLTR, W INTGRD ELEC RDGRM ANALYSIS	Pre-authorization required for all providers.	Prior to 09/01/2019
K0607	REPLACEMENT BATTERY FOR AUTOMATED EXTERNAL DEFIBRILLATOR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0608	REPLACEMENT GARMENT FOR USE WITH AUTOMATED EXTERNAL DEFIBRILLATOR, EACH	This service is not covered by Superior HealthPlan.	N/A
K0609	RPLCMNT ELECTRDS FOR USE W AUTOMTD EXTRNL DFBRLTR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0618	TLSO, SAGITTAL-CORONAL CONTROL, MODULAR SEGMENTED SPINAL SYSTEM	No pre-authorization is required for all providers.	N/A
K0619	TLSO, MODULAR SEGMENTED SPINAL SYSTEM, THREE RIGID PLASTIC SHELLS	No pre-authorization is required for all providers.	N/A
K0620	TUBULAR ELASTIC DRESSING, ANY WIDTH, PER LINEAR YARD	No pre-authorization is required for all providers.	N/A
K0628	FOR DIAB MX DENSITY INSERT DIRECT FORM PREFAB EA	No pre-authorization is required for all providers.	N/A
K0629	FOR DIAB MX DENSTY INSRT CUSTM MOLD CUSTM FAB EA	No pre-authorization is required for all providers.	N/A
K0630	SACROIL ORTHOS FLX RDUC MOT SI JNT	No pre-authorization is required for all providers.	N/A
K0631	SACROIL ORTHOS FLX RDUC MOT SI JNT	No pre-authorization is required for all providers.	N/A
K0632	SACROIL ORTHOS RIGD/SEMI-RIGD PANL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0633	SACROIL ORTHOS RIGD/SEMI-RIGD PANLS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0634	LUMB ORTHOS FLX POST L1 BELW L5 PRF	No pre-authorization is required for all providers.	N/A
K0635	LUMB ORTHOS SAGIT RIGD POST PANL L1	No pre-authorization is required for all providers.	N/A
K0636	LUMB ORTHOS SAGIT RIGD ANT&POST L1	No pre-authorization is required for all providers.	N/A
K0637	LSO FLX POST SACROCCOCYGL TO T-9 PR	No pre-authorization is required for all providers.	N/A
K0638	LSO FLX POST SACROCCOCYGEAL TO T-9	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0639	LSO SAGIT RIGD POST SACROCCOCYGEAL	No pre-authorization is required for all providers.	N/A
K0640	LSO SAGIT RIGD ANT&POST SACROCCOCYG	No pre-authorization is required for all providers.	N/A
K0641	LSO SAGIT RIGD ANT&POST SACROCCOCYG	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0642	LSO SAGIT-CORONAL RIGD POST SC TO T	No pre-authorization is required for all providers.	N/A
K0643	LSO SAGIT-CORONAL RIGD POST SC TO T	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0644	LSO SAGIT-CORONAL LUMB FLEX RIGD PO	No pre-authorization is required for all providers.	N/A
K0645	LSO SAGIT-CORONAL LUMB FLEX RIGD PO	No pre-authorization is required for all providers.	N/A
K0646	LSO SAGIT-CORONAL RIGD ANT&POST SC	No pre-authorization is required for all providers.	N/A
K0647	LSO SAGIT-CORONAL RIGD ANT&POST SC	No pre-authorization is required for all providers.	N/A
K0648	LSO SAGIT-CORONAL RIGD SHELL/PANL P	No pre-authorization is required for all providers.	N/A
K0649	LSO SAGIT-CORONAL RIGD SHELL/PANL P	No pre-authorization is required for all providers.	N/A
K0669	SEAT/BACK CUS NO DMEPDAC VER	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0670	ADDN TO LOW EXTREM PROSTH ENDOSKELETAL KNEE SHIN SYS NUCRIORICESSOR CNTR	No pre-authorization is required for all providers.	N/A
K0671	PORTABLE OXYGEN CONCENTRATOR RENTAL	No pre-authorization is required for all providers.	N/A
K0672	REMOVE SOFT INTERFACE, REPL	No pre-authorization is required for all providers.	N/A
K0730	CONTROLLED DOSE INHALATION DRUG DELIVERY SYSTEM	Pre-authorization required for all providers.	Prior to 09/01/2019

K0731	LITHIUM ION BATTERY FOR COCHLEAR IMPL DEV SPEECH PROCESS NON EAR LEVEL	No pre-authorization is required for all providers.	N/A
K0732	LITHIUM ION BATTERY FOR COCHLEAR IMPL DEV SPEECH PROCESS EAR LEVEL	No pre-authorization is required for all providers.	N/A
K0733	POWER WHEELCHAIR ACCESSORY 12 TO 24 AMP HOUR SEALED	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0736	SKIN PROT/POSITIONING WHEELCHAIR SEAT CUSHION ADJ WIDTH<22 IN	No pre-authorization is required for all providers.	N/A
K0737	SKIN PROT/POSITIONING WHEELCHAIR SEAT CUSHION ADJ WIDTH>22 IN	No pre-authorization is required for all providers.	N/A
K0738	PORTBL GASEOUS O2 STM RENTAL HOME COMPRESSOR FOR PORTABLE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
K0739	REPAIR/SVC DME NON-OXYGEN EQ	No pre-authorization is required for all providers.	N/A
K0740	REPAIR/SVC OXYGEN EQUIPMENT	This service is not covered by Superior HealthPlan.	N/A
K0743	PORTABLE HOME SUCTION PUMP	This service is not covered by Superior HealthPlan.	N/A
K0744	ABSORP DRG <= 16 SUC PUMP	This service is not covered by Superior HealthPlan.	N/A
K0745	ABSORP DRG >16 <=48 SUC PUMP	This service is not covered by Superior HealthPlan.	N/A
K0746	ABSORP DRG >48 SUC PUMP	This service is not covered by Superior HealthPlan.	N/A
K0800	PWR OP VEHICLE GRP 1 STNDRD PT WEIGHT UP TO 300 LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0801	PWR OP VEHICLE GRP 1 HEAVY DUTY PT WEIGHT 300-450 LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0802	PWR OP VEHICLE, GRP 1 VERY HVY DUTY PT WEIGHT 451-600 LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0806	PWR OP VEHICLE GRP 2 STNDRD PT WEIGHT UP TO 300 LB	This service is not covered by Superior HealthPlan.	N/A
K0807	PWR OP VEHICLE GRP 2 HEAVY DUTY PT WEIGHT 300-450 LB	This service is not covered by Superior HealthPlan.	N/A
K0808	PWR OP VEHICLE, GRP 2 VERY HVY DUTY PT WEIGHT 451-600 LB	This service is not covered by Superior HealthPlan.	N/A
K0812	PWR OP VEHICLE NOT OTHERWISE CLASSIFIED	No pre-authorization is required for all providers.	N/A
K0813	PWR WHEELCHAIR GRP 1 STNDRD SLING/SOLID SEAT WEIGHT UP TO 300LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0814	PWR WHEELCHAIR GRP 1 STNDRD CAPTN CHAIR WEIGHT UP TO 300LB	No pre-authorization is required for all providers.	N/A
K0815	PWR WHEELCHAIR GRP 1 STNDRD SLING/SOLID SEAT WEIGHT UP TO 300LB	No pre-authorization is required for all providers.	N/A
K0816	PWR WHEELCHAIR GRP 1 STNDRD CAPTN CHAIR WEIGHT UP TO 300LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0820	PWR WHEELCHAIR GRP 2 STNDRD SLING/SOLID SEAT WEIGHT UP TO 300LB	No pre-authorization is required for all providers.	N/A
K0821	PWR WHEELCHAIR GRP 2 STNDRD CAPTN CHAIR WEIGHT UP TO 300LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0822	PWR WHEELCHAIR GRP 2 STNDRD SLING/SOLID SEAT WEIGHT UP TO 300LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0823	PWR WHEELCHAIR GRP 2 STNDRD CAPTN CHAIR WEIGHT UP TO 300LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0824	PWR WHEELCHAIR GRP 2 HVY DUTY SLING/SOLID SEAT PT WT 301-450 LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0825	PWR WHEELCHAIR GRP 2 HVY DUTY CAPTN CHAIR PT WT 301-450 LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0826	PWR WHEELCHAIR GRP 2 HVY DUTY SLING/SOLID SEAT PT WT 451-600 LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0827	PWR WHEELCHAIR GRP 2 HVY DUTY CAPTN CHAIR PT WT 451-600 LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0828	PWR WHEELCHAIR GRP 2 HVY DUTY SLING/SOLID SEAT PT WT >601 LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0829	PWR WHEELCHAIR GRP 2 HVY DUTY CAPTN CHAIR PT WT >601 LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0830	PWR WHEELCHR GRP 2 STNDRD SEAT ELEVATOR PT WT UP TO 300 LB	No pre-authorization is required for all providers.	N/A
K0831	PWR WHEELCHR GRP 2 STNDRD SEAT ELEVATR CAPT CHAIR PT WT<301#	No pre-authorization is required for all providers.	N/A
K0835	PWR WHEELCHR GRP 2 SINGL PWR SLING/SOLID SEAT, PT WT <301#	Pre-authorization required for all providers.	Prior to 09/01/2019
K0836	PWR WHEELCHR GRP 2 SINGL PWR CAPTN CHAIR, PT WT <301#	No pre-authorization is required for all providers.	N/A
K0837	PWR WHEELCHAIR, GRP 2 SINGL PWR SLING/SOLID SEAT PT WT 301-450#	Pre-authorization required for all providers.	Prior to 09/01/2019
K0838	PWR WHEELCHAIR, GRP 2 SINGL PWR CAPTN CHAIR PT WT 301-450#	Pre-authorization required for all providers.	Prior to 09/01/2019
K0839	PWR WHEELCHAIR, GRP 2 SINGL PWR SLING/SOLID SEAT PT WT 451-600#	Pre-authorization required for all providers.	Prior to 09/01/2019
K0840	PWR WHEELCHAIR, GRP 2 SINGL PWR SLING/SOLID SEAT PT WT >601#	Pre-authorization required for all providers.	Prior to 09/01/2019
K0841	PWR WHEELCHR GRP 2 MULTI PWR SLING/SOLID SEAT, PT WT <301#	Pre-authorization required for all providers.	Prior to 09/01/2019
K0842	PWR WHEELCHR GRP 2 MULTI PWR CAPTN CHAIR, PT WT <301#	Pre-authorization required for all providers.	Prior to 09/01/2019
K0843	PWR WHEELCHR GRP 2 MULTI PWR SLING/SOLID SEAT, PT WT 301-450#	Pre-authorization required for all providers.	Prior to 09/01/2019
K0848	PWR WHEELCHAIR GRP 3 STNDRD SLING/SOLID SEAT WEIGHT UP TO 300LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0849	PWR WHEELCHAIR GRP 3 STNDRD CAPTN CHAIR WEIGHT UP TO 300LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0850	PWR WHEELCHAIR GRP 3 HVY DUTY SLING/SOLID SEAT WEIGHT 301-450LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0851	PWR WHEELCHAIR GRP 3 HVY DUTY CAPTN CHAIR WEIGHT 301-450LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0852	PWR WHEELCHAIR GRP 3 HVY DUTY SLING/SOLID SEAT WEIGHT 451-600LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0853	PWR WHEELCHAIR GRP 3 HVY DUTY CAPTN CHAIR WEIGHT 451-600LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0854	PWR WHEELCHAIR GRP 3 HVY DUTY SLING/SOLID SEAT WEIGHT >600LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0855	PWR WHEELCHAIR GRP 3 HVY DUTY CAPTN CHAIR WEIGHT >600LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0856	PWR WHEELCHAIR GRP 3 SING PWR SLING/SOLID SEAT WEIGHT UP TO 300LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0857	PWR WHEELCHAIR GRP 3 SING PWR CAPTN CHAIR WEIGHT UP TO 300LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0858	PWR WHEELCHAIR GRP 3 SING PWR SLING/SOLID SEAT WEIGHT 301-450LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0859	PWR WHEELCHAIR GRP 3 SING PWR CAPTN CHAIR WEIGHT 301-450LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0860	PWR WHEELCHAIR GRP 3 SING PWR SLING/SOLID SEAT WEIGHT 451-600LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0861	PWR WHEELCHAIR GRP 3 MULTI PWR SLING/SOLID SEAT WEIGHT UP TO 300LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0862	PWR WHEELCHAIR GRP 3 MULTI PWR SLING/SOLID SEAT WEIGHT 301-450LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0863	PWR WHEELCHAIR GRP 3 MULTI PWR SLING/SOLID SEAT WEIGHT 451-600LB	Pre-authorization required for all providers.	Prior to 09/01/2019
K0864	PWR WHEELCHAIR GRP 3 MULTI PWR SLING/SOLID SEAT WEIGHT >600#	Pre-authorization required for all providers.	Prior to 09/01/2019
K0868	PWR WHEELCHAIR GRP 4 STNDRD SLING/SOLID SEAT WEIGHT UP TO 300LB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0869	PWR WHEELCHAIR GRP 4 STNDRD CAPTN CHAIR WEIGHT UP TO 300LB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0870	PWR WHEELCHAIR GRP 4 HVY DUTY SLING/SOLID SEAT WEIGHT 301-450LB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0871	PWR WHEELCHAIR GRP 4 HVY DUTY SLING/SOLID SEAT WEIGHT 451-600LB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0877	PWR WHEELCHAIR GRP 4 SINGL PWR SLING/SOLID SEAT WEIGHT UP TO 300LB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0878	PWR WHEELCHAIR GRP 4 CAPTN CHAIR SLING/SOLID SEAT WEIGHT UP TO 300#	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0879	PWR WHEELCHAIR GRP 4 SINGL PWR SLING/SOLID SEAT WEIGHT301-450LB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0880	PWR WHEELCHAIR GRP 4 SINGL PWR SLING/SOLID SEAT WEIGHT 451-600LB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0884	PWR WHEELCHAIR GRP 4 MULTI PWR SLING/SOLID SEAT WEIGHT UP TO 300LB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0885	PWR WHEELCHAIR GRP 4 CAPTN CHAIR SLING/SOLID SEAT WEIGHT UP TO 300#	Pre-authorization required for all providers.	Prior to 09/01/2019
K0886	PWR WHEELCHAIR GRP 4 MULTI PWR SLING/SOLID SEAT WEIGHT301-450LB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0890	PWR WHEELCHR GRP 5 PEDS SINGL PWR SLING/SOLID SEAT PT WT UP TO 125#	Pre-authorization required for all providers.	Prior to 09/01/2019
K0891	PWR WHEELCHR GRP 5 PEDS MULTI PWR SLING/SOLID SEAT PT WT UP TO 125#	Pre-authorization required for all providers.	Prior to 09/01/2019
K0898	PWR WHEELCHR NOT OTHERWISE CLASSIFIED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0899	POW MOBIL DEV NO DMEPDAC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0900	CSTM DME OTHER THAN WHEELCHR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0901	KO SINGL UPRIGHT THIGH & CALF PREFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0902	KO DBLE UPRIGHT THIGH & CALF PREFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
K0903	MULT DEN INSERT DIR CARV/CAM	This is no longer a valid code.	N/A
K1001	ELECTRONIC POSIT OBSTRUCTIVE SLEEP APNEA TX SENS	This service is not covered by Superior HealthPlan.	N/A
K1002	CES SYS INCL ALL SUPPLIES AND ACCESSORIES ANY TYPE	This service is not covered by Superior HealthPlan.	N/A
K1003	WHIRLPOOL TUB WALK IN PORTABLE	This service is not covered by Superior HealthPlan.	N/A
K1004	LW FRQ U/S DIA TX DVC HM USE INCL CMPNT AND ACCESS	This service is not covered by Superior HealthPlan.	N/A
K1005	DISPOSABLE COLL AND STRG BAG BM ANY SIZE ANY T EA	This service is not covered by Superior HealthPlan.	N/A
K1083	ALLIED RESP: BIPAP/CPAP MASK (EXTRA) EXCLUDES SULLIVAN MASKS	No pre-authorization is required for all providers.	N/A
K1084	ALLIED RESP: NASAL PILLOWS	No pre-authorization is required for all providers.	N/A
L0100	CERV CRANIOTENOSIS HELMET MOLDED TO PT MODEL	This is no longer a valid code.	N/A
L0110	CERV CRANIOTENOSIS HELMET NON MOLDED	No pre-authorization is required for all providers.	N/A
L0112	CRANIAL CERVICAL ORTHOSIS, CONGENITAL TORTICOLLIS TYPE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0113	CRANIAL CERVICAL TORTICOLLIS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0120	CERV FLEXIBLE NON ADJUSTABLE (FOAM COLLAR)	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0130	CERV FLEXIBLE THERMOPLASTIC COLLAR MOLDED TO PT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0140	CERV SEMI-RIGID ADJUSTABLE (PLASTIC COLLAR)	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0150	CERV SEMI-RIGID ADJUSTABLE MOLDED CHIN CUP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0160	CERV SEMI RIGID WIRE FRAME OCCIPITAL/MANDIBLE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0170	CERV COLLAR MOLDED TO PT MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0172	CERV COLLAR SEMI RIGID THERMOPLASTIC 2 PIECE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0174	CERV COLLAR SEMI RIGID THERMOPLASTIC W/THORACIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0180	CERV MULT POST COLLAR OCCIP/MAND SUPP ADJ	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0190	CERV MULT POST COLLAR OCCIP/MAND ADJ CERV BARS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0200	CERV MULT POST COLLAR OCCIP/MAND ADJ CERV W/THOR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0220	THORACIC RIB BELT CUSTOM FABRICATED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0321	TLSO, ANTERIOR - POSTERIOR CONTROL	No pre-authorization is required for all providers.	N/A
L0331	TLSO, ANTERIOR POSTERIOR LATERAL CONTROL	No pre-authorization is required for all providers.	N/A
L0391	TLSO, ANTERIOR POSTERIOR LATERAL ROTARY CONTROL	No pre-authorization is required for all providers.	N/A
L0430	DEWALL POSTURE PROTECTOR	This is no longer a valid code.	N/A
L0450	TLSO FLEX TRNK UP THOR RGN PRFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0452	TLSO FLEX TRNK UP THOR RGN CSTM FAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0454	TLSO FLEX TRNK SC JUNC TO T-9 PRFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0455	TLSO FLEX TRNK SJ-T9 PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019

L0456	TLISO FLEX TRNK SC TO SCAP SPN PRFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0457	TLISO FLEX TRNK SJ-SS PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0458	TLISO TRIPLANR 2 SHELL ANT-XIPHOID	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0460	TLISO TRIPLANR 2 SHELL ANT-STERNL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0462	TLISO TRIPLANR 3 SHELL ANT-STERNL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0464	TLISO TRIPLANR 4 SHELL ANT-STERNL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0466	TLISO SAGIT POST FRME&ANT APRON PRFB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0467	TLISO R FRAM SOFT PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0468	TLISO SAGIT-CORONAL FRME&APRON PRFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0469	TLISO RIG FRAM PELVIC PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0470	TLISO TRIPLANAR FRME&APRON W/STRAP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0472	TLISO TRIPLANAR HYPREXT RIGD FRME	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0478	TLISO SAGIT-CORONAL CNTRL CSTM FAB	No pre-authorization is required for all providers.	N/A
L0480	TLISO TRIPLANR 1 PC NO INTERFCF CSTM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0482	TLISO TRIPLANAR 1 PC W/INTERFCF CSTM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0484	TLISO TRIPLANR 2 PC NO INTERFCF CSTM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0486	TLISO TRIPLANAR 2 PC W/INTERFCF CSTM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0488	TLISO TRIPLANR 1 PC W/INTERFCF PRFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0490	TLISO SAGIT-CORONAL REINFORCE PRFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0491	TLISO 2 PIECE RIGID SHELL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0492	TLISO 3 PIECE RIGID SHELL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0561	LSO, ANTERIOR POSTERIOR LATERAL CONTROL	No pre-authorization is required for all providers.	N/A
L0610	SACROILIAC FLEXIBLE CUSTOM FABRICATED	No pre-authorization is required for all providers.	N/A
L0621	SIO FLEX PELVISACRAL PREFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0622	SIO FLEX PELVISACRAL CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0623	SIO PANEL PREFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0624	SIO PANEL CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0625	LUMBAR ORTHOSIS FLEX IBL L1-BELOW L5 PREFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0626	LUMBAR ORTHOSIS SAGGITAL STAYS/PANELS PREFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0627	LUMBAR ORTHOSIS SAGGITA RIGID PANEL PREFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0628	LUMBAR ORTHOSIS FLEX W/O RIGID STAYS PREFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0629	LUMBAR SACRAL ORTHOSIS FLEX W/RIGID STAYS CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0630	LUMBAR SACRAL ORTHOSIS POST RIGID PANEL PREFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0631	LUMB-SAC ORTHOSIS,SAGGITAL CONTROL W RIGID ANT &POST PANELS, PREFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0632	LUMBAR SACRAL ORTHOSIS SAGGITAL RIGID FRAME CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0633	LUMBAR SACRAL ORTHOSIS FLEXION CONTROL PREFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0634	LUMBAR SACRAL ORTHOSIS FLEXION CONTROL CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0635	LUMBAR SACRAL ORTHOSIS SAGGITAL RIGID PANEL PREFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0636	LUMBAR SACRAL ORTHOSIS SAGGITAL RIGID PANEL CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0637	LUMBAR SACRAL ORTHOSIS SAGGITAL-CORONAL PANEL PREFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0638	LUMBAR SACRAL ORTHOSIS SAGGITAL-CORONAL PANEL CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0639	LUMBAR SACRAL ORTHOSIS SAGGITAL-CORONAL SHELL/PANEL PREFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0640	LUMBAR SACRAL ORTHOSIS SAGGITAL-CORONAL SHELL/PANEL CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0641	LO RIG POS PNL L1-L5 PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0642	LO SAG RI AN/POS PNL PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0643	LSO SAG CTR RIGI POS PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0648	LSO SAG R AN/POS PNL PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0649	LSO SC R POS/LAT PNL PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0650	LSO SC R ANT/POS PNL PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0651	LSO SAG-COR R AN/POS PNL ABD PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0700	CTLISO ANT/POST/LAT CONTROL MOLDED TO PT MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0710	CTLISO ANT/POST/LAT MOLDED TO PT W/INTERFACE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0810	HALO PROC CERV HALO INC INTO JACKET VEST	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0820	HALO PROC CERV HALO INC INTO PLASTER BODY JACKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0830	HALO PROC CERV HALO INC INTO MILWAUKEE TYPE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0859	ADDN TO HALO PROCEDURE MRI COMPATIBLE SYST RINGS & PINS ANY MATERIAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0860	ADD TO HALO PROC MRI COMPATIBLE SYSTEM	No pre-authorization is required for all providers.	N/A
L0861	ADDITION TO HALO PROCEDURE, REPLACEMENT LINER/INTERFACE MATERIAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0970	TLISO CORSET FRONT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0972	LSO CORSET FRONT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0974	TLISO FULL CORSET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0976	LSO FULL CORSET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0978	AXILLARY CRUTCH EXTENSION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0980	PERONEAL STRAPS PAIR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0982	STOCKING SUPPORTER GRIPS SET OF 4	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0984	PROTECTIVE BODY SOCK EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L0986	ADDITION TO SPINAL ORTHOSIS, RIGID OR SEMI-RIGID PANEL	No pre-authorization is required for all providers.	N/A
L0999	ADD SPINAL ORTHOSIS NOS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1000	CTLISO INCL INIT ORTHOSIS INCL MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1001	CERV THORACIC LUMB SAC ORTH IMMOBIL INFANT SIZE PREFAB INCL FIT & ADJ	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1005	TENSION BASED SCOLIOSIS ORTHOSIS AND ACCESSORY PADS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1010	ADD TO CTLISO SCOLIOSIS AXILLA SLING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1020	ADD CTLISO/SCOLIOSIS ORTHOSIS KYPHOSIS PAD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1025	ADD CTLISO/SCOLIOSIS ORTHOSIS FLOAT KYPHOSIS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1030	ADD CTLISO SCOLIOSIS LUMBAR BOLSTER PAD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1040	ADD CTLISO SCOLIOSIS LUMBAR/RIB PAD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1050	ADD CTLISO SCOLIOSIS STERNAL PAD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1060	ADD CTLISO SCOLIOSIS THORACIC PAD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1070	ADD CTLISO SCOLIOSIS TRAPEZIUS SLING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1080	ADD CTLISO SCOLIOSIS OUTRIGGER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1085	ADD CTLISO SCOLIOSIS OUTRIGGER BILAT W/EXTENSION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1090	ADD CTLISO SCOLIOSIS LUMBAR SLING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1100	ADD CTLISO SCOLIOSIS RING FLANGE PLASTIC/LEATHER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1110	ADD CTLISO SCOLIOSIS RING FLANGE MOLD TO PT MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1120	ADD CTLISO SCOLIOSIS EA UPRIGHT COVER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1200	TLISO INCL FURNISH INIT ORTHOSIS ONLY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1210	ADD TLISO LAT THORACIC EXTENSION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1220	ADD TLISO ANTERIOR THORACIC EXTENSION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1230	ADD TLISO MILWAUKEE TYPE SUPER STURCTURE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1240	ADD TLISO LUMBAR DEROTATION PAD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1250	ADD TLISO ANTERIOR ASIS PAD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1260	ADD TLISO ANTERIOR/THORACIC DEROTATION PAD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1270	ADD TLISO ABDOMINAL PAD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1280	ADD TLISO RIB GUSSET (ELASTIC) EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1290	ADD TLISO LATERAL TROCHANTERIC PAD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1300	OTHER SCOLIOSIS PROC BODY JACKET MOLDED TO MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1310	OTHER SCOLIOSIS PROC POST OP BODY JACKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1499	SPINAL ORTHOSIS NOS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1500	THKAO MOBILITY FRAME	This is no longer a valid code.	N/A
L1600	HO ABDUCTION HIP JOINTS FLEX FREJKA W/COVER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1610	HO ABDUCTION CONTROL FLEXIBLE FREJKA COVER ONLY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1620	HO ABDUCTION CONTROL FELXIBLE PAVLIK HARNESS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1630	HO ABDUCTION CONTROL SEMI FLEXIBLE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1640	HO ABDUCTION STATIC PELVIC BAND SPREAD BAR CUFFS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1650	HO-ABDUCT CNTRL HIP JT-STATIC-ADJUSTABLE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1652	HIP ORTHOS BIL THI CUFF ADLT PRFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1660	HO-ABDUCT CNTRL HIP JT-STATIC-PLASTIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1680	HO ABDUCTION DYNAMIC PELVIC/HIP CONTROL W/CUFFS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1685	HO ABDUCTION POST OP CUSTOM FABRICATED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1686	HO-ABDUCT CNTRL HIP JT-POST-OP HIP ABDUCT TYPE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1690	COMB BILAT LS HIP ORTH ADDUCT-INT ROTATION CNTRL	No pre-authorization is required for all providers.	N/A

L1700	LEGG PERTHES ORTHOSIS TORONTO TYPE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1710	LEGG PERTHES ORTHOSIS NEWINGTON TYPE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1720	LEGG PERTHES ORTHOSIS TRILATERAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1730	LEGG PERTHES ORTHOSIS SCOTTISH RITE TYPE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1750	LEGG PERTHES ORTHOSIS LEGG PERTHES SLING	No pre-authorization is required for all providers.	N/A
L1755	LEGG PERTHES ORTHOSIS PATTERN BOTTOM STYLE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1810	KO ELASTIC W/JOINTS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1812	KO ELASTIC W/JOINTS PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1820	KO ELASTIC W/CONDYLAR PADS & JOINTS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1830	KO IMMOBILIZER CANVAS LONGITUDINAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1831	KNEE ORTHOSIS, LOCKING KNEE JOINT(S), POSITIONAL ORTHOSIS, PREFABRICATED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1832	KO-ADJUST KNEE JTS-POSITION ORTHOSIS-RIGID SUPP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1833	KO ADJ JNT POS R SUP PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1834	KO WO/ JOINT RIGID MOLDED TO PT MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1836	KNEE ORTHOS RIGD NO JNT W/INTRFCE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1840	KO DEROTATOIN MED/LAT ANT CRUC LIG CUSTOM FAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1843	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1844	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, CSTM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1845	KO UPRIGHT THIGH/CALF ADJ FLEX CUSTOM FIT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1846	KO UPRIGHT THIGH/CALF ADJ FLEX MOLD TO PT MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1847	KNEE ORTH DBL UPRT ADJUST JT INFLAT SUPPRT CHAMB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1848	KO DBL UPRIGHT W/AIR PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1850	KO SWEDISH TYPE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1851	KO SINGLE UPRIGHT PREFAB OTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
L1852	KO DOUBLE UPRIGHT PREFAB OTS	Pre-authorization required for all providers.	Prior to 09/01/2019
L1860	KO MOD SUPRACONDYLAR PROS SOCKET MOLD TO PT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1900	AFO SPRING WIRE DORSIFLEX ASSIST CALF BAND	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1901	ANK ORTHOS ELAST PREFAB W/FIT&ADJ	No pre-authorization is required for all providers.	N/A
L1902	AFO ANKLE GAUNTLET PRE OTS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1904	AFO MOLDED ANKLE GAUNTLET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1906	AFO MX-LIGAMENT ANK SUPT PREFB OTS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1907	AFO, SUPRAMALLEOLAR WITH STRAPS, WITH OR WITHOUT INTERFACE/PADS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1910	AFO POST 1 BAR CLASP ATTACH TO SHOE COUNTER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1920	AFO 1 UPRIGHT W/STATIC/ADJUSTABLE STOP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1930	AFO-PLASTIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1932	AFO RIGD ANT TIBL TOT CARB FIBER/EQUIL MATL PRFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1940	AFO MOLD TO PT MODEL PLASTIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1945	AFO MOLDED PT MODEL PLASTIC RIGID ANT/TIB SECT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1950	AFO, SPIRAL PLASTIC, CUSTOM FABRICATED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1951	AFO, SPIRAL PLASTIC OR OTHER MATERIAL, PREFABRICATED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1960	AFO POST SOLID ANKLE MOLD TO PT MODEL PLASTIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1970	AFO PLASTIC MOLD TO PT MODEL W/ANKLE JOINT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1971	AFO, PLASTIC OR OTHER MATERIAL WITH ANKLE JOINT, PREFABRICATED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1980	AFO 1 UPRIGHT FREE PLANTAR SOLID STIRRUP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L1990	AFO 2 UPRIGHT FREE PLANTAR SOLID STIRRUP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2000	KAFO 1 UPRIGHT FREE KNEE/ANKLE SOLID STIRRUP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2005	KAFO SNG/DBL MECHANICAL ACT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2006	KAF DVC ANY MATERIAL ADJUSTABILITY CUSTOM FAB	No pre-authorization is required for all providers.	N/A
L2010	KAFO 1 UPRIGHT FREE ANKLE SOLID STIRRUP W/O JT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2020	KAFO UPRIGHT FREE KNEE/ANKLE SOLID STIRRUP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2030	KAFO UPRIGHT FREE ANKLE SOLID STIRRUP W/O JT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2034	KNEE ANKLE FOOT ORTHOSIS FULL PLASTIC PEDIATRIC SIZE CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2035	KAFO FULL PLSTC STAT PREFAB PEDS SZ	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2036	KAFO FULL PLASTIC UPRIGHT FREE KNEE MOLD TO PT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2037	KAFO FULL PLASTIC 1 UPRIGHT FREE KNEE MOLD TO PT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2038	KAFO FULL PLASTIC W/O JOINT W/MULTI AXIS ANKLE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2039	KAFO PLSTC HINGE-MED/LAT CONTRL MOLD TO PT-EA	No pre-authorization is required for all providers.	N/A
L2040	HKAFO BILAT ROTATION STRAPS PELVIC BAND/BELT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2050	HKAFO BILAT TORSION CABLES HIP JNT PELVIC BAND	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2060	HKAFO BILAT TORSION CABLE BALLBEARING HIP JNT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2070	HKAFO UNILAT ROTATION STRAP PELVIC BAND/BELT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2080	HKAFO UNILAT TORSION CABLE HIP JNT PELVIC BAND	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2090	HKAFO UNILAT TORSION CABLE BALLBEARING HIP JNT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2106	AFO FRACTURE/TIBIA ORTHOSIS THERMOPLASTIC MOLDED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2108	AFO FRACTURE/TIBIA ORTHOSIS MOLD TO MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2112	AFO-FRACTURE/TIBIAL FX ORTHOSIS-SOFT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2114	AFO-FRACTURE/TIBIAL FX ORTHOSIS-SEMI-RIGID	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2116	AFO-FRACTURE/TIBIAL FX ORTHOSIS-RIGID	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2126	KAFO FRACTURE/FEMORAL THERMOPLASTIC MOLD TO PT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2128	KAFO FRACTURE/FEMORAL MOLD TO PT MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2132	KAFO-FX/FEMORAL FX CAST ORTHOSIS-SOFT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2134	KAFO-FRACTURE/FEMORAL CAST ORTHOSIS-SEMI-RIGID	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2136	KAFO-FRACTURE/FEMORAL CAST ORTHOSIS-RIGID	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2180	ADD LOW EXT ORTH PLASTIC SHOE INS W/ANKLE JNT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2182	ADD LOW EXT ORTH DROP LOCK KNEE JOINT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2184	ADD LOW EXT ORTH LIMITED MOTION KNEE JOINT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2186	ADD LOW EXT ORTH ADJ KNEE JOINT LERMAN TYPE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2188	ADD LOW EXT ORTH QUADRILATERAL BRIM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2190	ADD LOW EXT ORTH WAIST BELT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2192	ADD LOW EXT ORTH HIP JNT THIGH FLANGE PELV BELT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2200	ADD LOW EXT LIMITED ANKLE MOTION EA JOINT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2210	ADD LOW EXT DORSIFLEXION ASSIST EA JOINT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2220	ADD LOW EXT DORSIFLEXION PLANTAR ASST/RESIST EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2230	ADD LOW EXT SPLIT FLAT CALIPER STIRRUP/PLATE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2232	ADD LOW EXT ORTHOS ROCKR BOTTOM TOT CNTC CSTM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2240	ADD LOW EXT ROUND CALIPER & PLATE ATTACH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2250	ADD LOW EXT FOOT PLATE MOLD TO PT MODELW/STIRRUP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2260	ADD LOW EXT REINFORCED SOLID STIRRUP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2265	ADD LOW EXT LONG TONGUE STIRRUP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2270	ADD LOW EXT VARUS/VALGUS CORRECT PAD/LINED PAD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2275	ADD LOWER EXT VARUS/VALGUS CORRECT PLASTIC MODIF	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2280	ADD LOW EXT MOLDED INNER BOOT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2300	ADD LOW EXT ABDUCTION BAR JOINTED ADJUSTABLE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2310	ADD LOW EXT ABDUCTION BAR STRAIGHT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2320	ADD LOW EXT NON MOLDED LACER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2330	ADD LOW EXT LACER MOLDED TO PT MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2335	ADD LOW EXT ANTERIOR SWING BAND	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2340	ADD LOW EXT PRETIBIAL SHELL MOLD TO PT MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2350	ADD LOW EXT PROSTHETIC SOCKET MOLD TO PT MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2360	ADD LOW EXT EXTENDED STEEL SHANK	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2370	ADD LOW EXT PATTEN BOTTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2375	ADD LOW EXT TORSION CONT ANKLE JNT HALF STIRRUP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2380	ADD LOW EXT TORSION CONT STRAIGHT KNEE JOINT EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2385	ADD LOW EXT STRAIGHT KNEE JNT HVY DTY EA JNT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2387	ADDN TO LOWER EXTREM POLY KNEE JOINT FOR CUSTOM FAB KNEE ANKLE FOOT ORTH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2390	ADD LOW EXT OFFSET KNEE JNT EA JNT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2395	ADD LOW EXT OFFSET KNEE JNT HVY DTY EA JNT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2397	ADD LOWER EXTREM ORTHOSIS SUSPENSION SLEVE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2405	ADDITION TO KNEE JOINT, LOCK DROP, STANCE OR SWING PHASE, EACH JOINT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2415	ADD KNEE JNT CAM LOCK EA JNT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2425	ADD KNEE JNT DISC/DIAL LOCK ADJ KNEE FLEX EA JNT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019

L2430	KNEE JNT ADD-RATCHET LOCK KNEE EXTENSTION-EA JT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2435	ADD KNEE JNT POLYCENTRIC JNT EA JNT	No pre-authorization is required for all providers.	N/A
L2492	ADD KNEE JNT LIFT LOOP DROP LOCK RING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2500	ADD LOW EXT THIGH/GLUTEAL/ISCHEAL WT BEAR RING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2510	ADD LOW EXT WT BEAR QUADRILATERAL BRIM MOLD PT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2520	ADD LOW EXT WT BEAR QUADRILATERAL BRIM CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2525	ADD LOW EXT ISCHIAL M-1 BRIM MOLD TO PT MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2526	ADD LOW EXT ISCHIAL M-1 BRIM CUSTOM FIT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2530	ADD LOW EXT WT BEAR LACER NON MOLDED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2540	ADD LOW EXT WT BEAR LACER MOLD PT MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2550	ADD LOW EXT WT BEAR HIGHROLL CUFF	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2570	ADD LOW EXT PELV HIP JNT CLEVIS TYPE 2 POS JNT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2580	ADD LOW EXT PELV SLING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2600	ADD LOW EXT PELV HIP JNT CLEVIS THRUST BEAR FREE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2610	ADD LOW EXT PELV HIP JNT CLEVIS THRUST BEAR LOCK	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2620	ADD LOW EXT PELV HIP JNT HVY DTY EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2622	ADD LOW EXT PELV HIP JNT ADJ FLEXION EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2624	ADD LOW EXT PELV HIP JNT ADJ FLEX, EXTEN, ABDUCT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2627	ADD LOW EXT PELV PLAST MOLD TO PT MODEL W/CABLE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2628	ADD LOW EXT PELV METAL FRAME RECIP HIP JNT CABLE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2630	ADD LOW EXT PELV BAND & BELT UNILAT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2640	ADD LOW EXT PELV BAND & BELT BILAT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2650	ADD LOW EXT PELV/THORAC GLUTEAL PAD EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2660	ADD LOW EXT THORACIC BAND	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2670	ADD LOW EXT THORACIC PARASPINAL UPRIGHTS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2680	ADD LOW EXT THORACIC LATERAL SUPPORT UPRIGHTS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2750	ADD LOW EXT ORTH PLATING CHROME/NICKEL PER BAR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2755	LOW EXTREM ADD ORTHOSIS CARBON GRAPHITE LAMINATE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2760	ADD LOW EXT ORTH (PRE)EXTENSION PER BAR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2768	ORTHOTIC SIDE BAR DISCONNECT DEVICE, PER BAR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2770	ADD LOW EXTREM ORTHOSIS ANY MATERIAL PER BAR/JT	No pre-authorization is required for all providers.	N/A
L2780	ADD LOW EXT ORTH NON CORROSIVE FINISH PER BAR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2785	ADD LOW EXT ORTH DROP LOCK RETAINER EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2795	ADD LOW EXT ORTH KNEE CONT FULL KNEE CAP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2800	ADD LOW EXT ORTH KNEE CONT CAP MED/LAT PULL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2810	ADD LOW EXT ORTH KNEE CONT CONDYLAR PAD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2820	ADD LOW EXT ORTH SOFT INTERFACE MOLD BELOW KNEE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2830	ADD LOW EXT ORTH SOFT INTERFACE MOLD ABOVE KNEE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2840	ADD LOW EXT ORTH TIBIAL SOCK FRACTURE/EQUAL EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2850	ADD LOW EXT ORTH FEMORAL SOCK FRACTURE/EQUAL EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2861	TORSION MECHANISM KNEE/ANKLE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L2999	LOWER EXTREMITY ORTHOSIS NOS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3000	FT INSERT MOLDED UCB TYPE BERKELEY SHELL EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3001	FT INSERT MOLDED SPENCO EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3002	FT INSERT MOLDED PLASTAZOTEOR EQUAL EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3003	FT INSERT MOLDED SILOCON GEL EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3010	FT INSERT MOLDED LONGITUDINAL ARCH SUPPORT EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3020	FT INSERT MOLDED LONGITUDINAL METATARSAL SUPP EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3030	FT INSERT FORMED TO PT FT EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3031	FOOT INSERT/ PLATE, REMOVABLE, ADDITION TO LOWER EXTREMITY ORTHOSIS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3040	FT ARCH SUPP PREMOLD LONGITUDINAL EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3050	FT ARCH SUPP PREMOLD METATARSAL EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3060	FT ARCH SUPP PREMOLD LONGITUDINAL/METATARSAL EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3070	FT ARCH SUPP ATTACHED SHOE LONGITUDINAL EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3080	FT ARCH SUPP ATTACH SHOE METATARSAL EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3090	FT ARCH SUPP ATTACH SHOE LONGITUDINAL/METATARSAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3100	HALLUS-VALGUS NIGHT DYNAMIC SPLINT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3140	FOOT-ABDUCTION ROTATION BAR-INCLUDING SHOES	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3150	FOOT-ABDUCTION ROTATION BAR-WO SHOES	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3160	FOOT-ADJUSTABLE SHOE-STYLED POSITIONING DEVICE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3170	FT PLASTIC HEEL STABILIZER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3201	ORTHO SHOE OXFORD W/SUPINATOR PRONATOR INFANT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3202	ORTHO SHOE OXFORD W/SUPINATOR PRONATOR CHILD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3203	ORTHO SHOE OXFORD W/SUPINATOR PRONATOR JUNIOR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3204	ORTHO SHOE HIGHTOP W/SUPINATOR PRONATOR INFANT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3206	ORTHO SHOE HIGHTOP W/SUPINATOR PRONATOR CHILD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3207	ORTHO SHOE HIGHTOP W/SUPINATOR PRONATOR JUNIOR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3208	SURG BOOT EA INFANT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3209	SURG BOOT EA CHILD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3211	SURG BOOT EA JUNIOR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3212	BENESCH BOOT PAIR INFANT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3213	BENESCH BOOT PAIR CHILD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3214	BENESCH BOOT PAIR JUNIOR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3215	ORTHO FOOTWEAR LADIES SHOE OXFORD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3216	ORTHO FOOTWEAR LADIES SHOE DEPTH INLAY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3217	ORTHO FOOTWEAR LADIES SHOE HIGHTOP DEPTH INLAY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3218	ORTHO FOOTWEAR LADIES SURG BOOT EA	No pre-authorization is required for all providers.	N/A
L3219	ORTHO FOOTWEAR MENS SHOE OXFORD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3221	ORTHO FOOTWEAR MENS SHOE DEPTH INLAY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3222	ORTHO FOOTWEAR MENS SHOE HIGHTOP DEPTH INLAY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3223	ORTHO FOOTWEAR MENS SURG BOOT EA	No pre-authorization is required for all providers.	N/A
L3224	ORTHO FOOTWEAR-WOMAN SHOE-OXFORD-PART OF BRACE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3225	ORTHO FOOTWEAR-MAN SHOE-OXFORD-PART OF BRACE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3230	ORTHO FOOTWEAR CUSTOM SHOES DEPTH INLAY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3250	ORTHO FOOTWEAR CUSTOM MOLD REMOV INNER MOLD EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3251	FT SHOE MOLD TO PT MODEL SILICONE SHOE EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3252	FT SHOE MOLD TO PT MODEL PLASTAZOTE CUSTOM FAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3253	FT MOLD SHOE PLASTAZOTE CUSTOM FIT EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3254	NON-STANDARD SIZE/WIDTH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3255	NON STANDARD SIZE/LENGTH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3257	ORTHO FOOTWEAR ADD CHARGE SPLIT SIZE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3260	SURGICAL BOOT/SHOE EACH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3265	PLASTAZOTE SANDAL EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3300	LIFT ELEVATE HEEL TAPERED TO METATARSALS PER IN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3310	LIFT ELEVATE HEEL/SOLE NEOPRENE PER IN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3320	LIFT ELEVATE HEEL/SOLE CORK PER INCH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3330	LIFT ELEVATE METAL EXTENSION (SKATE)	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3332	LIFT ELEVATE INSIDE SHOE TAPERED TO 1/2 IN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3334	LIFT ELEVATE HEEL PER IN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3340	HEEL WEDGE SACH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3350	HEEL WEDGE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3360	SOLE WEDGE OUTSIDE SOLE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3370	SOLE WEDGE BETWEEN SOLE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3380	CLUB FOOT WEDGE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3390	OUT FLARE WEDGE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3398	ADDITION TO UPPER EXTREMITY PROSTHESIS, BELOW/ ABOVE ELBOW, LOCK MECH.	No pre-authorization is required for all providers.	N/A
L3400	METATARSAL BAR WEDGE ROCKER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3410	METATARSAL BAR WEDGE BETWEEN SOLE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3420	FULL SOLE & HEEL WEDGE BETWEEN SOLE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3430	HEEL COUNTER PLASTIC REINFORCED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3440	HEEL COUNTER LEATHER REINFORCED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019

L3450	HEEL SACH CUSHION TYPE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3455	HEEL NEW LEATHER STANDARD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3460	HEEL NEW RUBBER STANDARD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3465	HEEL THOMAS W/WEDGE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3470	HEEL THOMAS EXTENDED TO BALL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3480	HEEL PAD & DEPRESSION FOR SPUR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3485	HEEL PAD REMOVABLE FOR SPUR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3500	ORTHO SHOE ADD INSOLE LEATHER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3510	ORTHO SHOE ADD INSOLE RUBBER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3520	ORTHO SHOE ADD INSOLE FELT COVERED W/LEATHER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3530	ORTHO SHOE ADD SOLE HALF	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3540	ORTHO SHOE ADD SOLE FULL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3550	ORTHO SHOE ADD TOE TAP STANDARD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3560	ORTHO SHOE ADD TOE TAP HORSESHOE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3570	ORTHO SHOE ADD SPEC EXT INSTEP/LEATHER W/EYELETS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3580	ORTHO SHOE ADD CONVERT INSTEP TO VELCRO CLOSE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3590	ORTHO SHOE ADD CONVERT FIRM COUNTER/SOFT COUNTER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3595	ORTHO SHOE ADD MARCH BAR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3600	TRF ORTHOS 1 SHOE-ANR CALIP PL EXST	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3610	TX ORTHOS 1 SHOE-ANOTH CALIP PLT N	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3620	TRF ORTHOS 1 SHOE-ANOTH SLD STIR EX	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3630	TRNS ORTHOS 1 SHOE-ANOTH SLD STIR N	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3640	TRNS ORTHOS SHOE-SHOE DENNS BRWNE B	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3649	ORTHO SHOE MOD ADD OR TRANSFER NOS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3650	SO FIGURE 8 DESIGN ABDUCT RESTRAINER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3651	SHLDR ORTHOS 1 SHLDR ELAST PRFAB	No pre-authorization is required for all providers.	N/A
L3652	SHLDR ORTHOS DBL SHLDR ELAST PRFAB	No pre-authorization is required for all providers.	N/A
L3660	SO FIGURE 8 ABDUCTION RESTRAIN CANVAS & WEBBING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3670	SO ACROMIO/CLAVICULAR CANVAS & WEBBING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3671	SO CAP DESIGN W/O JNTS CF	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3672	SHOULDER ORTH ABDUCT POSITION AIRPLANE DESIGN W/O JOINTS CUSTOM	No pre-authorization is required for all providers.	N/A
L3673	SHOULDER ORTH ABDUCT POSITION AIRPLANE DESIGN NONTORSION JOINTCUSTOM	No pre-authorization is required for all providers.	N/A
L3674	SO AIRPLANE W/WO JOINT CF	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3675	SO VEST TYPE ABDUCT RESTRAIN CANVAS WEB TYPE /=	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3677	SO HARD PLASTIC STABILIZER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3678	SO HARD PLAS STABILI PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3702	ELBOW ORTHOSIS W/O JOINTS MAY INCL SOFT INTERFACE STRAPS CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3710	EO ELASTIC W/METAL JNT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3720	EO DOUBLE UPRIGHT W/(FORE)ARM CUFF FREE MOTION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3730	EO DOUBLE UPRIGHT W/(FORE)ARM CUFF EXTEN/FLEX	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3740	EO DOUBLE UPRIGHT W/(FORE)ARM CUFF ADJ LOCK	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3760	EO ADJ POS LOCKING JNT PREFAB ITEM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3761	EO ADJ POS LOCKING JOINT PREFAB OTS	No pre-authorization is required for all providers.	N/A
L3762	ELB ORTHOS RIGD W/O JNT W/INTERFCE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3763	ELBOW WRIST HAND ORTHOSIS RIGID W/O JOINTS CUSTOM INCL FIT & ADJ	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3764	ELBOW WRIST HAND ORTHOSIS INCLS ONE OR MORE NONTORSION JOINTS CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3765	ELBOW WRIST HAND FINGER ORTHOSIS RIGID W/O JOINTS CUSTOM INCL FIT & ADJ	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3766	ELBOW WRIST HAND FINGER ORTHOSIS INCLS >= 1 NONTORSION JOINTS CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3805	WHFO LONG OPPONENS NO ATTACH	No pre-authorization is required for all providers.	N/A
L3806	WHFO W/JOINT(S) CUSTOM FAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3807	WHFO EXTENSION ASSIST W/INFLATABLE PALMER AIR SUPPORT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3808	WRIST HAND FINGER ORTHOSIS, RIGID W/O JOINTS, MAY INCL SOFT INTERFACE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3809	WHFO W/O JOINTS PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3825	WHFO ADD MP EXTEN STOP	No pre-authorization is required for all providers.	N/A
L3830	WHFO ADD MP EXTEN ASSIST	No pre-authorization is required for all providers.	N/A
L3845	WHFO THUMB IP EXTEN ASSIST W/MP STOP	No pre-authorization is required for all providers.	N/A
L3860	WHFO ADD ADJUSTABLE MP FLEXION CONTROL & IP	No pre-authorization is required for all providers.	N/A
L3890	ADD TO UP EXTREM JNT-WRST/ELB-ADJ TORSN MECH-EA	No pre-authorization is required for all providers.	N/A
L3891	TORSION MECHANISM WRIST/ELBO	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3900	WHFO DYNAMIC FLEX RECIPROCAL WRIST/FINGER DRIVEN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3901	WHFO DYNAMIC FLEX RECIPROCAL CABLE DRIVEN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3902	WHFO, EXTERNAL POWERED, COMPRESSED GAS, CUSTOM FABRICATED	This is no longer a valid code.	N/A
L3904	WHFO EXTERNAL POWER ELECTRIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3905	WRIST HAND ORTHOSIS INCLS ONE OR MORE NONTORSION JOINTS CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3906	WHO WRIST GAUNTLET MOLD TO PT MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3907	WHFO WRIST GAUNTLET W/THUMB SPICA MOLD TO MODEL	No pre-authorization is required for all providers.	N/A
L3908	WHO WRIST EXTEN CONTRL COCK-UP NONMOLDED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3912	HFO FLEX GLOVE W/ELASTIC FINGER CONTROL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3913	HAND FINGER ORTHOSIS W/O JOINTS MAY INCL SOFT INTERFACE STRAPS CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3914	WHO WRIST EXTENSION COCK-UP	This is no longer a valid code.	N/A
L3915	WRIST HAND ORTH INCL 1 OR MORE NONTORS JOINT(S), ELAST BANDS,TURNBUCK	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3916	WHO NONTORSION JNTS PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3917	HAND ORTHOSIS, METACARPAL FRACTURE ORTHOSIS, PREFABRICATED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3918	METACARP FX ORTHOSIS PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3919	HAND ORTHOSIS W/O JOINTS MAY INCL SOFT INTERFACE STRAPS CUSTOM FABR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3921	HAND FINGER ORTHOSIS INCLS ONE OR MORE NONTORSION JOINTS CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3923	PREFAB HND FINGR ORTHOSIS WO JT+	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3924	HFO WITHOUT JOINTS PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3925	FO PIP/DIP WITH JOINT/SPRING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3927	FO PIP/DIP W/O JOINT/SPRING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3928	HFO FINGER EXTEN W/CLOCK SPRING	No pre-authorization is required for all providers.	N/A
L3929	HFO NONTORSION JOINT PREFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3930	HFO NONTORSION JNTS PRE OT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3931	WHFO NONTORSION JOINT PREFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3933	FINGER ORTHOSIS W/O JOINTS MAY INCL SOFT INTERFACE CUSTOM INCL FIT & ADJ	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3934	FO SAFETY PIN MODIFIED	No pre-authorization is required for all providers.	N/A
L3935	FINGER ORTH NONTORSION JOINT / INCL SOFT INTERFACE CUSTOM INCL FIT & ADJ	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3938	WHFO DORSAL WRIST	No pre-authorization is required for all providers.	N/A
L3946	HFO COMPOSITE ELASTIC	No pre-authorization is required for all providers.	N/A
L3956	JT UPPER EXTREM ORTH ADD-ANY MATERIAL-PER JT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3960	SEWHO ABDUCT POSITION AIRPLANE DESIGN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3961	SHOULDER ELBOW WRIST HAND ORTHSHOULDER CAP DESIGN W/O JOINTS CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3962	SEWHO ABDUCT POSITION ERBS PALSEY DESIGN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3963	SEWHO MOLD SHOULDER/ARM/WRIST W/ARTIC ELBOW JNT	No pre-authorization is required for all providers.	N/A
L3967	SHOULDER ELBOW WRIST HAND ORTH ABDUCT POSITION AIRPLANE DSGN CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3971	SOULDER ELBOW WRIST HAND ORTHOSIS CAP DESIGN W/JOINTS CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3973	SHOULDER ELBOW WRIST HAND ORTHOSIS AIRPLANE W JOINTS CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3975	SHOULDER ELBOW WRIST HAND FINGER ORTHOSIS CAP DESIGN W/O JOINT CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3976	SHOULDER ELBOW WRIST HAND FINGER ORTHOSIS AIRPLANE W/O JOINTS CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3977	SHOULDER ELBOW WRIST HAND FINGER ORTHOSIS CAP DESIGN W JOINTS CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3978	SHOULDER ELBOW WRIST HAND FINGER ORTHOSIS AIRPLANE W JOINTS CUSTOM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3980	UP EXT FX ORTHOS HUMERAL NOS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3981	UE FX ORTH SHOUL CAP FOREARM	Pre-authorization required for all providers.	Prior to 09/01/2019
L3982	UP EXT FRACTURE ORTH RDIUS/ULNAR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3984	UP EXT FRACTURE ORTH WRIST	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3985	UP EXT FRACTURE ORTH FOREARM HAND W/WRIST HINGE	No pre-authorization is required for all providers.	N/A
L3995	ADD UP EXT ORTH SOCK FRACTURE OR EQUAL EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L3999	UPPER LIMB ORTHOSIS NOS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4000	REPLACE GIRDLE MILWAUKEE ORTH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4002	REPL STRAP ANY ORTHOSIS ALL CMPNTS ANY LEN TYPE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4010	REPLACE TRILATERAL SOCKET BRIM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019

L4020	REPLACE QUADRILAT SOCKET BRIM MOLD TO PT MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4030	REPLACE QUADRILAT SOCKET BRIM CUSTOM FIT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4040	REPLACE MOLD THIGH LACER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4045	REPLACE NON MOLDED THIGH LACER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4050	REPLACE MOLD CALF LACER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4055	REPLACE NON MOLD CALF LACER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4060	REPLACE HIGH ROLL CUFF	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4070	REPLACE PROXIMAL & DISTAL UPRIGHT FOR KAFO	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4080	REPLACE METAL BANDS KAFO PROXIMAL THIGH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4090	REPLACE METAL BAND KAFO/AFO CALF/DISTAL THIGH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4100	REPLACE LEATHER CUFF KAFO PROXIMAL THIGH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4110	REPLACE LEATHER CUFF KAFO/AFO CALF/DISTAL THIGH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4130	REPLACE PRETIBIAL SHELL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4205	REPR ORTHIC DEVICE LABOR COMPONENT-PER 15 MIN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4210	REPAIR ORTH DEVICE REPAIR/REPLACE MINOR PARTS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4310	MULTI PODUS ORTH PREP MANAGE SYSTEM LOW EXT	No pre-authorization is required for all providers.	N/A
L4350	ANKLE CONTROL ORTHOSIS, STIRRUP STYLE, RIGID PREFABRICATED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4360	PNEUMATI WALKING BOOT PREFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4361	PNEUMA/VAC WALK BOOT PRE OTS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4370	PNEUMAT FULL LEG SPLINT PRFAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4386	WALKING BOOT, NON-PNEUMATIC, W OR WOUT JOINTS W OR WOUT INTRFC MTRL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4387	NON-PNEUM WALK BOOT PRE OTS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4392	REPLACE SOFT INTRFC MAT ANK CONTRACTURE SPLINT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4394	REPLACE SOFT INTRFC MAT FT DROP SPLINT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4396	STATIC AFO	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4397	STATIC OR DYNAMI AFO PRE OTS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4398	FT DROP SPLINT-RECUMBENT POSITIONING DEVICE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L4631	AFO, WALK BOOT TYPE, CUS FAB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5000	PART FT SHOE INSERT W/LONGITUDINAL ARCH TOE FILL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5010	PART FT MOLD SOCKET ANKLE HT W/TOE FILLER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5020	PART FT MOLD SOCKET TUBIAL TUBERCLE HT W/TOEFILL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5050	ANKLE SYMES MOLD SOCKET SACH FT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5060	ANKLE SYMES METAL FRAME MOLD LEATHER SOCKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5100	BELOW KNEE MOLD SOCKET SHIN SACH FT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5105	BELOW KNEE PLAST SOCKET/JNTS THIGH LACER SACH FT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5110	BELOW KNEE, WOOD SOCKET, JOINTS AND THIGH LACER, SACH FOOT	No pre-authorization is required for all providers.	N/A
L5150	KNEE DISARTICULAT MOLD SOCKET EXT KNEE JNT SHIN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5160	KNEE DISARTICULATE MOLD SOCKET BENT KNEE EXT JNT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5200	ABOVE KNEE MOLD SOCK 1 AXIS CONSTANT FRICTION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5210	ABOVE KNEE SHORT PROSTH W/O BLOCK NO ANKLE JNT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5220	ABOVE KNEE SHORT PROS W/ARTIC ANKLE/FT DYNAMIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5230	ABOVE KNEE PROX FEMORAL DEFFICIENCY SACH FOOT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5250	HIP DISARTIC CANADIAN TYPE MOLD SOCK HIP JNT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5270	HIP DISARTIC TILT TABLE MOLD SOCK LOCK HIP JNT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5280	HEMIPELVECTOMY CANADIAN TYPE MOLD SOCK HIP JNT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5300	BELOW KNEE MOLD SOCK SACH FT INCL COVER & FINISH	No pre-authorization is required for all providers.	N/A
L5301	BELOW KNEE, MOLDED SOCKET, SHIN, SACH FOOT, ENDOSKELETAL SYSTEM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5310	KNEE DISARTIC MOLD SOCK SACH FT INC COVER/FINISH	No pre-authorization is required for all providers.	N/A
L5311	KNEE DISARTICULATION	This is no longer a valid code.	N/A
L5312	KNEE DISART, SACH FT, ENDO	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5320	ABOVE KNEE MOLD SOCK OPEN END 1 AXIS KNEE	No pre-authorization is required for all providers.	N/A
L5321	ABOVE KNEE MOLDED SOCKET, OPEN END	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5330	HIP DISARTIC CANADIAN TYPE 1 AXIS KNEE	No pre-authorization is required for all providers.	N/A
L5331	HIP DISARTICULATION, CANADIAN TYPE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5340	HEMIPELVECTOMY CANADIAN TYPE MOLDED INC COVER	No pre-authorization is required for all providers.	N/A
L5341	HEMIPEL VECTOMY, CANADIAN TYPE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5400	POST SURG APPLY RIGID DRESS W/1CHANGE BELOW KNEE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5410	POST SURG APPLY RIGID DRESS EA ADD CAST/REALIGN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5420	POST SURG APPLY RIGID DRESS 1 CHANGE AK KNEE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5430	POST SURG APPLY RIGID DRESS AK KNEE EA ADD CAST	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5450	POST SURG APPLY NON WT BEAR RIGID BELOW KNEE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5460	POST SURG APPLY NON WT RIGID ABOVE KNEE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5500	INIT BK PTB SOCK NON-ALIGN DIRECT FORM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5505	INIT AK/DISARTIC ISCHIAL LEVEL NON-ALIGN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5510	PREP BK PTB NON-ALIGN MOLD TO MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5520	PREP BK PTB NON-ALIGN PLASTIC DIRECT FORM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5530	PREP BK PTB NON-ALIGN THERMOPLASTIC MOLD-MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5535	PREP BK PTB PREFABRICATED ADJUS OPEN END	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5540	PREP BK PTB NON-ALIGN LAMINATED SOCK MOLD-MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5560	PREP AK/DISARTIC NON-ALIGN PLAST MOLD-MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5570	PREP AK/DISARTIC NON-ALIGN THERMOPLAS DIRECT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5580	PREP AK/DISARTIC NON-ALIGN THERMOPLAS MOLD-MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5585	PREP AK/DISARTIC NON-ALIGN PREFAB ADJUS OPEN END	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5590	PREP AK/DISARTIC NON-ALIGN LAMINATED MOLD-MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5595	PREP HIP/HEMIPELVECTOMY THERMOPLASTIC MOLD MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5600	PREP HIP/HEMIPELVECTOMY LAMINATE MOLD MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5610	ADD LO EXTREM ENDO AK HYDRACADENCE SYST	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5611	ADD LO EXTREM ENDO AK 4-BAR W/FRICT SWING CONTRL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5612	ADDITIONS TO LOWER EXTREMITY, ABOVE KNEE, POLYCADENCE	No pre-authorization is required for all providers.	N/A
L5613	ADD LO EXTREM ENDO AK 4-BAR W/HYDRAULIC SWING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5614	ADD LO EXTREM EXO AK 4-BAR W/PNEUMATIC SWING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5616	ADD LO EXTREM UNI ENDO MX SYST FRICTION SWING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5617	ADD LO EXTREM, QUICK CHANGE, SELF-ALIGN, AK/BK	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5618	ADD LOW EXT TEST SOCKET SYMES	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5620	ADD LOW EXT TEST SOCKET BELOW KNEE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5622	ADD LOW EXT TEST SOCKET KNEE DISARTICULATION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5624	ADD LOW EXT TEST SOCKET ABOVE KNEE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5626	ADD LOW EXT TEST SOCKET HIP DISARTICULATION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5628	ADD LOW EXT TEST SOCKET HEMIPELVECTOMY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5629	ADD LOW EXT BELOW KNEE ACRYLIC SOCKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5630	ADD LOW EXT SYMES TYPE EXPANDABLE WALL SOCKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5631	ADD LOW EXT ABOVE KNEE/DISARTICULATION ACRYLIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5632	ADD LOW EXT SYMES PTB BRIM DESIGN SOCKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5634	ADD LOW EXT SYMES TYPE POST OPEN CANADIAN SOCKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5636	ADD LOW EXT SYMES TYPE MEDIAL OPENIN SOCKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5637	ADD LOW EXT BELOW KNEE TOTAL CONTACT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5638	ADD LOW EXT BELOW KNEE LEATHER SOCKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5639	ADD LOW EXT BELOW KNEE WOOD SOCKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5640	ADD LOW EXT KNEE DISARTICULATE LEATHER SOCKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5642	ADD LOW EXT ABOVE KNEE LEATHER SOCKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5643	ADD LOW EXT HIP DISARTIC FLEX INNER EXT FRAME	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5644	ADD LOW EXT ABOVE KNEE WOOD SOCKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5645	ADD LOW EXT BELOW KNEE FLEX INNER EXT FRAME	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5646	ADDITION TO LWR EXTRMITY, BLW KNEE, AIR, FLUID, GEL OR =CUSHION SOCKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5647	ADD LOW EXT BELOW KNEE SUCTION SOCKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5648	ADDITION TO LWR EXTRMITY, ABOVE KNEE, AIR, FLUID, GEL OR =CUSHION SOCKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5649	ADD LOW EXT ISCHIAL CONTAIN NARROW M-1 SOCKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5650	ADD LOW EXT TOTAL CONTACT ABOVE KNEE/DISARTIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5651	ADD LOW EXT ABOVE KNEE FLEX INNER EXT FRAME	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5652	ADD LOW EXT SUCTION SUSPEN ABOVE KNEE/DISARTIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5653	ADD LOW EXT KNEE DISARTIC EXPANDABLE WALL SOCKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019

L5654	ADD LOW EXT SOCKET INSERT SYMES	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5655	ADD LOW EXT SOCKET INSERT BELOW KNEE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5656	ADD LOW EXT SOCKET INSERT KNEE DISARTICULATION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5658	ADD LOW EXT SOCKET INSERT ABOVE KNEE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5660	ADD LOW EXT SOCKET INSERT SYMES SILICONE GEL	No pre-authorization is required for all providers.	N/A
L5661	ADD LOW EXT SOCKET INSERT MULTI-DUROMETER SYMES	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5662	ADD LOW EXT SOCKET INSERT BELOW KNEE SILICONE	No pre-authorization is required for all providers.	N/A
L5663	ADD LOW EXT SOCKET INSERT KNEE DISARTIC SILICONE	No pre-authorization is required for all providers.	N/A
L5664	ADD LOW EXT SOCKET INSERT ABOVE KNEE SILICONE	No pre-authorization is required for all providers.	N/A
L5665	ADD LOW EXT SOCKET INSERT MULTI-DUROMETER BELOW	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5666	ADD LOW EXT BELOW KNEE CUFF SUSPENSION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5667	ADD SOCKET INSRT ABOV/BELO KNEE-SUC SUSP W/LOCK	No pre-authorization is required for all providers.	N/A
L5668	BK MOLDED DISTAL CUSHION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5669	ADD SOCKET INSRT ABOV/BELO KNEE-SUC SUSP WO LOCK	No pre-authorization is required for all providers.	N/A
L5670	ADD LOW EXT BELOW KNEE MOLD SUPRACONDYLAR SUSP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5671	ADDITION TO LOWER EXTREMITY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5672	ADD LOW EXT BELOW KNEE REMOVABLE MEDIAL BRIM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5673	ADDITION TO LOWER EXTREMITY, BELOW KNEE/ABOVE KNEE, CUSTOM FABR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5674	ADD LOW EXT BELOW KNEE LATEX SLEEVE SUSP EA	No pre-authorization is required for all providers.	N/A
L5675	ADD LOW EXT BELOW KNEE LATEX SLEEVE HVY DTY	No pre-authorization is required for all providers.	N/A
L5676	ADD LOW EXT BELOW KNEE KNEE JNTS 1 AXIS PAIR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5677	ADD LOW EXT BELOW KNEE KNEE JNT POLYCENTRIC PAIR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5678	ADD LOW EXT BELOW KNEE JOINT COVERS PAIR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5679	ADDTN TO LWR EXTRITY, BLW KNEE/ ABOVE KNEE, CSTM/W LOCKING MECH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5680	ADD LOW EXT BELOW KNEE THIGH LACER NON MOLDED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5681	ADDTN TO LWR EXTRMTY, BELOW KNEE/ABOVE KNEE, CSTM SOCKET INSERT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5682	ADD LOW EXT BELOW KNEE THIGH LACER GLUTAAL/ISCH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5683	ADDTN TO LWR EXTRMTY, BELOW KNEE/ABOVE KNEE, CSTM SOCKET INSERT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5684	ADD LOW EXT BELOW KNEE FORK STRAP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5685	ADD LOW EXT PROS BELW KNEE SUSP/SEAL SLEEVE EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5686	ADD LOW EXT BELOW KNEE BACK CHECK (EXTENSION)	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5688	ADD LOW EXT BELOW KNEE WAIST BELT WEBBING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5690	ADD LOW EXT BELOW KNEE WAIST BELT PADDED/LINED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5692	ADD LOW EXT ABOVE KNEE PELV CONTROL BELT LIGHT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5694	ADD LOW EXT ABOVE KNEE PELV CONT BELT PAD/LINED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5695	ADD LOW EXT ABOVE KNEE PELV CONT NEOPRENE SLEEVE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5696	ADD LOW EXT ABOVE KNEE/DISARTIC PELV JNT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5697	ADD LOW EXT ABOVE KNEE/DISARTIC PELV BAND	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5698	ADD LOW EXT ABOVE KNEE/DISARTIC SILESIA BANDAGE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5699	ALL LOW EXT PROSTHESIS SHOULDER HARNESS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5700	REPLAC SOCKET BELOW KNEE MOLDED PT MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5701	REPLAC SOCKET ABOVE KNEE/DISART INCL ATTACH PLAT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5702	REPLAC SOCKET HIP DISARTIC INCL HIP JT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5703	ANKLE SYMS W/O SOLID ANKLE CUSHION HEEL SACH FOOT REPLACE ONLY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5704	REPLAC CUSTOM SHAPED COVER BELOW KNEE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5705	REPLAC CUSTOM SHAPED COVER ABOVE KNEE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5706	REPLAC CUSTOM SHAPED COVER KNEE DISARTIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5707	REPLAC CUSTOM SHAPED COVER HIP DISARTIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5710	ADD KNEE/SHIN 1 AXIS MANUAL LOCK	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5711	ADD KNEE/SHIN 1 AXIS MANUAL LOCK ULTRA LIGHT MAT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5712	ADD KNEE/SHIN 1 AXIS FRICTION SWING STANCE PHASE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5714	ADD KNEE/SHIN 1 AXIS VARIABLE FRICTION SWING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5716	ADD KNEE/SHIN POLYCENTRIC MECHANICAL STANCE LOCK	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5718	ADD KNEE/SHIN POLYCENTRIC FRICTION SWING STANCE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5722	ADD KNEE/SHIN 1 AXIS PNEUMATIC SWING FRIC STANCE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5724	ADD KNEE/SHIN 1 AXIS FLUID SWING PHASE CONTROL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5726	ADD KNEE/SHIN 1 AXIS EXT JNTS FLUID SWING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5728	ADD KNEE/SHIN 1 AXIS FLUID SWING STANCE PHASE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5780	ADD KNEE/SHIN 1 AXIS (HYDRA)PNEUMATIC SWING CONT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5781	ADD LW LIMB PROS LIMB MGMT SYS	This service is not covered by Superior HealthPlan.	N/A
L5782	ADD LW LIMB PROS LIMB MGMT HVY DUTY	This service is not covered by Superior HealthPlan.	N/A
L5785	ADD BELOW KNEE ULTRA LIGHT MATERIAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5790	ADD ABOVE KNEE ULTRA LIGHT MATERIAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5795	ADD HIP DISARTIC ULTRA LIGHT MATERIAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5810	ADD KNEE/SHIN 1 AXIS MANUAL LOCK	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5811	ADD KNEE/SHIN 1 AXIS MANUAL LOCK ULTRA LIGHT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5812	ADD KNEE/SHIN 1 AXIS FRICTION SWING STANCE PHASE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5814	ADD KNEE-SHIN SYST HYDRAUL CNTRL STNC PHASE LOCK	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5816	ADD KNEE/SHIN POLYCENTRIC MECH STANCE PHASE CONT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5818	ADD KNEE/SHIN POLYCENTRIC FRICTION SWING STANCE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5822	ADD KNEE/SHIN 1 AXIS PNEUMATIC SWING FRICTION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5824	ADD KNEE/SHIN 1 AXIS FLUID SWING PHASE CONTROL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5826	ADD KNEE/SHIN 1 AXIS HYDRO SWING PHASE CNTRL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5828	ADD KNEE/SHIN 1 AXIS FLUID SWING STANCE PHASE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5830	ADD KNEE/SHIN 1 AXIS PNEUMATIC SWING PHASE CONT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5840	ADD ENDOSKEL KNEE-SHIN SYST 4-BAR LINK/MULTI	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5845	ADD, ENDO, KNEE-SHIN SYST, STANCE FLEX ADJUS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5846	ADD, ENDO, KNEE-SHIN, MICROPRO CNTRL, SWING ONLY	No pre-authorization is required for all providers.	N/A
L5847	ADDITION, ENDOSKELETAL KNEE SHIN SYSTEM	No pre-authorization is required for all providers.	N/A
L5848	ADDITION TO ENDOSKELETAL KNEE-SHIN SYST, FLUID STANCE EXT, DAMPEN FEATUE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5850	ADD ABOVE KNEE/HIP DISARTIC KNEE EXTENSION ASST	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5855	ADD ENDOSKELETAL SYST HIP DISART MECH HIP EXTEN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5856	ADD LOW EXT PROS KNEE-SHIN SYS SWING&STANCE PHSE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5857	ADD LOW EXT PROS KNEE-SHIN SYS SWING PHASE ONLY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5858	ADDTN TO LOWER EXTREM PROSTH ENDOSKELETAL KNEE SHIN SYS STANCE PHASE ONLY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5859	KNEE-SHIN PRO FLEX/EXT CONT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5910	ADD BELOW KNEE ALIGNABLE SYSTEM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5920	ADD ABOVE KNEE HIP DISARTIC ALIGNABLE SYSTEM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5925	ADD ENDOSKELETAL SYST AK KNEE/HIP DISART MANUAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5930	ADD, ENDO SYSTEM, HIGH ACTIVITY KNEE CNTRL FRAM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5940	ADD BELOW KNEE ULTRA LIGHT MATERIAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5950	ADD ABOVE KNEE ULTRA LIGHT MATERIAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5960	ADD HIP DISARTIC ULTRA LIGHT MATERIAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5961	ENDO POLY HIP, PNEU/HYD/ROT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5962	ADD ENDOSKELETAL SYST BK FLEX PROTECTIVE COVER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5964	ADD ENDOSKELETAL SYST AK FLEX PROTECTIVE COVER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5966	ADD ENDOSKELETAL SYST HIP DISARTIC FLEX COVER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5968	ALL LOW EXTREM PROSTH ANKLE MULTIAXIAL SHOCK	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5969	AK/FT POWER ASST INCL MOTORS	This service is not covered by Superior HealthPlan.	N/A
L5970	ALL LOW EXT PROS FT EXTERNAL KEEL SACH FT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5971	ALL LOWER EXTREM PROSTH SOLID ANKLE CUSHION HEEL SACH FOOT REPLACE ONLY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5972	FLEXIBLE KEEL FOOT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5973	ANK-FOOT SYS DORS-PLANT FLEX	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5974	ALL LOW EXT PROS FT SINGLE AXIS ANKLE/FT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5975	ALL LOW EXTREM PROSTH COMB 1 AXIS ANKLE-KEEL FT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5976	ALL LOW EXT PROS ENERGY STORING FT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5978	ALL LO EXTREM PROSTH FT MULTI-AXIAL ANKLE/FT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5979	ALL LO EXTREM PROSTH MULTI-AXIAL ANKLE/FT DYNAMIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5980	ALL LOW EXT PROS FLEX FT SYSTEM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5981	ALL LOW EXTREM PROSTH FLEX-WALK SYST/EQUAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5982	ALL EXO LOW EXT PROS AXIAL ROTATION UNIT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019

L5984	ALL ENDOSKELETAL LOWER EXTREMITY PROSTHESIS, AXIAL ROTATION UNIT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5985	ALL ENDO LO EXTREM PROSTH, DYN PROSTH PYLON	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5986	ALL LOW EXT PROS MULTI AXIAL ROTATION UNIT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5987	ALL LO EXTREM PROSTH SHANK FT SYST W/LOAD PYLON	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5988	ALL LOW EXTREM PROSTH VERT SHOCK/ROTATION PYLON	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5989	ADDITION LOWER EXTREMITY PROSTHESIS	No pre-authorization is required for all providers.	N/A
L5990	ADDITION TO LOWER EXTREMITY PROSTHESIS, USER ADJUSTABLE HEEL HEIGHT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L5993	ADDN TO LOW EXTR PROSTH HEAVY DUTY, FOOT ONLY, (PAT WGT GR 300 LBS)	This service is not covered by Superior HealthPlan.	N/A
L5994	ADDN TO LOW EXTR PROSTH HEAVY DUTY, KNEE ONLY, (PAT WGT GR 300 LBS)	This is no longer a valid code.	N/A
L5995	ADDN TO LOWER EXTREM PROSTH, H DUTY FEATURE OTH TH FOOT OR KNEE,300#	This is no longer a valid code.	N/A
L5999	LOW EXT PROS NOS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6000	PART HAND THUMB REM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6010	PART HAND LITTLE/RING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6020	PART HAND NO FINGERS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6025	TRNSCARPL/MC/PART HND DISARTIC PROS	This is no longer a valid code.	N/A
L6026	PART HAND MYO EXCLU TERM DEV	Pre-authorization required for all providers.	Prior to 09/01/2019
L6050	WRIST DISARTIC MOLD SOCK FLEX ELBOW HING TRICEP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6055	WRIST DISARTIC MOLD SOCK W/EXPAND INTERFACE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6100	BELOW ELBOW MOLD SOCK FLEX ELBOW HINGE TRICEP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6110	BELOW ELBOW MOLD SOCK (MUNSTER/NORTHWEST TYPE)	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6120	BELOW ELBOW MOLD DBL WALL SPLIT SOCK SETUP HINGE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6130	BELOW ELBOW MOLD DBL WALL SPLIT SOCK STUMP ACT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6200	ELBOW DISARTIC MOLDED OUTSIDE LOCK HINGE FOREARM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6205	ELBOW DISARTIC MOLDED W/EXP INTERFACE FOREARM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6250	ABOVE ELBOW MOLD DBL WALL SOCK INT LOCK FOREARM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6300	SHOULDER DISARTIC MOLDED SOCKET SHOULDER DOWN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6310	SHOULDER DISARTIC PASSIVE RESTORE COMPLETE PROS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6320	SHOULDER DISARTIC PASSIVE RESTORE SHOULDER CAP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6350	INTERSCAP/THORAC MOLDED SOCKET SHOULDER DOWN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6360	INTERSCAP/THORAC PASSIVE RESTORE COMPLETE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6370	INTERSCAP/THORAC PASSIVE RESTORE SHOULDER CAP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6380	POST SURG APPLY RIGID DRESS WRIST DISARTIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6382	POST SURG APPLY RIGID DRESS ELBOW DISARTIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6384	POST SURG APPLY RIGID DRESS SHOULDER DISARTIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6386	POST SURG/FITTING EA ADD CAST CHANGE/REALIGNMENT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6388	POST SURG/FITTING APPLY RIGID DRESSING ONLY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6400	BELOW ELBOW MOLD SOCKET INCL SOFT PROSTH TISS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6450	ELBOW DISARTIC MOLD SOCKET INCL SOFT PROSTH TISS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6500	ABOVE ELBOW MOLD SOCK INCL SOFT PROSTH TISS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6550	SHOULDER DISARTIC MOLD SOCK INCL SOFT PROSTH TIS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6570	INTERSCAPULA/THORACIC MOLD SOCK INCL SOFT PROSTH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6580	PREP WRIST DISARTIC 1 WALL PLASTIC MOLD TO PT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6582	PREP WRIST DISARTIC 1 WALL SOCK DIRECT FORM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6584	PREP ELBOW 1 WALL PLAST FAIR LEAD MOLD PT MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6586	PREP ELBOW 1 WALL PLAST FAIR LEAD DIRECT MOLD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6588	PREP SHOULDER 1 WALL PLAST SOCK MOLD PT MODEL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6590	PREP SHOULDER 1 WALL SOCK FAIR LEAD DIRECT FORM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6600	UP EXT ADD POLYCENTRIC HINGE PAIR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6605	UP EXT ADD 1 PIVOT HINGE PAIR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6610	UP EXT ADD FLEX METAL HINGE PAIR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6611	ADDN TO UP EXTR PROSTH, EXTERNAL POWERED, ADDN SWITCH, ANY TYPE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6615	UP EXT ADD DISCONNECT LOCKING WRIST UNIT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6616	UP EXT ADD DISCONNECT INSERT LOCK WRIST EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6620	UPPER EXTREMITY ADDITION, FLEXION/EXTENSION WRIST UNIT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6621	UP /EXTREM PROSTH ADDN FLEX EXT WRIST W/ OR W/O FRICTION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6623	UP EXT ADD SPRING ASSIST ROTATION WRIST W/LATCH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6624	UPPER EXTREMITY ADDITION FLEXION/EXTENSION & ROTATION WRIST UNIT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6625	UP EXT ADD ROTATE WRIST UNIT W/CABLE LOCK	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6628	UP EXT ADD QUICK DISCONNECT HOOK ADAP OTTO BACK	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6629	UP EXT ADD DISCONNECT LAMINAT COLLAR W/COUPLING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6630	UP EXT ADD STAINLESS STEEL ANY WRIST	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6632	UP EXT ADD LATEX SUSP SLEEVE EACH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6635	UP EXT ADD LIFT ASSIST FOR ELBOW	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6637	UP EXT ADD NUDGE CONTROL ELBOW LOCK	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6638	UP EXT ADD PROS LOCK W/MNL PWR ELB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6639	UPPER EXTREMITY ADDITION, HEAVY DUTY FEATURE, ANY ELBOW	This service is not covered by Superior HealthPlan.	N/A
L6640	UP EXT ADD SHOULDER ABDUCTION JNT PAIR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6641	UP EXT ADD EXCURSION AMPLIFIER PULLEY TYPE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6642	UP EXT ADD EXCURSION AMPLIFIER LEVER TYPE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6645	UP EXT ADD SHOULDER FLEXION-ABDUCTION JNT EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6646	UP EXT ADD SHLDR JNT MX PSTN SYS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6647	UP EXT ADD SHLDR LOCK MECH BDY PWR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6648	UP EXT ADD SHLDR LOCK MECH EXT PWR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6650	UP EXT ADD SHOULDER UNIVERSAL JNT EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6655	UP EXT ADD STANDARD CONTROL CABLE EXTRA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6660	UP EXT ADD HVY DTY CONTROL CABLE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6665	UP EXT ADD TEFLON OR EQUAL CABLE LINING	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6670	UP EXT ADD HOOK TO HAND CABLE ADAPTER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6672	UP EXT ADD HARNESS CHEST/SHOULDER SADDLE TYPE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6675	UPPER EXTREMITY ADDITION, HARNESS, SINGLE CABLE DESIGN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6676	UPPER EXTREMITY ADDITION, HARNESS DUAL CABLE DESIGN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6677	UP /EXTREM ADDN HARNESS TRIPLE CONTROL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6680	UP EXT ADD TEST SOCKET WRIST DISARTIC BELOW ELB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6682	UP EXT ADD TEST SOCKET ELBOW DISARTIC ABOVE ELB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6684	UP EXT ADD TEST SOCKET SHOULDER DISARTIC/THORAC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6686	UP EXT ADD SUCTION SOCKET	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6687	UP EXT ADD FRAME SOCKET BELOW ELBOW	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6688	UP EXT ADD FRAME SOCKET ABOVE ELBOW	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6689	UP EXT ADD FRAME SOCKET SHOULDER DISARTIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6690	UP EXT ADD FRAME SOCKET INTERSCAPULAR/THORACIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6691	UP EXT ADD REMOVABLE INSERT EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6692	UP EXT ADD SILICONE GEL INSERT/EQUAL EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6693	UP EXTREM ADD EXT LOCK ELBOW FORARM COUNTRBALANC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6694	ADD UP EXT PROS BELW/ABVE ELB CSTM W/LOCK MECH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6695	ADD UP EXT PROS BELW/ABVE ELB CSTM W/O LOCK MECH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6696	ADD UP EXT PROS ELB CSTM CNGN/TRAUMAT AMP INIT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6697	ADD UP EXT PROS ELB CSTM NOT CNGN/TRAUM AMP INIT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6698	ADD UP EXT PROS ELB LOCK MECH EXCL SCKT INSR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6700	TERM DEVICE HOOK DORRANCE MODEL #3	No pre-authorization is required for all providers.	N/A
L6703	TERMINAL DEVICE, PASSIVE HAND/MITT, ANY MATERIAL, ANY SIZE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6704	TERMINAL DEV, SPORT/RECREATION/WORK ATTACH, ANY MATERIAL, ANY SIZE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6705	TERM DEVICE HOOK DORRANCE MODEL #5	This is no longer a valid code.	N/A
L6706	TERMINAL DEV, HOOK, MECH, VOL OPEN, ANY MAT, ANY SIZE, LINED OR UNLINED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6707	TERMINAL DEV HOOK MECH VOL CLOS ANY MATERIAL ANY SIZE LINED OR UNLIN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6708	TERMINAL DEV HAND MECHAN VOL OPENING ANY MATERIAL ANY SIZE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6709	TERMINAL DEV HAND MECHAN VOL CLOSING ANY MATERIAL/SIZE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6710	TERM DEVICE HOOK DORRANCE MODEL #5X	This is no longer a valid code.	N/A
L6711	PED TERM DEV HOOK VOL OPEN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6712	PED TERM DEV HOOK VOL CLOS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6713	PED TERM DEV HAND VOL OPEN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6714	PED TERM DEV HAND VOL CLOS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019

L6715	TERM DEVICE, MULTI ART DIGIT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6720	TERM DEVICE HOOK DORRANCE MODEL #6	This is no longer a valid code.	N/A
L6721	HOOK HAND HVY DTY VOL OPEN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6722	HOOK HAND HVY DTY VOL CLOS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6725	TERM DEVICE HOOK DORRANCE MODEL #7	This is no longer a valid code.	N/A
L6730	TERM DEVICE HOOK DORRANCE MODEL #7LO	This is no longer a valid code.	N/A
L6735	TERM DEVICE HOOK DORRANCE MODEL #8	This is no longer a valid code.	N/A
L6740	TERM DEVICE HOOK DORRANCE MODEL #8X	This is no longer a valid code.	N/A
L6745	TERM DEVICE HOOK DORRANCE MODEL #88X	This is no longer a valid code.	N/A
L6750	TERM DEVICE HOOK DORRANCE MODEL #10P	This is no longer a valid code.	N/A
L6755	TERM DEVICE HOOK DORRANCE MODEL #10X	No pre-authorization is required for all providers.	N/A
L6765	TERM DEVICE HOOK DORRANCE MODEL #12P	No pre-authorization is required for all providers.	N/A
L6770	TERM DEVICE HOOK DORRANCE MODEL #99X	This is no longer a valid code.	N/A
L6775	TERM DEVICE HOOK DORRANCE MODEL #555	This is no longer a valid code.	N/A
L6780	TERM DEVICE HOOK DORRANCE MODEL #SS555	This is no longer a valid code.	N/A
L6790	TERM DEVICE HOOK ACCU HOOK OR EQUAL	This is no longer a valid code.	N/A
L6795	TERM DEVICE HOOK 2 LOAD OR EQUAL	This is no longer a valid code.	N/A
L6800	TERM DEVICE HOOK APRL VC OR EQUAL	No pre-authorization is required for all providers.	N/A
L6805	ADDITION TO TERMINAL DEVICE, MODIFIER WRIST UNIT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6806	TERM DEVICE-HOOK-TRS GRIP-GRIP III-VC OR EQ	This is no longer a valid code.	N/A
L6807	TERM DEVICE/HOOK/GRIP I/GRIP II VC OR EQUAL	This is no longer a valid code.	N/A
L6808	TERM DEVICE-HOOK-TRS ADEPT-INFANT/CHILD-VC OR EQ	This is no longer a valid code.	N/A
L6809	TERM DEVICE HOOK TRS SUPER SPORT PASSIVE	No pre-authorization is required for all providers.	N/A
L6810	ADDITIONAL TO TERMINAL DEVICE, PRECISION PINCH DEVICE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6825	TERM DEVICE HAND DORRANCE VO	No pre-authorization is required for all providers.	N/A
L6830	TERM DEVICE HAND APRL VC	No pre-authorization is required for all providers.	N/A
L6835	TERM DEVICE HAND SIERRA VO	No pre-authorization is required for all providers.	N/A
L6840	TERM DEVICE HAND BECKER IMPERIAL	No pre-authorization is required for all providers.	N/A
L6845	TERM DEVICE BECKER LOCK GRIP	No pre-authorization is required for all providers.	N/A
L6850	TERM DEVICE BECKER PLYLITE	No pre-authorization is required for all providers.	N/A
L6855	TERM DEVICE HAND ROBIN-AIDS VO	No pre-authorization is required for all providers.	N/A
L6860	TERM DEVICE HAND ROBIN-AIDS VO SOFT	No pre-authorization is required for all providers.	N/A
L6865	TERM DEVICE HAND PASSIVE HAND	No pre-authorization is required for all providers.	N/A
L6867	TERM DEVICE HAND DETROIT INFANT HAND (MECH)	No pre-authorization is required for all providers.	N/A
L6868	TERM DEVICE HAND PASSIVE INFANT (STEEPER/HOSMER)	No pre-authorization is required for all providers.	N/A
L6870	TERM DEVICE HAND CHILD MITT	No pre-authorization is required for all providers.	N/A
L6872	TERM DEVICE HAND NYU CHILD HAND	No pre-authorization is required for all providers.	N/A
L6873	TERM DEVICE HAND MECHANICAL INFANT STEEPER/EQUAL	No pre-authorization is required for all providers.	N/A
L6875	TERM DEVICE HAND BOCK VC	No pre-authorization is required for all providers.	N/A
L6880	ELEC HAND IND ART DIGITS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6881	AUTO GRASP FEATURE, ADDTN TO UP LIMB ELECTRIC PROSTHETIC TERMINAL DEVICE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6882	MICROPROCESSOR CONTROL FEATURE, ADDITION TO UPPER LIMB	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6883	REPLACE SOCKET BELOW ELBOW WRIST DISARTICULATION MOLDED TO PATIENT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6884	REPLACE SOCKET, ABOVE ELBOW/ELBOW DISARTICULATION, MOLDED TO PAT, USE W	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6885	REPLACE SOCKET SHOULDER DISARTICULATION INTERSCAPULAR MOLDED TO PATIENT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6890	TERM DEVICE GLOVE FOR ABOVE PRODUCTION GLOVE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6895	TERM DEVICE GLOVE FOR ABOVE CUSTOM GLOVE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6900	HAND RESTORE PART HAND W/GLOVE THUMB/1 FINGER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6905	HAND RESTORE PART HAND W/GLOVE MULT FINGERS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6910	HAND RESTORE PART HAND W/GLOVE NO FINGERS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6915	HAND RESTORE REPLACEMENT GLOVE FOR ABOVE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6920	WRIST DISARTIC SWITCH CONTROL TERM DEVICE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6925	WRIST DISARTIC MYOELECTRONIC CONTROL TERM DEVICE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6930	BELOW ELBOW SWITCH CONTROL TERM DEVICE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6935	BELOW ELBOW MYOELECTRONIC CONTROL TERM DEVICE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6940	ELBOW DISARTIC SWITCH CONTROL TERM DEVICE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6945	ELBOW DISARTIC MYOELECTRONIC CONTROL TERM DEVICE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6950	ABOVE ELBOW SWITCH CONTROL TERM DEVICE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6955	ABOVE ELBOW MYOELECTRONIC CONTROL TERM DEVICE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6960	SHOULDER DISARTIC SWITCH CONTROL TERM DEVICE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6965	SHOULDER DISARTIC MYOELECTRONIC CONTROL TERM DEVICE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6970	INTERSCAPULAR/THORACIC SWITCH CONTROL TER DEV	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L6975	INTERSCAPULAR/THORACIC MYOELECTRONIC CONTROL TERM DEV	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7007	ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7008	ELECTRIC HAND, SWITCH OR MYOELECTRIC, CONTROLLED, PEDIATRIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7009	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7010	ELECT HAND OTTO BOCK STEEPER/EQUAL SWITCH CONT	No pre-authorization is required for all providers.	N/A
L7015	ELECT HAND TEKNIK VARIETY VILLAGE SWITCH CONT	No pre-authorization is required for all providers.	N/A
L7020	ELECT GREIFER OTTO BOCK SWITCH CONTROL	No pre-authorization is required for all providers.	N/A
L7025	ELECT HAND OTTO BOCK MYOELECTRONICALLY CONT	No pre-authorization is required for all providers.	N/A
L7030	ELECT HAND TEKNIK VARIETY VILLAGE MYOELECTRONIC	No pre-authorization is required for all providers.	N/A
L7035	ELECT GREIFER OTTO BOCK MYOELECTRONICALLY CONT	No pre-authorization is required for all providers.	N/A
L7040	PREHENSILE ACTUATOR, SWITCH CONTROLLED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7045	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, PEDIATRIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7170	ELECT ELBOW HOSMER SWITCH CONTROL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7180	ELEC ELBOW-BOSTON/UT/OR EQ-MYOELECTRONIC CNTRL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7181	ELEC ELB MICROPRC SIMULTAN CNTRL ELB&TERM DEVC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7185	ELECT ELBOW ADOLESCENT VARIETY VILLAGE SWITCH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7186	ELECT ELBOW CHILD VARIETY VILLAGE SWITCH CONTROL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7190	ELECT ELBOW ADOLESCENT VARIETY VILL MYOELECTRON	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7191	ELECT ELBOW CHILD VARIETY VILLAGE MYOELECTRON	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7259	ELECTRONIC WRIST ROTATOR ANY	Pre-authorization required for all providers.	Prior to 09/01/2019
L7260	ELECT WRIST ROTATOR OTTO BOCK/EQUAL	This is no longer a valid code.	N/A
L7261	ELECT WRIST ROTATOR FOR UTAH ARM	This is no longer a valid code.	N/A
L7360	SIX VOLT BAT OTTO BOCK/EQ EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7362	BATTERY CHRGR SIX VOLT OTTO	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7364	TWELVE VOLT BATTERY UTAH/EQU	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7366	BATTERY CHRGR 12 VOLT UTAH/E	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7367	REPLACMNT LITHIUM IONBATTER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7368	LITHIUM ION BATTERY CHARGER	Pre-authorization required for all providers.	Prior to 09/01/2019
L7400	ADDN TO UP EXTREM PROSTH BELOW ELBOW WRIST DISARTICULATION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7401	ADDN TO UP EXTREM PROSTH ABOVE ELBOW DISARTICULATION ULTRALIGHT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7402	ADDN TO UP EXTREM PROSH SHOULDER DISARTIC INTERSCAP THORACIC ULTRALIGHT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7403	ADDN TO UP EXTREM PROSTH BELOW ELBOW WRIST DISARTICULATION ACRYLIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7404	ADDN TO UP EXTREM PROSTH ABOVE ELBOW DISARTICULATION ACRYLIC MATERIAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7405	ADDN TO UP EXTREM PROSH SHOULDER DISARTIC INTERSCAP THORACIC ACRYLIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7499	UP EXT PROS NOS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7510	REP PROS DEVC REP/REPL MINOR PART	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7520	REPR PROSTH DEVICE LABOR COMPONENT PER 15 MIN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7600	PROSTHETIC DONNING SLEEVE ANY MATERIAL EACH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L7611	PED TERM DEV HOOK VOL OPEN	This is no longer a valid code.	N/A
L7612	PED TERM DEV HOOK VOL CLOS	No pre-authorization is required for all providers.	N/A
L7613	PED TERM DEV HAND VOL OPEN	This is no longer a valid code.	N/A
L7614	PED TERM DEV HAND VOL CLOS	This is no longer a valid code.	N/A
L7621	HOOK/HAND HVY DTY VOL OPEN	No pre-authorization is required for all providers.	N/A
L7622	HOOK/HAND HVY DTY VOL CLOS	This is no longer a valid code.	N/A
L7700	GKT/SEAL USE PROS SOC INS ANY TY EA	No pre-authorization is required for all providers.	N/A
L7900	MALE VACUUM ERECTION SYSTEM	This service is not covered by Superior HealthPlan.	N/A
L7902	TENSION RING, FOR VACUUM ERECTION DEVICE, ANY TYPE, REPLACEMENT ONLY, EA	This service is not covered by Superior HealthPlan.	N/A
L8000	MASTECTOMY BRA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8001	BREAST PROSTHESIS BRA & FORM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019

L8002	BRST PRSTH BRA & BILAT FORM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8010	BREAST PROSTHESIS MASTECTOMY SLEEVE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8015	EXT BREAST PROSTH GARMENT W/MAST FORM POST MAST	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8020	BREAST PROSTHESIS MASTECTOMY FORM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8030	BREAST PROSTHESIS W/O ADHESIVE	Pre-authorization required for all providers.	Prior to 09/01/2019
L8031	BREAST PROSTHESIS W ADHESIVE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8032	NIPPLE PROSTHESIS PREFAB REUSABLE ANY TYPE EACH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8033	NIPPLE PROSTH CSTM FAB REUSABL ANY MATL ANY T EA	No pre-authorization is required for all providers.	N/A
L8035	CUST BREAST PROSTH POST MAST MOLD PT MODEL	Pre-authorization required for all providers.	Prior to 09/01/2019
L8039	BREAST PROSTH NOS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8040	NASAL PROSTH PROV BY A NON-PHY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8041	MIDFACIAL PROSTH PROV BY A NON-PHY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8042	ORBIT PROSTH PROV BY A NON-PHY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8043	UPP/FACIAL PROSTH PROV BY A NON-PHY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8044	HEMI-FACIAL PROSTH PROV BY NON-PHY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8045	AURICULAR PROSTH PROV BY A NON-PHY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8046	PART FACIAL PROSTH PROV BY NON-PHYS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8047	NASAL SEPTAL PROSTH PROV BY NON-PHY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8048	UNS MAXIL-FAC PROSTH BR	This service is not covered by Superior HealthPlan.	N/A
L8049	REPR MAXILLOFAC PROS-NON PHY-15MIN	This service is not covered by Superior HealthPlan.	N/A
L8100	GRAD COMPRES STOCKING BK 18-30 MMHG EACH	No pre-authorization is required for all providers.	N/A
L8110	GRAD COMPRES STOCKING BK 30-40 MMHG EACH	No pre-authorization is required for all providers.	N/A
L8120	GRAD COMPRES STOCKING BK 40-50 MMHG EACH	No pre-authorization is required for all providers.	N/A
L8130	GRAD COMPRES STOCKING THIGH LT 18-30 MMHG EACH	No pre-authorization is required for all providers.	N/A
L8140	GRAD COMPRES STOCKING THIGH LT 30-40 MMHG EACH	No pre-authorization is required for all providers.	N/A
L8150	GRAD COMPRES STOCKING THIGH LT 40-50 MMHG EACH	No pre-authorization is required for all providers.	N/A
L8160	GRAD COMP STOCKING FULL LT/CHAP 18-30 MMHG EACH	No pre-authorization is required for all providers.	N/A
L8170	GRAD COMP STOCKING FULL LT/CHAP 30-40 MMHG EACH	No pre-authorization is required for all providers.	N/A
L8180	GRAD COMP STOCKING FULL LT/CHAP 40-50 MMHG EACH	No pre-authorization is required for all providers.	N/A
L8190	GRAD COMP STOCKING WAIST LT 18-30 MMHG EACH	No pre-authorization is required for all providers.	N/A
L8195	GRAD COMPRESS STOCKNG WAIST LENGTH 30-40 MMHG EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8200	GRAD COMP STOCKING WAIST LT 40-50 MMHG EACH	No pre-authorization is required for all providers.	N/A
L8210	GRAD COMPRESS STOCKING CUSTOM MADE	No pre-authorization is required for all providers.	N/A
L8220	GRAD COMPRES STOCKING LYMPHEDEMA	No pre-authorization is required for all providers.	N/A
L8230	GRAD COMPRES STOCKING GARTER BELT	No pre-authorization is required for all providers.	N/A
L8239	GRAD COMPRES STOCKING NOS	No pre-authorization is required for all providers.	N/A
L8300	TRUSS SINGLE W/STANDARD PAD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8310	TRUSS DOUBLE W/STANDARD PADS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8320	TRUSS ADDITION TO STANDARD PAD WATER PAD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8330	TRUSS ADDITION TO STANDARD PAD SCROTAL PAD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8400	PROSTH SHEATH BELOW KNEE EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8410	PROSTH SHEATH ABOVE KNEE EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8415	PROSTH SHEATH UPPER LIMB EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8417	PROSTH SHEATH SOCK INC GEL CUSH LAYER AK/BK-EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8420	PROSTHETIC SOCK MULT PLY BK EACH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8430	PROSTH SOCK MULT PLY ABOVE KNEE EACH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8435	PROSTH SOCK MULT PLY UPPER LIMB EACH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8440	PROSTH SHRINKER BELOW KNEE EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8460	PROSTH SHRINKER ABOVE KNEE EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8465	PROSTH SHRINKER UPPER LIMB EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8470	PROSTH SOCK SINGLE PLY FITTING BELOW KNEE EACH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8480	PROSTH SOCK SINGLE PLY FITTING ABOVE KNEE EACH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8485	PROSTH SOCK SINGLE PLY FITTING UPPER LIMB EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8490	ADD PROSTH SHEATH/SOCK AIR SEAL SUCTION RETENT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8499	UNLISTED PROC MISC PROSTH SERVICES	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8500	ARTIFICIAL LARYNX ANY TYPE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8501	TRACHEOSTOMY SPEAKING VALVE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8505	ARTIFICIAL LARYNX REPLACEMENT BATTERY / ACCESSORY, ANY TYPE	This service is not covered by Superior HealthPlan.	N/A
L8507	TRACHEO-ESOPHAGEAL VOICE PROSTHESIS, PATIENT INSERTED, ANY TYPE, EACH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8509	TRACHEO ESOPHAGEAL VOICE PROSTHESIS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8510	VOICE AMPLIFIER	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8511	INSERT FOR INDWELLING TRACHEOESOPHAGEAL PROSTHESIS, W/WOUT VLV	This service is not covered by Superior HealthPlan.	N/A
L8512	GELATIN CAPSULES OR EQUIVALENT/W TRACHEOESOPHAGEAL VOICE PROS	This service is not covered by Superior HealthPlan.	N/A
L8513	CLEANING DEVICE USED WITH TRACHEOESOPHAGEAL VOICE PROSTHESIS	This service is not covered by Superior HealthPlan.	N/A
L8514	TRACHEOESOPHAGEAL PUNCTURE DILATOR, REPLACEMENT ONLY, EACH	This service is not covered by Superior HealthPlan.	N/A
L8515	GELATIN CAP APPLIC DEVIC TRACHEOESOPH VOICE PROSTH	This service is not covered by Superior HealthPlan.	N/A
L8600	IMPLANTABLE BREAST PROSTHESIS SILICONE OR EQUAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8603	COLLAGEN IMPLANT-URIN TRACT/2.5CC SYR-INCLU SUPP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8604	DEXTRANOMER HYALURONIC ACID	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8605	INJ BULKING AGENT ANAL CANAL	Pre-authorization is required for all providers.	Prior to 09/01/2019
L8606	INJ SYN IMP URIN TRACT 1 ML SYRNG	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8607	INJ BLK AGT VC MEDIALIZATION 0.1 ML	This service is not covered by Superior HealthPlan.	N/A
L8608	MISC EXT COMP SPL/ACSS FOR ARGUS II RET PROS SYS	This service is not covered by Superior HealthPlan.	N/A
L8609	ARTIFICIAL CORNEA	This service is not covered by Superior HealthPlan.	N/A
L8610	OCULAR IMPLANT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8611	ORBITAL IMPLANT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8612	AQUEOUS SHUNT	This service is not covered by Superior HealthPlan.	N/A
L8613	OSSICULA IMPLANT	This service is not covered by Superior HealthPlan.	N/A
L8614	COCHLEAR DEVICE INCLUDES ALL INT&EXT COMPONENTS	Pre-authorization required for all providers.	Prior to 09/01/2019
L8615	HEADSET/HEADPIECE COCHLEAR IMPLANT DEVICE REPL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8616	MICROPHONE COCHLEAR IMPLANT DEVICE REPLACEMENT	No pre-authorization is required for all providers.	N/A
L8617	TRANSMITTING COIL COCHLEAR IMPLANT DEVICE REPL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8618	TX CBL U CI/AUD OSSEINTG DVC REPL	No pre-authorization is required for all providers.	N/A
L8619	COCHLEAR IMPL EXT SPEECH PROCESSR/CONTROLLER REPL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8620	RADIAL HEAD IMPLANT	No pre-authorization is required for all providers.	N/A
L8621	REPL ZINC AIR BATTERY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8622	ALKALIN BATTERY COCHLEAR IMPL DEVIC ANY SZ REPL EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8623	LITHIUM ION BATTERY OTH THAN EAR LEVEL REPL EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8624	LIB CI/AO DVC SP EAR LEVEL REPL EA	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8625	EXT RECHRG BATT CI/AO DEVIC REPL EA	No pre-authorization is required for all providers.	N/A
L8626	WRIST IMPLANT	This is no longer a valid code.	N/A
L8627	COCHLEAR IMPL EXT SPEECH PROCESSR COMPONENT REPL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8628	COCHLEAR IMPLANT EXT CONTROLLER COMPONENT REPL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8629	TRANSMITTING COIL CABLE COCHLEAR IMPL DEV REPL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8630	METACARPOMPHALANGEAL JOINT IMPLANT	Pre-authorization is required for all providers.	Prior to 09/01/2019
L8631	METRACARPAL PHALANGEAL JOINT RPLCMNT, TWO OR MORE PIECES, METAL	Pre-authorization required for all providers.	Prior to 09/01/2019
L8640	PATELLA IMPLANT	This is no longer a valid code.	N/A
L8641	METATARSAL JOINT IMPLANT	Pre-authorization is required for all providers.	Prior to 09/01/2019
L8642	HALLUX IMPLANT	Pre-authorization is required for all providers.	Prior to 09/01/2019
L8655	FLEXOR TENDON IN HAND OR FINGER, IMPLANT	This is no longer a valid code.	N/A
L8656	EXTENSOR TENDON IN HAND OR FINGER, IMPLANT	This is no longer a valid code.	N/A
L8657	ITENDON OTHER THAN HAND OR FINGER, IMPLANT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8658	INTERPHALANGEAL JOINT SPACER, SILICONE OR EQUAL, EACH	Pre-authorization is required for all providers.	Prior to 09/01/2019
L8659	INTERPHALANGEAL FINGER JOINT REPLACEMENT, TWO OR MORE PIECES, METAL	Pre-authorization required for all providers.	Prior to 09/01/2019
L8670	VASCULAR GRAFT MATERIAL-SYN-IMPLANT	This service is not covered by Superior HealthPlan.	N/A
L8679	IMP NEUROSTI PLS GN ANY TYPE	This service is not covered by Superior HealthPlan.	N/A
L8680	IMPLT NEUROSTIM ELCTR EACH	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
L8681	PT PRGRM FOR IMPLT NEUROSTIM	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
L8682	IMPLANTABLE NEUROSTIMULATOR RADIOFREQUENCY RECEIVER	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
L8683	RADIOFREQUENCY TRANSMIT EXTERNAL USE W IMPLANT NEUROSTIM RADIOFREQ RCVR	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
L8684	RADIOFREQUENCY TRANSMIT EXTERNALUSE W IMPLANT SACR ROOT NEUROSTIM RVCR	Pre-authorization is required for all providers.	Prior to 09/01/2019

L8685	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR SINGLE ARRAY RECHARGEABLE	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
L8686	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR SINGLE ARRAY NON-RECHARGE	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
L8687	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR DUAL ARRAY RECHARGEABLE	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
L8688	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR DUAL ARRAY NON-RECHARGE	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
L8689	EXTERNAL RECHARG SYS INTERN	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
L8690	AUDITORY OSSEOINTEGRATED DEVICE, INCL ALL INTERNAL & EXTERNAL COMPONENTS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8691	AO D EXT SP EXCL TRNDCR/ACTR RPL EA	Pre-authorization required for all providers.	Prior to 09/01/2019
L8692	NON-OSSEOINTEGRATED SND PROC	Pre-authorization required for all providers.	Prior to 09/01/2019
L8693	AUD OSSEO DEV. ABUTMENT	Pre-authorization required for all providers.	Prior to 09/01/2019
L8694	AUD OI DVC TRNSDUCR/ACTUATR REPL EA	No pre-authorization is required for all providers.	N/A
L8695	EXTERNAL RECHARG SYS EXTERN	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
L8696	EXT ANTENNA PHREN NERVE STIM	New procedure code, please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
L8698	MISC COMP SPL/ACCESS FOR USE WITH TOT AH SYSTEM	This service is not covered by Superior HealthPlan.	N/A
L8699	PROSTH IMPLNT NOS	This service is not covered by Superior HealthPlan.	N/A
L8701	PWR UE ROM AST DVC ELB WR HAND 1/DBL UP CUS FAB	This service is not covered by Superior HealthPlan.	N/A
L8702	PWR UE ROM AST DVC ELBO WR H FINGER 1/DBL UP CUS	This service is not covered by Superior HealthPlan.	N/A
L9900	ORTHOTIC & PROSTHETIC SUPPLY	No pre-authorization is required for all providers.	N/A
M0009	NOT OTHERWISE CLASS OFFICE VISIT	No pre-authorization is required for all providers.	N/A
M0064	BRIEF OFFICE VISIT MONITOR/CHANGE PSYCH SERVICES	This is no longer a valid code.	N/A
M0075	CELLULAR THERAPY	This service is not covered by Superior HealthPlan.	N/A
M0076	PROLOTHERAPY	This service is not covered by Superior HealthPlan.	N/A
M0100	INTRAGASTRIC HYPOTHERMIA USING GASTRIC FREEZING	This service is not covered by Superior HealthPlan.	N/A
M0300	IV CHELATION THERAPY	No pre-authorization is required for all providers.	N/A
M0301	FABRIC WRAPPING OF ABDOMINAL ANEURYSM	This service is not covered by Superior HealthPlan.	N/A
M1106	THE START OF AN EPISODE OF CARE DOC MED RECORD	No authorization required. Code is for informational purposes only.	N/A
M1107	DOC STAT PT DX DEG NEURO COND DX TM BFOR/DUR EOC	No authorization required. Code is for informational purposes only.	N/A
M1108	ONGOING CARE NOT INDICATED PT SEEN ONLY 1-2 VST	No authorization required. Code is for informational purposes only.	N/A
M1109	DOC STAT PT DX DEG NEURO COND DX TM BFOR/DUR EOC	No authorization required. Code is for informational purposes only.	N/A
M1110	ONGOING CARE NO INDIC PT SLF-D/C ERLY AND 1-2 VISIT	No authorization required. Code is for informational purposes only.	N/A
M1111	THE START OF AN EPISODE OF CARE DOC MED RECORD	No authorization required. Code is for informational purposes only.	N/A
M1112	DOC PT DX DEG NEURO COND ALS/PARKINSONS DX TM E	No authorization required. Code is for informational purposes only.	N/A
M1113	ONGOING CARE NOT INDICATED PT SEEN 1-2 VISITS	No authorization required. Code is for informational purposes only.	N/A
M1114	ONGO CR NO IPT D/C 1-2 V DT ME DOC TX EPI IMPOS	No authorization required. Code is for informational purposes only.	N/A
M1115	ONG CARE NOT IND PT SLF-D/C ERLY AND SN 1-2 VISIT	No authorization required. Code is for informational purposes only.	N/A
M1116	THE START OF AN EPISODE OF CARE DOC MED RECORD	No authorization required. Code is for informational purposes only.	N/A
M1117	DOC STATING PT DX DEGEN NEURO COND DX TIME EOC	No authorization required. Code is for informational purposes only.	N/A
M1118	ONGOING CARE NOT INDICATED PT SEEN ONLY 1-2 VST	No authorization required. Code is for informational purposes only.	N/A
M1119	ONGO CARE NOT IND PT D/C 1-2 VST D/T MED EVT DOC	No authorization required. Code is for informational purposes only.	N/A
M1120	ONGOING CARE NOT IND PT SLF-D/C EARLY AND 1-2 VSTS	No authorization required. Code is for informational purposes only.	N/A
M1121	THE START OF AN EPISODE OF CARE DOC MED RECORD	No authorization required. Code is for informational purposes only.	N/A
M1122	DOC PT DX DEGEN NEURO COND DX TM BFOR/DUR EOC	No authorization required. Code is for informational purposes only.	N/A
M1123	ONGOING CARE NOT INDICATED PT SEEN ONLY 1-2 VST	No authorization required. Code is for informational purposes only.	N/A
M1124	ONGOING CAR NOT IND PT D/C 1-2 VST D/T MED EVNT	No authorization required. Code is for informational purposes only.	N/A
M1125	ONGOING CARE NOT IND PT SLF-D/C EARLY AND 1-2 VST	No authorization required. Code is for informational purposes only.	N/A
M1126	THE START OF AN EPISODE OF CARE DOC MED RECORD	No authorization required. Code is for informational purposes only.	N/A
M1127	DOC PT DX DEG NEURO COND DX TM BEFORE/DUR EOC	No authorization required. Code is for informational purposes only.	N/A
M1128	ONGOING CARE NOT IND PT SEEN ONLY 1-2 VISITS	No authorization required. Code is for informational purposes only.	N/A
M1129	ONGO CAR N IPT D/C AFTR 1-2 V D/T SPC MED EVNT	No authorization required. Code is for informational purposes only.	N/A
M1130	ONGO CAR NO IND SLF-D/C ERLY AND SEEN ONLY 1-2 VST	No authorization required. Code is for informational purposes only.	N/A
M1131	DOC STAT PT DX DEG NEURO COND DX TM BFR/DUR EOC	No authorization required. Code is for informational purposes only.	N/A
M1132	ONGOING CARE NOT INDICATED PT SEEN ONLY 1-2 VSTS	No authorization required. Code is for informational purposes only.	N/A
M1133	ONGO CARE NOT IND PT SEEN ONLY ONE TO TWO VISITS	No authorization required. Code is for informational purposes only.	N/A
M1134	ONGO CARE NOT IND PT D/C 1-2 VST D/T SPC MD EVNT	No authorization required. Code is for informational purposes only.	N/A
M1135	THE START OF AN EPISODE OF CARE DOC MED RECORD	No authorization required. Code is for informational purposes only.	N/A
M1136	THE START OF AN EPISODE OF CARE DOC MED RECORD	No authorization required. Code is for informational purposes only.	N/A
M1137	DOC PT DX DEG NEURO COND DX ANY TIME BFR/DUR EOC	No authorization required. Code is for informational purposes only.	N/A
M1138	ONGOING CARE NOT INDICATED PT SEEN ONLY 1-2 VST	No authorization required. Code is for informational purposes only.	N/A
M1139	ONGO CARE NO INDICAT PT SD EAR AND SN ONLY 1-2 VST	No authorization required. Code is for informational purposes only.	N/A
M1140	ONGO CAR NO IND DC ONLY 1-2 VST D/T MED EVNT DOC	No authorization required. Code is for informational purposes only.	N/A
M1141	FUNCTIONAL STATUS WAS NOT MSR OKS 1 YR POSTOP	No authorization required. Code is for informational purposes only.	N/A
M1142	EMERGENT CASES	No authorization required. Code is for informational purposes only.	N/A
M1143	INITIATED EPI REHAB TH MED/CHIRO CARE NCK IMPAIR	No authorization required. Code is for informational purposes only.	N/A
M1144	ONGOING CARE NOT INDICATED PT SEEN ONLY 1-2 VST	No authorization required. Code is for informational purposes only.	N/A
P2028	CEPHALIN FLOCCULATION BLOOD	This service is not covered by Superior HealthPlan.	N/A
P2029	CONGO RED BLOOD	This service is not covered by Superior HealthPlan.	N/A
P2031	HAIR ANALYSIS (EXCLUDING ARSENIC)	This service is not covered by Superior HealthPlan.	N/A
P2033	THYMOL TURBIDITY BLOOD	This service is not covered by Superior HealthPlan.	N/A
P2038	MUCOPROTEIN BLOOD (SEROMUCOID) (MED NEC)	This service is not covered by Superior HealthPlan.	N/A
P3000	SCREEN PAP TO 3 SMEARS TECH UNDER PHYS DIRECT	This service is not covered by Superior HealthPlan.	N/A
P3001	SCREEN PAP TO 3 SMEARS REQUIRE INTERP BY PHYS	This service is not covered by Superior HealthPlan.	N/A
P6120	HEPATITIS A VIRUS ANTIBODY	No pre-authorization is required for all providers.	N/A
P7001	CULTURE URINE BACTERAI QUANTITATIVE SENSITIVITY	This service is not covered by Superior HealthPlan.	N/A
P7020	VACCINE AUTOGENOUS	No pre-authorization is required for all providers.	N/A
P9010	BLOOD (WHOLE) FOR TRANSFUSION PER UNIT	No pre-authorization is required for all providers.	N/A
P9011	BLOOD, SPLIT UNIT	No pre-authorization is required for all providers.	N/A
P9012	CRYOPRECIPITATE EACH UNIT	No pre-authorization is required for all providers.	N/A
P9016	LEUKOCYTE POOR BLOOD EACH UNIT	No pre-authorization is required for all providers.	N/A
P9017	FRESH FROZEN PLASMA FROZEN WITHIN 8 HOURS OF COLLECTION, EACH UNIT	No pre-authorization is required for all providers.	N/A
P9019	PLATELET CONCENTRATE EACH UNIT	No pre-authorization is required for all providers.	N/A
P9020	PLATELET RICH PLASMA EACH UNIT	No pre-authorization is required for all providers.	N/A
P9021	RED BLOOD CELLS EACH UNIT	No pre-authorization is required for all providers.	N/A
P9022	WASHED RED BLOOD CELLS EACH UNIT	No pre-authorization is required for all providers.	N/A
P9023	PLASMA POOLED MULTIPLE DONOR	No pre-authorization is required for all providers.	N/A
P9031	PLATELETS LEUKOCYTES REDUC EA UNT	No pre-authorization is required for all providers.	N/A
P9032	PLATELETS IRRADIATED EA UNT	No pre-authorization is required for all providers.	N/A
P9033	PLATELETS LEUKOCYTES REDUC IRRAD	No pre-authorization is required for all providers.	N/A
P9034	PLATELETS PHERESIS EA UNT	No pre-authorization is required for all providers.	N/A
P9035	PLATELETS PHERESIS LEUKOCYTES RED	No pre-authorization is required for all providers.	N/A
P9036	PLATELETS PHERESIS IRRADIATED EA	No pre-authorization is required for all providers.	N/A
P9037	PLTLTS PHERESIS LEUKOCYTS RED IRRAD	No pre-authorization is required for all providers.	N/A
P9038	RED BLD CELLS IRRADIATED EA UNT	No pre-authorization is required for all providers.	N/A
P9039	RB CELLS DEGLYCEROLIZED EA UNT	No pre-authorization is required for all providers.	N/A
P9040	RED BLD CELLS LYLES RED IRRADIATED	No pre-authorization is required for all providers.	N/A
P9041	INFUS ALBUMIN (HUMAN) 5% 50 ML	No pre-authorization is required for all providers.	N/A
P9042	INFUS ALBUMIN (HUMAN) 25% 10 ML	No pre-authorization is required for all providers.	N/A
P9043	INFUS PLASMA PROT FRACTION 5% 50 ML	No pre-authorization is required for all providers.	N/A
P9044	PLASMA CRYOPRECIPITATE REDUC EA	No pre-authorization is required for all providers.	N/A
P9045	INFUSION, ALBUMIN (HUMAN), 5%, 250 ML	No pre-authorization is required for all providers.	N/A
P9046	INFUSION, ALBUMIN (HUMAN), 25%, 20 ML	No pre-authorization is required for all providers.	N/A
P9047	INFUSION, ALBUMIN (HUMAN), 25%, 50 ML	No pre-authorization is required for all providers.	N/A
P9048	INFUSION, PLASMA PROTEIN FRACTION (HUMAN), 5%, 250ML	No pre-authorization is required for all providers.	N/A
P9050	GRANULOCYTES, PHERESIS, EACH UNIT	No pre-authorization is required for all providers.	N/A
P9051	WHOLE BLOOD OR RED BLOOD CELLS, LEUKOCYTES REDUCED, CMV-NEGATIVE	No pre-authorization is required for all providers.	N/A
P9052	PLATELETS, HLA-MATCHED LEUKOCYTES REDUCED, APHERESIS/PHERESIS, EACH UNIT	No pre-authorization is required for all providers.	N/A
P9053	PLATELETS, PHERESIS, LEUKOCYTES REDUCED, CMV-NEGATIVE, IRRADIATED	No pre-authorization is required for all providers.	N/A
P9054	WHOLE BLOOD/RED BLOOD CELLS/LEUKO RDCD/FROZEN/DEGLYCEROL/EAH UNIT	No pre-authorization is required for all providers.	N/A
P9055	PLATELETS/LEUKO RDCD/CMV-NEG/ APHERESIS/PHERESIS, EACH UNIT	No pre-authorization is required for all providers.	N/A
P9056	WHOLE BLOOD, LEUKOCYTES REDUCED, IRRADIATED, EACH UNIT	No pre-authorization is required for all providers.	N/A
P9057	RED BLOOD CELLS/FRZN/DEGLYCEROLIZED/WHSD/LEUKO RDCD/IRRADTD/EACH UNIT	No pre-authorization is required for all providers.	N/A
P9058	RED BLOOD CELLS, LEUKOCYTES REDUCED, CMV-NEGATIVE, IRRADIATED, EACH UNIT	No pre-authorization is required for all providers.	N/A
P9059	FRESH FROZEN PLASMA BETWEEN 8-24 HOURS OF COLLECTION, EACH UNIT	No pre-authorization is required for all providers.	N/A

P9060	FRESH FROZEN PLASMA, DONOR RETESTED, EACH UNIT	No pre-authorization is required for all providers.	N/A
P9070	PL POOLD MX DNR PATH RDUC FRZN EA U	This service is not covered by Superior HealthPlan.	N/A
P9071	PLASMA PATHOGEN REDUCED FROZEN EA U	This service is not covered by Superior HealthPlan.	N/A
P9072	PLT PHRS PATH RDUC/RPD BACT TST E U	This is no longer a valid code.	N/A
P9073	PLATELETS PHERESIS PATHOGEN-REDUCED	No pre-authorization is required for all providers.	N/A
P9099	BLOOD COMPONENT OR PRODUCT NOC	No pre-authorization is required for all providers.	N/A
P9100	PATHOGEN TEST FOR PLATELETS	No pre-authorization is required for all providers.	N/A
P9603	TRAVEL 1 WAY MED NEC LAB SPEC PRORATED ACTUAL	This service is not covered by Superior HealthPlan.	N/A
P9604	TRAVEL 1 WAY MED NEC LAB SPEC PRORATED TRIP	This service is not covered by Superior HealthPlan.	N/A
P9612	CATH COLLECT SPECMN 1 PT ALL POS	This service is not covered by Superior HealthPlan.	N/A
P9615	CATH COLLECT SPEC MULT PTS	This service is not covered by Superior HealthPlan.	N/A
Q0035	CARDIOKYMGRAPHY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0037	OXYGEN AND WATER VAPOR ENRICHING SYSTEM	No pre-authorization is required for all providers.	N/A
Q0044	BRIEF OFFICE VISIT DRUG MONITOR	This is no longer a valid code.	N/A
Q0047	BLEPHAROPLASTY ANESTHESIA	This is no longer a valid code.	N/A
Q0060	SCREEN PAP SMEAR TECHNICIAN	No pre-authorization is required for all providers.	N/A
Q0061	SCREENING PAP SMEAR INTERP MD	This is no longer a valid code.	N/A
Q0069	MRI BRAIN WITH/WITHOUT CONTRAST	No pre-authorization is required for all providers.	N/A
Q0070	MRI SPINAL CANAL/CONTENTS CERV	This is no longer a valid code.	N/A
Q0071	MRI SPINAL CANAL/CONTENTS THOR	This is no longer a valid code.	N/A
Q0072	MRI SPINAL CANAL/CONTENTS LUMBAR	No pre-authorization is required for all providers.	N/A
Q0083	CHEMO ADMIN NOT INFUSION TECHNIQUE PER VISIT	This service is not covered by Superior HealthPlan.	N/A
Q0090	SKYLA 13.5MG	This is no longer a valid code.	N/A
Q0091	SCREEN PAP SMEAR OBTAIN PREP CONVEY TO LAB	This service is not covered by Superior HealthPlan.	N/A
Q0092	SET-UP PORTABLE X-RAY EQUIPMENT	This service is not covered by Superior HealthPlan.	N/A
Q0093	FILGRASTIM (G-CSF), PER 100 MCG	This is no longer a valid code.	N/A
Q0094	SARGRAMOSTIM (GM-CSF), PER 250 MCG	This is no longer a valid code.	N/A
Q0100	URINALYSIS BY DIP STICK OR TABLET	This is no longer a valid code.	N/A
Q0103	PHYSICAL THERAPY EVAL INTIAL	This is no longer a valid code.	N/A
Q0104	PHYSICAL THERAPY RE-EVAL INTIAL	No pre-authorization is required for all providers.	N/A
Q0109	OCCUPATIONAL THERAPY	This is no longer a valid code.	N/A
Q0110	OCCUPATIONAL THERPAY	This is no longer a valid code.	N/A
Q0111	WET MOUNTS INCL PREP VAG/CERV/SKIN SPECMN	This service is not covered by Superior HealthPlan.	N/A
Q0112	ALL POTASSIUM HYDROXIDE PREP	This service is not covered by Superior HealthPlan.	N/A
Q0113	PINWORM EXAM	This service is not covered by Superior HealthPlan.	N/A
Q0114	FERN TEST	This service is not covered by Superior HealthPlan.	N/A
Q0115	POST-COITAL DIRECT QUAL EXAM VAG/CERV MUCOUS	This service is not covered by Superior HealthPlan.	N/A
Q0132	DISPENS FEE-COVERED DRUG-ADMIN THRU DME NEBULIZ	No pre-authorization is required for all providers.	N/A
Q0136	INJ EPOETIN ALPHA (NON ESRD USE) PER 1000 UNITS	No pre-authorization is required for all providers.	N/A
Q0137	INJECTION, DARBEPOETIN ALFA, 1MCG (NON-ESRD USE)	No pre-authorization is required for all providers.	N/A
Q0138	FERUMOXYTOL, NON-ESRD	Pre-authorization is required for all providers.	Prior to 09/01/2019
Q0139	FERUMOXYTOL, ESRD USE	Pre-authorization is required for all providers.	Prior to 09/01/2019
Q0161	CHLORPROMAZINE HCL 5MG ORA	This service is not covered by Superior HealthPlan.	N/A
Q0162	ONDAN 1 MG ORL NOT EXCEED 48 HR DOS	This service is not covered by Superior HealthPlan.	N/A
Q0163	DIPHENHYDRAMINE HCL 50 MG ORAL CHEMO ANTI-EMETIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0164	PROCHLORPERAZINE MALEATE 5 MG ORAL ANTI-EMETIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0165	PROCHLORPERAZINE MALEATE 10 MG ORAL ANTI-EMETIC	This is no longer a valid code.	N/A
Q0166	GRANISETRON HCL 1 MG ORAL CHEMO ANTI-EMETIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0167	DRONABINOL 2.5 MG ORAL APPRVD CHEMO ANTI-EMETIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0168	DRONABINOL 5 MG ORAL FDA APPRVD CHEMO ANTI-EMETC	This is no longer a valid code.	N/A
Q0169	PROMETHAZINE HCL 12.5 MG ORAL CHEMO ANTI-EMETIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0170	PROMETHAZINE HCL 25 MG ORAL CHEMO ANTI-EMETIC	This is no longer a valid code.	N/A
Q0171	CHLORPROMAZINE HCL 10 MG ORAL CHEMO ANTI-EMETIC	This is no longer a valid code.	N/A
Q0172	CHLORPROMAZINE HCL 25 MG ORAL CHEMO ANTI-EMETIC	This is no longer a valid code.	N/A
Q0173	TRIMETHOBENZAMIDE HCL 250 MG ORAL ANTI-EMETIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0174	THIETHYLPERAZINE MALEATE 10 MG ORAL ANTI-EMETIC	This service is not covered by Superior HealthPlan.	N/A
Q0175	PERPHENZINE 4 MG ORAL CHEMO ANTI-EMETIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0176	PERPHENZINE 8 MG ORAL CHEMO ANTI-EMETIC	This is no longer a valid code.	N/A
Q0177	HYDROXYZINE PAMOATE 25 MG ORAL CHEMO ANTI-EMETIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0178	HYDROXYZINE PAMOATE 50 MG ORAL CHEMO ANTI-EMETIC	This is no longer a valid code.	N/A
Q0180	DOLASETRON MESYLATE 100 MG ORAL CHEMO ANTI-EMETC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0181	UNSPEC ORAL DOSE FORM CHEMO ANTI-EMETIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0182	DERMAL&EPIDERMAL/TISSUE/N-HUMAN ORIGIN/W/WOUT BIOENGINEERED/PRCSD ELMNTS	No pre-authorization is required for all providers.	N/A
Q0183	HUMAN DERM TISS W/WO BIOENGIN ELEMENTS PER SQ CM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0184	DERM METABOL ACT TISS W/WO BIOENGIN ELEM /SQ CM	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0187	FACT VIIA (COAG FACT RECOM)/1.2 MCG	No pre-authorization is required for all providers.	N/A
Q0477	PWR MODULE PT CABL ELEC/PN VAD REPL	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
Q0478	POWER ADAPTER, COMBO VAD	This service is not covered by Superior HealthPlan.	N/A
Q0479	POWER MODULE COMBO VAD, REP	This service is not covered by Superior HealthPlan.	N/A
Q0480	DRIVER FOR USE W PNEUMATIC VENTRICULAR ASSIST DEVICE REPLACE ONLY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0481	MICROPROCESSOR CONTR UNIT USE W ELECTR VENTR ASSIST DEVICE REPLACE ONLY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0482	MICROPROCESSOR CU USE W ELECTRIC/PNEUMATIC COMBINATION VENTR ASST DEV	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0483	MONITOR/DISPLAY MODULE USE W ELECTRIC VENTRICULAR ASSIST DEVICE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0484	MONITOR/DISPLAY MODULE USE W ELECTRIC OR COMB VENTR ASST DEV	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0485	MONITOR CONTROL CABLE FOR USE W ELECTRIC VENTRICULAR ASSIST DEVICE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
Q0486	MONITOR CONTROL CABLE USE W ELECTRIC/PNEUMATIC VENTRICULAR ASST DEVICE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
Q0487	LEADS PNEUMATIC/ELECTRICAL USE W ANY TYPE COMB VENTR ASST DEV	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
Q0488	POWER PACK BASE FOR USE W ELECTRIC VENTRICULAR ASSIST DEVICE REPLACE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0489	POWER PACK BASE USE W ELECTRIC/PNEUMATIC VENTRICULAR ASST DEVICE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0490	EMERG POWER SOURCE FOR USE W ELECTRIC VENTRICULAR ASST DEVICE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0491	EMERG POWER SOURCE USE W ELECTRIC/PNEUMATIC VENTRICULAR ASST DEVICE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0492	EMERG POWER SUPPLY CABLE FOR USE W ELECTRIC VENTRICULAR ASST DEVICE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
Q0493	EMERG POWER SUPPLY CABLE FOR USE W ELECTRIC/PNEUMATIC VENTRICULAR ASST	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
Q0494	EMERG HAND PUMP FOR USE W ELECTRIC OR COMB VENTR ASST DEVICE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
Q0495	BATTERY/POWER PACK CHARGER USE W ELECT OR ELECT/PNEUMATIC VENTR ASST DEV	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0496	BATTERY ELEC/COMBO VAD, REP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0497	BATTERY CLIPS USE W ELECTRIC OR COMB VENTRICULAR ASSIST DEVICE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
Q0498	HOLSTER USE W ELECTRIC OR ELECTRIC/PNEUMATIC VENTRICULAR ASSIST DEVICE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
Q0499	BELT/VEST ELEC/COMBO VAD REP	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
Q0500	FILTERS USE W ELECTRIC OR ELECTRIC/PNEUMATIC VENTRICULAR ASSIST DEVICE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
Q0501	SHOWER COVER USE W ELECTRIC OR COMB VENTRICULAR ASSIST DEVICE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
Q0502	MOBILITY CART FOR PNEUMATIC VENTRICULAR ASSIST DEVICE REPLACE ONLY	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0503	BATTERY FOR PNEUMATIC VENTRICULAR ASSIST DEVICE REPLACE ONLY EACH	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0504	POWER ADAPTER FOR PNEUMATIC VENTR ASSIST DEVICE REPLACE ONLY VEHICLE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0505	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE W VENTRICULAR ASSIST DEVICE	This is no longer a valid code.	N/A
Q0506	LITH-ION BATT ELEC/PNEUM VAD	Pre-authorization is required for all providers.	Prior to 09/01/2019
Q0507	MISC SUPPLY/ACCESSORY USE W/EXT VAD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0508	MISC SUPPL/ACCSSRY USE W/IMPLANT VAD	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q0509	MIS SUP/AC IMP VAD NOPAY MED	No pre-authorization is required for all providers.	N/A
Q0510	PHARMACY SUPPLY FEE FOR INITIAL IMMUNOSUPPR DRUGS 1ST MO FOLLOW INPLANT	This service is not covered by Superior HealthPlan.	N/A
Q0511	PHARM SUP FEE /ORAL ANTI-CANCER ORAL ANTI-EMETIC OR IMMUNOSUP RX 1ST 30	This service is not covered by Superior HealthPlan.	N/A
Q0512	PHARM SUP FEE /ORAL ANTI-CANCER ORAL ANTI-EMETIC OR IMMUNOSUP RX NXT 30	This service is not covered by Superior HealthPlan.	N/A
Q0513	PHARMACY DISPENSING FEE FOR INHALATION DRUGS /30 DAYS	This service is not covered by Superior HealthPlan.	N/A
Q0514	PHARMACY DISPENSING FEE FOR INHALATION DRUGS /90 DAYS	This service is not covered by Superior HealthPlan.	N/A
Q0515	INJECTION SERMORELIN ACETATE 1 MICROGRAM	This service is not covered by Superior HealthPlan.	N/A
Q1001	NEW TECH IO LENS CAT 1-DEF FED REG	This is no longer a valid code.	N/A
Q1002	NEW TECH IO LENS CAT 2-FED REG	This is no longer a valid code.	N/A
Q1003	NEW TECHN INTRAOCULAR LENS CATEGORY 3 (REDUCED SPHERICAL ABERRATION)	This is no longer a valid code.	N/A
Q1004	NEW TECH INTRAOCULAR LENS CATEGORY 4	This service is not covered by Superior HealthPlan.	N/A
Q1005	NEW TEC INTRAOCULAR LENS CATEGORY 5	This service is not covered by Superior HealthPlan.	N/A
Q2001	ORAL CABERGOLINE 0.5 MG	No pre-authorization is required for all providers.	N/A

Q2002	INJ ELLIOTTS B SOLUTION P/ML	No pre-authorization is required for all providers.	N/A
Q2003	INJ APROTININ 10 000 KIU	No pre-authorization is required for all providers.	N/A
Q2004	IRRIG SOLN TX OF BLDR CALCULI 500ML	No pre-authorization is required for all providers.	N/A
Q2005	INJ CORTICORELIN OVINE TRIFLUTATE	No pre-authorization is required for all providers.	N/A
Q2006	INJ DIGOXIN IMMUNE FAB (OVINE) VIAL	No pre-authorization is required for all providers.	N/A
Q2007	INJ ETHANOLAMINE OLEATE 100 MG	No pre-authorization is required for all providers.	N/A
Q2008	INJ FOMEPIZOLE 1.5 MG	No pre-authorization is required for all providers.	N/A
Q2009	FOSPHENYTOIN INJ PE	This service is not covered by Superior HealthPlan.	N/A
Q2011	INJ HEMIN P/1 MG	No pre-authorization is required for all providers.	N/A
Q2012	INJ PEGADEMASE BOVINE 25 IU	No pre-authorization is required for all providers.	N/A
Q2013	INJ PENTASTARCH 10% SOL P/100 ML	No pre-authorization is required for all providers.	N/A
Q2014	INJ SERMORELIN ACETATE 0.5 MG	No pre-authorization is required for all providers.	N/A
Q2017	INJ TENIPOSIDE 50 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
Q2018	INJ UROFOLLITROPIN 75 IU	No pre-authorization is required for all providers.	N/A
Q2019	INJ BASILIXIMAB 20 MG	No pre-authorization is required for all providers.	N/A
Q2020	INJ HISTRELIN ACETATE 10 MG	No pre-authorization is required for all providers.	N/A
Q2021	INJ LEPIRUDIN 50 MG	No pre-authorization is required for all providers.	N/A
Q2022	VON WILLEBRAND FACTOR COMPLX HUMAN	No pre-authorization is required for all providers.	N/A
Q2026	RADIESSE INJECTION	Pre-authorization is required for all providers.	Prior to 09/01/2019
Q2027	SCULPTRA INJECTION	This is no longer a valid code.	N/A
Q2028	INJ, SCULPTRA, 0.5M	This service is not covered by Superior HealthPlan.	N/A
Q2033	INFLUENZA VACCINE, (FLUBLOK)	This is no longer a valid code.	N/A
Q2034	AGRIFLU VACCINE	This service is not covered by Superior HealthPlan.	N/A
Q2035	AFLURIA VACC, 3 YRS & >, IM	This service is not covered by Superior HealthPlan.	N/A
Q2036	FLULAVAL VACC, 3 YRS & >, IM	This service is not covered by Superior HealthPlan.	N/A
Q2037	FLUVIRIN VACC, 3 YRS & >, IM	This service is not covered by Superior HealthPlan.	N/A
Q2038	FLUZONE VACC, 3 YRS & >, IM	This service is not covered by Superior HealthPlan.	N/A
Q2039	INFLUENZA VIRUS VACCINE NOS	This service is not covered by Superior HealthPlan.	N/A
Q2040	TISAGENLEUCEL TO 250 M CAR-T C	This is no longer a valid code.	N/A
Q2041	KTE-C19 TO 200 M A ANTI-CD19 CAR POS T CE P TD	Pre-authorization required for all providers.	Prior to 09/01/2019
Q2042	TISAGENLEUCEL TO 600 M CAR-POS VI T CE PER TD	Pre-authorization required for all providers.	Prior to 09/01/2019
Q2043	SIPLEUCEL-T AUTO CD54+	This service is not covered by Superior HealthPlan.	N/A
Q2049	IMPORTED LIPODOX INJ	This service is not covered by Superior HealthPlan.	N/A
Q2050	DOXORUBICIN INJ 10MG	No pre-authorization is required for all providers.	N/A
Q2051	ZOLDEDRONIC ACID 1MG	This is no longer a valid code.	N/A
Q2052	SERVICE SUPP HOME MEDICARE IVIG DEM	This service is not covered by Superior HealthPlan.	N/A
Q3000	SUPPLY OF RADIOPHARMACEUTICAL DIAGN IMAGING AGENT RUBIDIUM RB-82 /DOSE	No pre-authorization is required for all providers.	N/A
Q3001	RADIOELEMENTS FOR BRACHYTHERAP	This service is not covered by Superior HealthPlan.	N/A
Q3002	SUP RDIA GALLIUM GA 67 P/MCI	No pre-authorization is required for all providers.	N/A
Q3003	SUP RD TECH TC99M BICISATE UNT DOS	No pre-authorization is required for all providers.	N/A
Q3004	SUP RDIA XENON XE 133 P/10 MCI	No pre-authorization is required for all providers.	N/A
Q3005	SUP RD TECH TC-99M MERTIATIDE P/MCI	No pre-authorization is required for all providers.	N/A
Q3006	SUP RD TECH TC 99M GLUCEPATATE 5MCI	No pre-authorization is required for all providers.	N/A
Q3007	SUP RDIA NA PHOSPHATE P32 P/MCI	No pre-authorization is required for all providers.	N/A
Q3008	SUP RDIA INDIUM 111-IN PENTETREOTID	No pre-authorization is required for all providers.	N/A
Q3009	SUP RD TECH TC-99M OXIDRONATE P/MCI	No pre-authorization is required for all providers.	N/A
Q3010	SUP RDIA TECH TC99M-LBLD RB CELLS	No pre-authorization is required for all providers.	N/A
Q3011	SUP RDIA CHROMIC PHOSPHATE P32 SUSP	No pre-authorization is required for all providers.	N/A
Q3012	ORL CYANOCOBALAMIN CBLT CO57 0.5MCI	No pre-authorization is required for all providers.	N/A
Q3014	TELEHEALTH ORIGINATING SITE FACILITY FEE	No pre-authorization is required for all providers.	N/A
Q3019	ALS vehicle Emerg trnsprt no ALS	This is no longer a valid code.	N/A
Q3020	ALS veh non-Emerg transport no ALS	This is no longer a valid code.	N/A
Q3025	INJ INTRFER BETA-1A 11 MCG IM USE	This is no longer a valid code.	N/A
Q3026	INJ INTRFER BETA-1A 11 MCGSUBQUSE	This is no longer a valid code.	N/A
Q3027	INJ BETA INTERFERON IM 1 MC	Pre-authorization is required for all providers.	Prior to 09/01/2019
Q3028	INJ BETA INTERFERON SQ 1 MC	Pre-authorization is required for all providers.	Prior to 09/01/2019
Q3031	COLLAGEN SKIN TEST	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
Q4001	CASTING SUPPLIES, BODY CAST ADULT, WITH OR WITHOUT HEAD, PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4002	CAST SUPPLIES, BODY CAST ADULT, WITH OR WITHOUT HEAD, FIBERGLASS	This service is not covered by Superior HealthPlan.	N/A
Q4003	CAST SUPPLIES, SHOULDER CAST, ADULT (11 YEARS +), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4004	CAST SUPPLIES, SHOULDER CAST, ADULT (11 YEARS +), FIBERGLASS	This service is not covered by Superior HealthPlan.	N/A
Q4005	CAST SUPPLIES, LONG ARM CAST, ADULT (11 YEARS +), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4006	CAST SUPPLIES, LONG ARM CAST, ADULT (11 YEARS +), FIBERGLASS	This service is not covered by Superior HealthPlan.	N/A
Q4007	CAST SUPPLIES, LONG ARM CAST, PEDIATRIC (0-10 YEARS), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4008	CAST SUPPLIES, LONG ARM CAST, PEDIATRIC (0-10 YEARS), FIBERGLASS	This service is not covered by Superior HealthPlan.	N/A
Q4009	CAST SUPPLIES, SHORT ARM CAST, ADULT (11 YEARS +), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4010	CAST SUPPLIES, SHORT ARM CAST, ADULT (11 YEARS+), FIBERGLASS	This service is not covered by Superior HealthPlan.	N/A
Q4011	CAST SUPPLIES, SHORT ARM CAST, PEDIATRIC (0-10 YEARS), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4012	CAST SUPPLIES, SHORT ARM CAST, PEDIATRIC (0-10 YEARS), FIBERGLASS	This service is not covered by Superior HealthPlan.	N/A
Q4013	CAST SUPPLIES, GAUNTLET CAST	This service is not covered by Superior HealthPlan.	N/A
Q4014	CAST SUPPLIES, GAUNTLET CAST	This service is not covered by Superior HealthPlan.	N/A
Q4015	CAST SUPPLIES, GAUNTLET CAST	This service is not covered by Superior HealthPlan.	N/A
Q4016	CAST SUPPLIES, GAUNTLET CAST	This service is not covered by Superior HealthPlan.	N/A
Q4017	CAST SUPPLIES, LONG ARM SPLINT, ADULT (11 YEARS +), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4018	CAST SUPPLIES, LONG ARM SPLINT, ADULT (11 YEARS +), FIBERGLASS	This service is not covered by Superior HealthPlan.	N/A
Q4019	CAST SUPPLIES, LONG ARM SPLINT, PEDIATRIC (0-10 YEARS), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4020	CAST SUPPLIES, LONG ARM SPLINT, PEDIATRIC (0-10 YEARS), FIBERGLASS	This service is not covered by Superior HealthPlan.	N/A
Q4021	CAST SUPPLIES, SHORT ARM SPLINT, ADULT (11 YEARS +), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4022	CAST SUPPLIES, SHORT ARM SPLINT, ADULT (11 YEARS +), FIBERGLASS	This service is not covered by Superior HealthPlan.	N/A
Q4023	CAST SUPPLIES, SHORT ARM SPLINT, PEDIATRIC (0-10 YEARS), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4024	CAST SUPPLIES, SHORT ARM SPLINT, PEDIATRIC (0-10 YEARS), FIBERGLASS	This service is not covered by Superior HealthPlan.	N/A
Q4025	CAST SUPPLIES, HIP SPICA (ONE OR BOTH LEGS), ADULT (11 YEARS +), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4026	CAST SUPPLIES, HIP SPICA	This service is not covered by Superior HealthPlan.	N/A
Q4027	CAST SUPPLIES, HIP SPICA	This service is not covered by Superior HealthPlan.	N/A
Q4028	CAST SUPPLIES, HIP SPICA	This service is not covered by Superior HealthPlan.	N/A
Q4029	CAST SUPPLIES, LONG LEG CAST, ADULT (11 YEARS +), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4030	CAST SUPPLIES, LONG LEG CAST, ADULT (11 YEARS +), FIBERGLASS	This service is not covered by Superior HealthPlan.	N/A
Q4031	CAST SUPPLIES, LONG LEG CAST, PEDIATRIC (0-10 YEARS), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4032	CAST SUPPLIES, LONG LEG CAST, PEDIATRIC (0-10 YEARS), FIBERGLASS	This service is not covered by Superior HealthPlan.	N/A
Q4033	CAST SUPPLIES, LONG LEG CYLINDER CAST, ADULT (11 YEARS +), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4034	CAST SUPPLIES, LONG LEG CYLINDER CAST, ADULT (11 YEARS +), FIBERGLASS	This service is not covered by Superior HealthPlan.	N/A
Q4035	CAST SUPPLIES, LONG LEG CYLINDER CAST, PEDIATRIC (0-10 YEARS), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4036	CAST SUPPLIES, LONG LEG CYLINDER CAST PEDIATRIC	This service is not covered by Superior HealthPlan.	N/A
Q4037	CAST SUPPLIES, SHORT LEG CAST, ADULT (11 YEARS +), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4038	CAST SUPPLIES, SHORT LEG CAST, ADULT (11+ YEARS), FIBERGLASS	This service is not covered by Superior HealthPlan.	N/A
Q4039	CAST SUPPLIES, SHORT LEG CAST, PEDIATRIC (0-10 YEARS), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4040	CAST SUPPLIES, SHORT LEG CAST, PEDIATRIC (0-10 YEARS), FIBERGLASS	This service is not covered by Superior HealthPlan.	N/A
Q4041	CAST SUPPLIES, LONG LEG SPLINT, ADULT (11 YEARS +), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4042	CAST SUPPLIES, LONG LEG SPLINT, ADULT (11 YEARS +), FIBERGLASS	This service is not covered by Superior HealthPlan.	N/A
Q4043	CAST SUPPLIES, LONG LEG SPLINT, PEDIATRIC (0-10 YEARS), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4044	CAST SUPPLIES, LONG LEG SPLINT, PEDIATRIC (0-10 YEARS), FIBERGLASS	This service is not covered by Superior HealthPlan.	N/A
Q4045	CAST SUPPLIES, SHORT LEG SPLINT, ADULT (11 YEARS +), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4046	CAST SUPPLIES, SHORT LEG SPLINT, ADULT (11 YEARS +), FIBERGLASS	This service is not covered by Superior HealthPlan.	N/A
Q4047	CAST SUPPLIES, SHORT LEG SPLINT, PEDIATRIC (0-10 YEARS), PLASTER	This service is not covered by Superior HealthPlan.	N/A
Q4048	CAST SUPPLIES, SHORT LEG SPLINT, PEDIATRIC (0-10 YEARS), FIBERGLASS	This service is not covered by Superior HealthPlan.	N/A
Q4049	FINGER SPLINT, STATIC	This service is not covered by Superior HealthPlan.	N/A
Q4050	CAST SUPPLIES, FOR UNLISTED TYPES AND MATERIALS OF CASTS	This service is not covered by Superior HealthPlan.	N/A
Q4051	SPLINT SUPPLIES MISC	This service is not covered by Superior HealthPlan.	N/A
Q4054	INJECTION, DARBEPOETIN ALFA, 1 MCG (FOR ESRD ON DIALYSIS)	This is no longer a valid code.	N/A
Q4055	INJECTION EPOETIN ALFA, 1000 UNITS (FOR ESRD ON DIALYSIS)	No pre-authorization is required for all providers.	N/A
Q4074	ILOPROST NON-COMP UNIT DOSE	This service is not covered by Superior HealthPlan.	N/A

Q4075	INJECTION, ACYCLOVIR, 5 MG	No pre-authorization is required for all providers.	N/A
Q4076	INJECTION, DOPAMINE HCl, 40 MG	No pre-authorization is required for all providers.	N/A
Q4077	INJECTION, TREPROSTINIL, 1 MG	No pre-authorization is required for all providers.	N/A
Q4080	ILOPROST NON-COMP UNIT DOSE	Pre-authorization is required for all providers.	Prior to 09/01/2019
Q4081	INJECTION, EPOETIN ALFA, 100 UNITS (FOR ESRD ON DIALYSIS)	Pre-authorization is required for all providers.	Prior to 09/01/2019
Q4082	DRUG OR BIOLOGICAL, NOT OTHW CLASS, PART B DRUG COMP ACQ PROG (CAP)	This service is not covered by Superior HealthPlan.	N/A
Q4083	HYALGAN/SUPARTZ INJ PER DOSE	This is no longer a valid code.	N/A
Q4096	VWF COMPLEX, NOT HUMATE-P	This is no longer a valid code.	N/A
Q4097	INJ IVIG PRIVIGEN 500 MG	This is no longer a valid code.	N/A
Q4098	INJ IRON DEXTRAN	This is no longer a valid code.	N/A
Q4099	FORMOTEROL FUMARATE, INH	This service is not covered by Superior HealthPlan.	N/A
Q4100	SKIN SUBSTITUTE NOS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q4101	APLIGRAF	No pre-authorization is required for all providers.	N/A
Q4102	OASIS WOUND MATRIX	No pre-authorization is required for all providers.	N/A
Q4103	OASIS BURN MATRIX	No pre-authorization is required for all providers.	N/A
Q4104	INTEGRA BMWD	No pre-authorization is required for all providers.	N/A
Q4105	INTGRA DRT/OMNIGR DERM RGN MTX P SC	No pre-authorization is required for all providers.	N/A
Q4106	DERMAGRAFT	No pre-authorization is required for all providers.	N/A
Q4107	GRAFTJACKET	No pre-authorization is required for all providers.	N/A
Q4108	INTEGRA MATRIX	No pre-authorization is required for all providers.	N/A
Q4109	TISSUEMEND SKIN SUB	No pre-authorization is required for all providers.	N/A
Q4110	PRIMATRIX	No pre-authorization is required for all providers.	N/A
Q4111	GAMMAGRAFT	Pre-authorization required for all providers.	Prior to 09/01/2019
Q4112	CYMETRA INJECTABLE	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
Q4113	GRAFTJACKET XPRESS	No pre-authorization is required for all providers.	N/A
Q4114	INTEGRA FLOWABLE WOUND MATRI	No pre-authorization is required for all providers.	N/A
Q4115	ALLOSKIN	No pre-authorization is required for all providers.	N/A
Q4116	ALLODERM	No pre-authorization is required for all providers.	N/A
Q4117	HYALOMATRIX	This service is not covered by Superior HealthPlan.	N/A
Q4118	MATRISTEM MICROMATRIX	This service is not covered by Superior HealthPlan.	N/A
Q4119	MATRISTEM WOUND MATRIX	This is no longer a valid code.	N/A
Q4120	MATRISTEM BURN MATRIX	This is no longer a valid code.	N/A
Q4121	THERASKIN	No pre-authorization is required for all providers.	N/A
Q4122	DERMACLL DERMACLL AWM/DERMACLL AWM POROUS P SC	No pre-authorization is required for all providers.	N/A
Q4123	ALLOSKIN	No pre-authorization is required for all providers.	N/A
Q4124	OASIS TRI-LAYER WOUND MATRIX	No pre-authorization is required for all providers.	N/A
Q4125	ARTHROFLEX	This service is not covered by Superior HealthPlan.	N/A
Q4126	MEMODERM/DERMA/TRANZ/INTEGUP	No pre-authorization is required for all providers.	N/A
Q4127	TALYMED	No pre-authorization is required for all providers.	N/A
Q4128	FLEXHD/ALLOPATCHHD/MATRIXHD	No pre-authorization is required for all providers.	N/A
Q4129	UNITE BIOMATRIX	This is no longer a valid code.	N/A
Q4130	STRATTICE TM	No pre-authorization is required for all providers.	N/A
Q4131	EPIFIX OR EPICORD PER SQ CM	This is no longer a valid code.	N/A
Q4132	GRAFIX CORE & GRAFIXPL CORE-SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4133	GRAFIX PRM GRAFIXPL PRM STRAVIX AND STRAVIXPL P SC	This service is not covered by Superior HealthPlan.	N/A
Q4134	HMATRIX	No pre-authorization is required for all providers.	N/A
Q4135	MEDISKIN	No pre-authorization is required for all providers.	N/A
Q4136	EZDERM	No pre-authorization is required for all providers.	N/A
Q4137	AMNIOEXCEL AMNIOEXCEL PLUS/BIODEXCEL PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4138	BIODFENCE DRYFLEX, 1C	No pre-authorization is required for all providers.	N/A
Q4139	AMNIO OR BIODMATRIX, INJ 1C	This service is not covered by Superior HealthPlan.	N/A
Q4140	BIODFENCE 1C	No pre-authorization is required for all providers.	N/A
Q4141	ALLOSKIN AC, 1 C	No pre-authorization is required for all providers.	N/A
Q4142	XCM BIOLOGIC TISS MATRIX 1C	No pre-authorization is required for all providers.	N/A
Q4143	REPRIZA, 1C	No pre-authorization is required for all providers.	N/A
Q4145	EPIFIX, INJ, 1M	This service is not covered by Superior HealthPlan.	N/A
Q4146	TENSIX, 1C	No pre-authorization is required for all providers.	N/A
Q4147	ARCHITECT ECM PX FX 1 SQ CM	No pre-authorization is required for all providers.	N/A
Q4148	NEOX CORD 1K-RT/CLARIX CORD 1K-SC	No pre-authorization is required for all providers.	N/A
Q4149	EXCELLAGEN, 0.1 C	No pre-authorization is required for all providers.	N/A
Q4150	ALLOWRAP DS OR DRY 1 SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4151	AMNIOBAND, GUARDIAN 1 SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4152	DERMAPURE 1 SQUARE CM	This service is not covered by Superior HealthPlan.	N/A
Q4153	DERMAVEST, PLURIVEST SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4154	BIOVANCE 1 SQUARE CM	This service is not covered by Superior HealthPlan.	N/A
Q4155	NEOXFLO OR CLARIFLO 1 MG	This service is not covered by Superior HealthPlan.	N/A
Q4156	NEOX 100 OR CLARIX 100-SQUARE CM	This service is not covered by Superior HealthPlan.	N/A
Q4157	REVITALON 1 SQUARE CM	This service is not covered by Superior HealthPlan.	N/A
Q4158	KERECIS OMEGA3 PER SQUARE CM	This service is not covered by Superior HealthPlan.	N/A
Q4159	AFFINITY1 SQUARE CM	This service is not covered by Superior HealthPlan.	N/A
Q4160	NUSHIELD 1 SQUARE CM	This service is not covered by Superior HealthPlan.	N/A
Q4161	BIO-CONNKT WOUND MATRIX PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4162	WOUNDEX FLOW BIOSKIN FLOW 0.5 CC	This service is not covered by Superior HealthPlan.	N/A
Q4163	WOUNDEX BIOSKIN PER SQUARE CM	This service is not covered by Superior HealthPlan.	N/A
Q4164	HELICOLL PER SQUARE CENTIMETER	This service is not covered by Superior HealthPlan.	N/A
Q4165	KERAMATRIX OR KERASORB PER SQ CM	No authorization required. Code is for informational purposes only.	N/A
Q4166	CYTAL PER SQUARE CENTIMETER	This service is not covered by Superior HealthPlan.	N/A
Q4167	TRUSKIN PER SQ CENTIMETER	This service is not covered by Superior HealthPlan.	N/A
Q4168	AMNIOBAND 1 MG	This service is not covered by Superior HealthPlan.	N/A
Q4169	ARTACENT WOUND PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4170	CYGNUS PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4171	INTERFYL 1 MG	This service is not covered by Superior HealthPlan.	N/A
Q4172	PURAPLY OR PURAPLY AM	This is no longer a valid code.	N/A
Q4173	PALINGEN OR PALINGEN XPLUS	This service is not covered by Superior HealthPlan.	N/A
Q4174	PALINGEN OR PROMATRX	This service is not covered by Superior HealthPlan.	N/A
Q4175	MIRODERM	This service is not covered by Superior HealthPlan.	N/A
Q4176	NEOPATCH OR THERION PER SQ CM	No pre-authorization is required for all providers.	N/A
Q4177	FLOWERAMNIOFLO 0.1 CC	No pre-authorization is required for all providers.	N/A
Q4178	FLOWERAMNIOPATCH PER SQUARE CM	No pre-authorization is required for all providers.	N/A
Q4179	FLOWERDERM PER SQUARE CM	No pre-authorization is required for all providers.	N/A
Q4180	REVITA PER SQUARE CM	No pre-authorization is required for all providers.	N/A
Q4181	AMNIO WOUND PER SQUARE CM	No pre-authorization is required for all providers.	N/A
Q4182	TRANSCYTE PER SQUARE CM	No pre-authorization is required for all providers.	N/A
Q4183	SURGIGRAFT PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4184	CELLESTA OR CELLESTA DUO PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4185	CELLESTA FLOWABLE AMNION PER 0.5 CC	This service is not covered by Superior HealthPlan.	N/A
Q4186	EPIFIX PER SQ CM	No pre-authorization is required for all providers.	N/A
Q4187	EPICORD PER SQ CM	No pre-authorization is required for all providers.	N/A
Q4188	AMNIOARMOR PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4189	ARTACENT AC 1 MG	This service is not covered by Superior HealthPlan.	N/A
Q4190	ARTACENT AC PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4191	RESTORIGIN PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4192	RESTORIGIN 1 CC	This service is not covered by Superior HealthPlan.	N/A
Q4193	COLL-E-DERM PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4194	NOVACHOR PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4195	PURAPLY PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4196	PURAPLY AM PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4197	PURAPLY XT PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4198	GENESIS AMNIOTIC MEMBRANE PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4200	SKINTE PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4201	MATRION PER SQ CM	This service is not covered by Superior HealthPlan.	N/A

Q4202	KEROXX (2.5G/CC) 1CC	This service is not covered by Superior HealthPlan.	N/A
Q4203	DERMA-GIDE PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4204	XWRAP PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4205	MEMBRANE GRAFT OR MEMBRANE WRAP PER SQ CM	No authorization required. Code is for informational purposes only.	N/A
Q4206	FLUID FLOW OR FLUID GF 1 CC	No authorization required. Code is for informational purposes only.	N/A
Q4208	NOVAFIX PER SQ CM	No authorization required. Code is for informational purposes only.	N/A
Q4209	SURGRAFT PER SQ CM	No authorization required. Code is for informational purposes only.	N/A
Q4210	AXOLOTL GRAFT OR AXOLOTL DUALGRAFT PER SQ CM	No authorization required. Code is for informational purposes only.	N/A
Q4211	AMNION BIO OR AXOBIO MEMBRANE PER SQ CM	No authorization required. Code is for informational purposes only.	N/A
Q4212	ALLOGEN PER CC	No authorization required. Code is for informational purposes only.	N/A
Q4213	ASCENT 0.5 MG	No authorization required. Code is for informational purposes only.	N/A
Q4214	CELLESTA CORD PER SQ CM	No authorization required. Code is for informational purposes only.	N/A
Q4215	AXOLOTL AMBIENT OR AXOLOTL CRYO 0.1 MG	No authorization required. Code is for informational purposes only.	N/A
Q4216	ARTACENT CORD PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4217	WNDFIX BIOWND WNDFIX+BIOWND+WNDFIX X+/X+ P SC	This service is not covered by Superior HealthPlan.	N/A
Q4218	SURGICORD PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4219	SURGIGRAFT-DUAL PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4220	BELLACELL HD OR SUREDERM PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4221	AMNIO WRAP2 PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4222	PROGENAMATRIX PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4226	MYOWN SKIN INCL HARVEST AND PREP PROC PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4227	AMNIOCORETM PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4228	BIONEXTPATCH PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4229	COGENEX AMNIOTIC MEMBRANE PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4230	COGENEX FLOWABLE AMNION PER 0.5 CC	This service is not covered by Superior HealthPlan.	N/A
Q4231	CORPLEX P PER CC	This service is not covered by Superior HealthPlan.	N/A
Q4232	CORPLEX PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4233	SURFACTOR OR NUDYN PER 0.5 CC	This service is not covered by Superior HealthPlan.	N/A
Q4234	XCELLERATE PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4235	AMNIOREPAIR OR ALTIPLY PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4236	CAREPATCH PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4237	CRYO-CORD PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4238	DERM-MAXX PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4239	AMNIO-MAXX OR AMNIO-MAXX LITE PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4240	CORECYTE FOR TOPICAL USE ONLY PER 0.5 CC	This service is not covered by Superior HealthPlan.	N/A
Q4241	POLYCYTE FOR TOPICAL USE ONLY PER 0.5 CC	This service is not covered by Superior HealthPlan.	N/A
Q4242	AMNIOCYTE PLUS PER 0.5 CC	This service is not covered by Superior HealthPlan.	N/A
Q4244	PROCENTA PER 200 MG	This service is not covered by Superior HealthPlan.	N/A
Q4245	AMNIOTEXT PER CC	This service is not covered by Superior HealthPlan.	N/A
Q4246	CORETEXT OR PROTEXT PER CC	No authorization required. Code is for informational purposes only.	N/A
Q4247	AMNIOTEXT PATCH PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q4248	DERMACYTE AMNIOTIC MEMBRANE ALLOGRAFT PER SQ CM	This service is not covered by Superior HealthPlan.	N/A
Q5001	HOSPICE OR HOME HLTH IN HOME	This service is not covered by Superior HealthPlan.	N/A
Q5002	HOSPICE/HOME HLTH IN ASST LVG	This service is not covered by Superior HealthPlan.	N/A
Q5003	HOSPICE CARE IN NURS Long-term CARE FAC (LTC) OR NON-SK NURS FAC (NF)	This service is not covered by Superior HealthPlan.	N/A
Q5004	HOSPICE CARE PROVIDED IN SKILLED NURSING FACILITY (SNF)	This service is not covered by Superior HealthPlan.	N/A
Q5005	HOSPICE CARE PROVIDED IN INPATIENT HOSPITAL	This service is not covered by Superior HealthPlan.	N/A
Q5006	HOSPICE CARE PROVIDED IN INPATIENT HOSPICE FACILITY	This service is not covered by Superior HealthPlan.	N/A
Q5007	HOSPICE CARE PROVIDED IN Long-term CARE FACILITY	This service is not covered by Superior HealthPlan.	N/A
Q5008	HOSPICE CARE PROVIDED IN INPATIENT PSYCHIATRIC FACILITY	This service is not covered by Superior HealthPlan.	N/A
Q5009	HOSPICE/HOME HLTH, PLACE NOS	This service is not covered by Superior HealthPlan.	N/A
Q5010	HOSPICE HOME CARE IN HOSPICE	This service is not covered by Superior HealthPlan.	N/A
Q5101	INJ FILGRASTIM BIOSIMILAR 1 MCG	No pre-authorization is required for all providers.	N/A
Q5102	INJECTION, INFILIXIMAB, BIOSIMILAR, 10 MG	This is no longer a valid code.	N/A
Q5103	INJECTION, INFLECTRA	Pre-authorization required for all providers.	Prior to 09/01/2019
Q5103	INJECTION, INFLECTRA	Pre-authorization required for all providers.	Prior to 09/01/2019
Q5104	INJECTION, RENFLEXIS	Pre-authorization required for all providers.	Prior to 09/01/2019
Q5104	INJECTION, RENFLEXIS	Pre-authorization is required for all providers.	Prior to 09/01/2019
Q5105	INJECTION EPOETIN ALFA-EPBX BIOSIMILAR 100 UNITS	No pre-authorization is required for all providers.	N/A
Q5106	INJECTION EPOETIN ALFA-EPBX BIOSIMILAR 1000 U	No pre-authorization is required for all providers.	N/A
Q5107	INJECTION BEVACIZUMAB-AWWB BIOSIMILAR 10 MG	No pre-authorization is required for all providers.	N/A
Q5108	INJ PEGFLGRSTM-JMDB BIOSIMILR 0.5 MG	No pre-authorization is required for all providers.	N/A
Q5109	INJECTION INFILIXIMAB-QBTX BIOSIMILAR 10 MG	This service is not covered by Superior HealthPlan.	N/A
Q5110	INJ FILGRASTIM-AAFI BIOSIMILR 1 MCG	No pre-authorization is required for all providers.	N/A
Q5111	INJECTION, PEGFILGRASTIM-CBQV, BIOSIMILAR, (UDENYCA), 0.5 MG	No pre-authorization is required for all providers.	N/A
Q5112	INJECTION TRASTUZUMAB-DTTB BIOSIMILAR 10 MG	This service is not covered by Superior HealthPlan.	N/A
Q5113	INJECTION TRASTUZUMAB-PKRB BIOSIMILAR 10 MG	No pre-authorization is required for all providers.	N/A
Q5114	INJECTION TRASTUZUMAB-DKST BIOSIMILAR 10 MG	No pre-authorization is required for all providers.	N/A
Q5115	INJECTION RITUXIMAB-ABBS BIOSIMILAR 10 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
Q5116	INJECTION TRASTUZUMAB-QYYP BIOSIMILAR 10 MG	No pre-authorization is required for all providers.	N/A
Q5117	INJECTION TRASTUZUMAB-ANNS BIOSIMILAR 10 MG	No pre-authorization is required for all providers.	N/A
Q5118	INJECTION BEVACIZUMAB-BVCR BIOSIMILAR 10 MG	No pre-authorization is required for all providers.	N/A
Q5119	INJ RITUXIMAB-PVVR BIOSIMILAR RUXIENICE 10 MG	Pre-authorization required for all providers.	Prior to 09/01/2019
Q5120	INJ PEGFILGRASTIM-BMEZ BIOSIMILR ZIEXTENZO 0.5 MG	No pre-authorization is required for all providers.	N/A
Q5121	INJ INFILIXIMAB-AXXQ BIOSIMILAR AVSOLA 10 MG	This service is not covered by Superior HealthPlan.	N/A
Q9941	INJECTION IMMUNE GLOBULIN INTRAVENOUS LYOPHILIZED 1G	No pre-authorization is required for all providers.	N/A
Q9942	INJECTION IMMUNE GLOBULIN INTRAVENOUS LYOPHILIZED 10 MG	No pre-authorization is required for all providers.	N/A
Q9943	INJECTION IMMUNE GLOBULIN INTRAVENOUS NON-LYOPHILIZED 1G	No pre-authorization is required for all providers.	N/A
Q9944	INJECTION IMMUNE GLOBULIN INTRAVENOUS NON-LYOPHILIZED 10 MG	No pre-authorization is required for all providers.	N/A
Q9945	LOW OSMOLAR CONTRAST MATERIAL UP TO 149 MG/ML IODINE CONCENTRATION /ML	No pre-authorization is required for all providers.	N/A
Q9946	LOW OSMOLAR CONTRAST MATERIAL 150-199 MG/ML IODINE CONCENTRATION /ML	No pre-authorization is required for all providers.	N/A
Q9947	LOW OSMOLAR CONTRAST MATERIAL 200-249 MG/ML IODINE CONCENTRATION /ML	No pre-authorization is required for all providers.	N/A
Q9948	LOW OSMOLAR CONTRAST MATERIAL 250-299 MG/ML IODINE CONCENTRATION /ML	No pre-authorization is required for all providers.	N/A
Q9949	LOW OSMOLAR CONTRAST MATERIAL 300-349 MG/ML IODINE CONCENTRATION /ML	No pre-authorization is required for all providers.	N/A
Q9950	INJ S HEXAFLUORIDE LIPID MSS PER ML	No pre-authorization is required for all providers.	N/A
Q9951	LOW OSMOLAR CONTRAST MATERIAL 400 OR GREATER MG/ML IODINE CONCENTR /ML	This service is not covered by Superior HealthPlan.	N/A
Q9952	INJECTION GADOLINIUM-BASED MAGNETIC RESONANCE CONTRAST AGENT /ML	No pre-authorization is required for all providers.	N/A
Q9953	INJECTION IRON-BASED MAGNETIC RESONANCE CONTRAST AGENT /ML	This service is not covered by Superior HealthPlan.	N/A
Q9954	ORAL MAGNETIC RESONANCE CONTRAST AGENT /100 ML	This service is not covered by Superior HealthPlan.	N/A
Q9955	INJECTION PERFLEXANE LIPID MICROSPHERES /ML	This service is not covered by Superior HealthPlan.	N/A
Q9956	INJECTION OCTAFLUOROPROPANE MICROSPHERES /ML	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q9957	INJECTION PERFLUTREN LIPID MICROSPHERES /ML	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Q9958	HIGH OSMOLAR CONTRAST MATERIAL UP TO 149 MG/ML IODINE CONCENTRATION /ML	This service is not covered by Superior HealthPlan.	N/A
Q9959	HIGH OSMOLAR CONTRAST MATERIAL 150-199 MG/ML IODINE CONCENTRATION /ML	This service is not covered by Superior HealthPlan.	N/A
Q9960	HIGH OSMOLAR CONTRAST MATERIAL 200-249 MG/ML IODINE CONCENTRATION /ML	This service is not covered by Superior HealthPlan.	N/A
Q9961	HIGH OSMOLAR CONTRAST MATERIAL 250-299 MG/ML IODINE CONCENTRATION /ML	This service is not covered by Superior HealthPlan.	N/A
Q9962	HIGH OSMOLAR CONTRAST MATERIAL 300-349 MG/ML IODINE CONCENTRATION /ML	This service is not covered by Superior HealthPlan.	N/A
Q9963	HIGH OSMOLAR CONTRAST MATERIAL 350-399 MG/ML IODINE CONCENTRATION /ML	This service is not covered by Superior HealthPlan.	N/A
Q9964	HIGH OSMOLAR CONTRAST MATERIAL 400 OR > MG/ML IODINE CONCENTRATION /ML	This service is not covered by Superior HealthPlan.	N/A
Q9965	LOCM 100-199MG/ML IODINE 1ML	This service is not covered by Superior HealthPlan.	N/A
Q9966	LOCM 200-299MG/ML IODINE 1ML	This service is not covered by Superior HealthPlan.	N/A
Q9967	LOCM 300-399MG/ML IODINE 1ML	This service is not covered by Superior HealthPlan.	N/A
Q9968	VISUALIZATION ADJUNCT	This service is not covered by Superior HealthPlan.	N/A
Q9969	NON-HEU TC-99M ADD-ON/DOSE	This service is not covered by Superior HealthPlan.	N/A
Q9970	INJ FERRIC CARBOXYMALTOS 1MG	This is no longer a valid code.	N/A
Q9972	INJ EPO 1 MCG ESRD ON DIALYSI	This is no longer a valid code.	N/A
Q9973	INJ EPOETIN BETA 1 MCG NON-ESRD US	This is no longer a valid code.	N/A
Q9974	MORPHINE EPIDURAL/INTRATHECA	This is no longer a valid code.	N/A
Q9975	INJ FACTR VIII FC FUSN PROTIN PER IU	This is no longer a valid code.	N/A
Q9976	INJ FERRIC PYROPHOSPHATE CIT	This is no longer a valid code.	N/A
Q9977	COMPOUNDED DRUG NOC	This is no longer a valid code.	N/A

Q9978	NETUPITANT PALONOSETRON ORAL	This is no longer a valid code.	N/A
Q9979	INJECTION, ALEMTUZUMAB, 1 MG	This is no longer a valid code.	N/A
Q9980	HYLAN/DER GENVISC 850 FOR IA INJ	This is no longer a valid code.	N/A
Q9981	ROLAPITANT, ORAL, 1 MG	This is no longer a valid code.	N/A
Q9982	FLUTEMETAMOL F18 DIAGNOSTIC	This service is not covered by Superior HealthPlan.	N/A
Q9983	FLORBETABEN F18 DIAGNOSTIC	This service is not covered by Superior HealthPlan.	N/A
Q9984	KYLEENA	This is no longer a valid code.	N/A
Q9985	INJ, HYDROXYPROGESTERONE, NOS	This is no longer a valid code.	N/A
Q9986	INJ, MAKENA	This is no longer a valid code.	N/A
Q9987	PATHOGEN TEST FOR PLATELETS	This is no longer a valid code.	N/A
Q9988	PLATELETS PHERES PATH RDUC EA UNIT	This is no longer a valid code.	N/A
Q9989	USTEKINUMAB IV INJ, 1 MG	This is no longer a valid code.	N/A
Q9991	BUPRENORPH XR 100 MG OR LESS	Pre-authorization is required for all providers.	Prior to 09/01/2019
Q9992	BUPRENORPHINE XR OVER 100 MG	Pre-authorization is required for all providers.	Prior to 09/01/2019
Q9993	INJ TRIAMCINOLONE EXT REL	This is no longer a valid code.	N/A
Q9994	ENZYME CARTRIDGE ENTERAL NUT	This is no longer a valid code.	N/A
Q9995	INJ EMICIZUMAB-KXWH, 0.5 MG	This is no longer a valid code.	N/A
R0189	#N/A	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
S0012	BUTORPHANOL TARTRATE NAS SPRAY 25MG	This service is not covered by Superior HealthPlan.	N/A
S0014	TACRINE HYDROCHLORIDE 10 MG	This service is not covered by Superior HealthPlan.	N/A
S0017	INJ AMINOCAPROIC ACID 5 GMS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S0020	INJ BUPIVICAINE HYDROCHLORIDE 30 ML	No pre-authorization is required for all providers.	N/A
S0021	INJ CEFTOPERAZONE NA 1 GM	This service is not covered by Superior HealthPlan.	N/A
S0023	INJ CIMETIDINE HYDROCHLORIDE 300 MG	No pre-authorization is required for all providers.	N/A
S0028	INJ FAMOTIDINE 20 MG	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S0030	INJ METRONIDAZOLE 500 MG	This service is not covered by Superior HealthPlan.	N/A
S0032	INJ NAFACILLIN NA 2 GMS	This service is not covered by Superior HealthPlan.	N/A
S0034	INJ OFLOXACIN 400 MG	This service is not covered by Superior HealthPlan.	N/A
S0039	INJ SULFAMETHOXAZOLE/TRIMETHOPRIM	This service is not covered by Superior HealthPlan.	N/A
S0040	INJ TICARCILLIN/CLAVULANATE 3.1 GM	This service is not covered by Superior HealthPlan.	N/A
S0071	INJ ACYCLOVIR NA 50 MG	No pre-authorization is required for all providers.	N/A
S0072	INJ AMIKACIN SULFATE 100 MG	No pre-authorization is required for all providers.	N/A
S0073	INJ AZTREONAM 500 MG	This service is not covered by Superior HealthPlan.	N/A
S0074	INJ CEFOTETAN DINA 500 MG	This service is not covered by Superior HealthPlan.	N/A
S0077	INJ CLINDAMYCIN PHOSPHATE 300 MG	This service is not covered by Superior HealthPlan.	N/A
S0078	INJ FOSPHENYTOIN NA 750 MG	This service is not covered by Superior HealthPlan.	N/A
S0080	INJ PENTAMIDINE ISETHIONATE 300 MG	No pre-authorization is required for all providers.	N/A
S0081	INJ PIPERACILLIN NA 500 MG	This service is not covered by Superior HealthPlan.	N/A
S0088	IMATINIB, 100 MG	This service is not covered by Superior HealthPlan.	N/A
S0090	SILDENAFIL CITRATE 25 MG	This service is not covered by Superior HealthPlan.	N/A
S0091	GRANISETRON HYDROCHLORIDE, 1 MG	This service is not covered by Superior HealthPlan.	N/A
S0092	INJ HYDMORPHONE HYDROCHLORID 250 MG	This service is not covered by Superior HealthPlan.	N/A
S0093	INJECTION MORPHINE SULFATE 500 MG .	This service is not covered by Superior HealthPlan.	N/A
S0104	ZIDOVUDINE, ORAL, 100 MG	This service is not covered by Superior HealthPlan.	N/A
S0106	BUPROPION HCI SR TAB 150 MG 60 TABS	This service is not covered by Superior HealthPlan.	N/A
S0108	MERCAPTOPURINE ORAL 50 MG	This service is not covered by Superior HealthPlan.	N/A
S0109	METHADONE ORAL 5MG	This service is not covered by Superior HealthPlan.	N/A
S0114	INJECTION TREPROSTINIL SODIUM 05 MG	No pre-authorization is required for all providers.	N/A
S0116	BEVACIZUMAB 100 MG	This is no longer a valid code.	N/A
S0117	TRETINOIN TOPICAL 5 GRAMS	This service is not covered by Superior HealthPlan.	N/A
S0118	INJECTION ZICONOTIDE FOR INTRATHECAL INFUSION 1 MCG	No pre-authorization is required for all providers.	N/A
S0119	ONDANSETRON 4 MG	This service is not covered by Superior HealthPlan.	N/A
S0122	INJECTION MENOTROPINS 75 IU	This service is not covered by Superior HealthPlan.	N/A
S0126	INJECTION FOLLITROPIN ALFA 75 IU	This service is not covered by Superior HealthPlan.	N/A
S0128	INJECTION FOLLITROPIN BETA 75 IU	This service is not covered by Superior HealthPlan.	N/A
S0132	INJECTION GANIRELIX ACETATE 250 MCG	This service is not covered by Superior HealthPlan.	N/A
S0133	HISTRELIN IMPLANT 50 MG	This is no longer a valid code.	N/A
S0135	INJECTION, PEGFILGRASTIM, 6 MG	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S0136	CLOZPINE, 25 MG	This service is not covered by Superior HealthPlan.	N/A
S0137	DIDANOSINE (DDI), 25 MG	No pre-authorization is required for all providers.	N/A
S0138	FINASTERIDE, 5 MG	No pre-authorization is required for all providers.	N/A
S0139	MINOXIDIL, 10 MG	This service is not covered by Superior HealthPlan.	N/A
S0140	SAQUINAVIR, 200 MG	This service is not covered by Superior HealthPlan.	N/A
S0142	COLISTIMETHATE SODIUM INHAL SOLUTION ADMIN THROUGH DME CONCENTR FORM /MG	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S0143	AZTREONAM INHALATION SOLUTION ADMIN THROUGH DME CONCENTRATED FORM /GRAM	This is no longer a valid code.	N/A
S0144	INJ, PROPOFOL, 10MG	This is no longer a valid code.	N/A
S0145	INJECTION PEGYLATED INTERFERON ALFA-2A 180 MCG /ML	Pre-authorization is required for all providers.	Prior to 09/01/2019
S0146	INJECTION PEGYLATED INTERFERON ALFA-2B 10 MCG /0.5 ML	This is no longer a valid code.	N/A
S0148	PEG INTERFERON ALFA-2B/10	Pre-authorization is required for all providers.	Prior to 09/01/2019
S0155	STERILE DILUTANT FOR EPOPROSTENOL, 50ML	This service is not covered by Superior HealthPlan.	N/A
S0156	EXEMESTANE 25 MG	This service is not covered by Superior HealthPlan.	N/A
S0157	BECAPLERMIN GEL 0.01% 0.5 GM	This service is not covered by Superior HealthPlan.	N/A
S0160	DEXTROAMPHETAMINE SULFATE 5 MG	This service is not covered by Superior HealthPlan.	N/A
S0162	INJECTION EFALIZUMAB 125 MG	This is no longer a valid code.	N/A
S0164	INJECTION PANTOPRAZOLE SODIUM 40 MG	No pre-authorization is required for all providers.	N/A
S0166	INJECTION OLANZAPINE 2.5 MG	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S0168	INJECTION AZACITIDINE 100 MG	No pre-authorization is required for all providers.	N/A
S0169	CALCITROL	This service is not covered by Superior HealthPlan.	N/A
S0170	ANASTROZOLE, ORAL, 1MG	This service is not covered by Superior HealthPlan.	N/A
S0171	INJECTION, BUMETANIDE, 0.5MG	This service is not covered by Superior HealthPlan.	N/A
S0172	CHLORAMBUCIL, ORAL, 2MG	This service is not covered by Superior HealthPlan.	N/A
S0173	DEXAMETHASONE, ORAL, 4MG	No pre-authorization is required for all providers.	N/A
S0174	DOLASETRON MESYLATE	This service is not covered by Superior HealthPlan.	N/A
S0175	FLUTAMIDE, ORAL, 125MG	This service is not covered by Superior HealthPlan.	N/A
S0176	HYDROXYUREA, ORAL, 500MG	This service is not covered by Superior HealthPlan.	N/A
S0177	LEVAMISOLE HYDROCHLORIDE, ORAL, 50MG	This service is not covered by Superior HealthPlan.	N/A
S0178	LOMUSTINE, ORAL, 10MG	This service is not covered by Superior HealthPlan.	N/A
S0179	MEGESTROL ACETATE, ORAL, 20MG	This service is not covered by Superior HealthPlan.	N/A
S0180	ETONOGESTREL IMPLANT SYSTEM	This service is not covered by Superior HealthPlan.	N/A
S0182	PROCARBAZINE, ORAL	This service is not covered by Superior HealthPlan.	N/A
S0183	PROCHLORPERAZINE 5 MG	This service is not covered by Superior HealthPlan.	N/A
S0187	TAMOXIFEN CITRATE, ORAL, 10MG	No pre-authorization is required for all providers.	N/A
S0189	TESTOSTERONE PELLETT, 75MG	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S0190	MIFEPRISTONE ORAL 200 MG	This service is not covered by Superior HealthPlan.	N/A
S0191	MISOPROSTOL ORAL 200 MCG	This service is not covered by Superior HealthPlan.	N/A
S0194	DIALYSIS/STRESS VITAMIN SUPPL ORAL 100 CAPSULES	This service is not covered by Superior HealthPlan.	N/A
S0195	PNEUMOCOCC VAC IM 5-9 YR NOT PREV	This is no longer a valid code.	N/A
S0197	PRENATAL VITAMINS 30-DAY SUPPLY	This service is not covered by Superior HealthPlan.	N/A
S0198	INJECTION PEGAPTANIB SODIUM 0.3 MG	This is no longer a valid code.	N/A
S0199	MED INDUCED ABORTION BY ORAL INGEST OF MEDS INCL ALL ASSOC SVC & SUPPL	This service is not covered by Superior HealthPlan.	N/A
S0201	PART HOSPITALZTION SRVC <24 HR-DIEM	This service is not covered by Superior HealthPlan.	N/A
S0207	PARAMEDIC INTERCEPT NON-HOSP ALS	This service is not covered by Superior HealthPlan.	N/A
S0208	PARAMEDIC INTERCEPT HOSPITAL BASED ALS SERVICE	This service is not covered by Superior HealthPlan.	N/A
S0209	WHEELCHAIR VAN, MILEAGE, PER MILE	This service is not covered by Superior HealthPlan.	N/A
S0215	NON-EMERG TRANSPORTATION; PER MILE	This service is not covered by Superior HealthPlan.	N/A
S0220	MED CONF W/PT PROF TM/AGTS 30MIN	This service is not covered by Superior HealthPlan.	N/A
S0221	MED CONF W/PT PROF TM/AGTS 60MIN	This service is not covered by Superior HealthPlan.	N/A
S0250	COMPREHENSIVE GERIATRIC ASSESSMENT	This service is not covered by Superior HealthPlan.	N/A
S0255	HOSPICE REFERRAL VISIT	This service is not covered by Superior HealthPlan.	N/A
S0257	CNSL&DISCUSS ADV DIRCTV/EOL CARE PT&SURROGATE	This service is not covered by Superior HealthPlan.	N/A
S0260	HISTORY AND PHYSICAL OUTPATIENT	This service is not covered by Superior HealthPlan.	N/A

S0265	GENETIC COUNSELING UNDER PHYSICIAN SUPERVISION EACH 15 MINUTES	This service is not covered by Superior HealthPlan.	N/A
S0270	HOME STD CASE RATE 30 DAYS	This service is not covered by Superior HealthPlan.	N/A
S0271	HOME HOSPICE CASE 30 DAYS	This service is not covered by Superior HealthPlan.	N/A
S0272	HOME EPISODIC CASE 30 DAYS	This service is not covered by Superior HealthPlan.	N/A
S0273	MD HOME VISIT OUTSIDE CAP	This service is not covered by Superior HealthPlan.	N/A
S0274	NURSE PRACTR VISIT OUTS CAP	This service is not covered by Superior HealthPlan.	N/A
S0280	MEDICAL HOME, INITIAL PLAN	This service is not covered by Superior HealthPlan.	N/A
S0281	MEDICAL HOME, MAINTENANCE	This service is not covered by Superior HealthPlan.	N/A
S0285	CNSLT BEFORE SCREEN COLONOSCOPY	This service is not covered by Superior HealthPlan.	N/A
S0302	COMPLETED EARLY PERIODIC SCREENING DX AND TREATMENT	This service is not covered by Superior HealthPlan.	N/A
S0310	HOSPITALIST SERVICES	This service is not covered by Superior HealthPlan.	N/A
S0311	COMP MGMT CARE COORD ADV ILL	This service is not covered by Superior HealthPlan.	N/A
S0315	DZ MGMT PROG; INIT ASSESS&INIT PROG	This service is not covered by Superior HealthPlan.	N/A
S0316	DISEASE MANAGEMENT PROGRAM, FOLLOW UP/ ASSESSMENT	This service is not covered by Superior HealthPlan.	N/A
S0317	DISEASE MANAGEMENT PROGRAM, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S0320	TEL CALL BY RN DZ MGMT PROG;-MONTH	This service is not covered by Superior HealthPlan.	N/A
S0340	LIFESTYLE MODIFICATION PROGRAM	This service is not covered by Superior HealthPlan.	N/A
S0341	LIFESTYLE MODIFICATION PROGRAM	This service is not covered by Superior HealthPlan.	N/A
S0342	LIFESTYLE MODIFICATION PROGRAM	This service is not covered by Superior HealthPlan.	N/A
S0353	CANCER TREATMENT PLAN INITIAL	This service is not covered by Superior HealthPlan.	N/A
S0354	CANCER TREATMENT PLAN CHANGE	This service is not covered by Superior HealthPlan.	N/A
S0390	ROUTINE FOOT CARE; PER VISIT	This service is not covered by Superior HealthPlan.	N/A
S0395	IMPRESSION CASTING OF A FOOT	This service is not covered by Superior HealthPlan.	N/A
S0400	GLOBAL FEE FOR EXTRACORPORAL SHOCKWAVE	This service is not covered by Superior HealthPlan.	N/A
S0500	DISPOSABLE CONTACT LENS, PER LENS	This service is not covered by Superior HealthPlan.	N/A
S0504	SINGLE VISION PRESCRIPTION LENS	This service is not covered by Superior HealthPlan.	N/A
S0506	BIFOCAL VISION PRESCRIPTION LENS	This service is not covered by Superior HealthPlan.	N/A
S0508	TRIFOCAL VISION PRESCRIPTION LENS	This service is not covered by Superior HealthPlan.	N/A
S0510	NON-PRESCRIPTION LENS (SAFETY, ATHLETIC, OR SUNGLASS), PER LENS	This service is not covered by Superior HealthPlan.	N/A
S0512	DAILY WEAR SPECIALTY CONTACT LENS, PER LENS	This service is not covered by Superior HealthPlan.	N/A
S0514	COLOR CONTACT LENS, PER LENS	This service is not covered by Superior HealthPlan.	N/A
S0515	SCLERAL LENS LIQUID BANDAGE DEVICE PER LENS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S0516	SAFETY EYEGLASS FRAMES	This service is not covered by Superior HealthPlan.	N/A
S0518	SUNGLASSES FRAMES	This service is not covered by Superior HealthPlan.	N/A
S0580	POLYCARBONATE LENS	This service is not covered by Superior HealthPlan.	N/A
S0581	NONSTANDARD LENS	This service is not covered by Superior HealthPlan.	N/A
S0590	INTEGRAL LENS	This service is not covered by Superior HealthPlan.	N/A
S0592	COMPREHENSIVE CONTACT LENS EVALUATION	This service is not covered by Superior HealthPlan.	N/A
S0595	DISPENSING NEW SPECTACLE LENSES FOR PATIENT SUPPLIED FRAME	This service is not covered by Superior HealthPlan.	N/A
S0596	PHAKIC IOL REFRACTIVE ERROR	This service is not covered by Superior HealthPlan.	N/A
S0601	SCRN PROCTOSCOPY	This service is not covered by Superior HealthPlan.	N/A
S0610	ANNUAL GYNE EXAM NEW PT	This service is not covered by Superior HealthPlan.	N/A
S0612	ANNUAL GYNE EXAM ESTAB PT	This service is not covered by Superior HealthPlan.	N/A
S0613	ANNUAL GYNECOLOGICAL EXAM CLINICAL BREAST EXAM WOUT PELVIC EVAL	This service is not covered by Superior HealthPlan.	N/A
S0618	AUDIOMETRY FOR HEARING AID EVALUATION	This service is not covered by Superior HealthPlan.	N/A
S0620	ROUT OPHTH EXAM INCLU REFRAC NEW PT	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
S0621	ROUT OPHTH EXAM INCLU REFRAC EST PT	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
S0622	PHYSICAL EXAM FOR COLLEGE	This service is not covered by Superior HealthPlan.	N/A
S0630	SUT REMOV BY OTH PHYS	This service is not covered by Superior HealthPlan.	N/A
S0800	LASER IN SITU KERATOMILEUSIS (LASIK)	This service is not covered by Superior HealthPlan.	N/A
S0810	PHOTOREFRAC KERATECTOMY (PRK)	This service is not covered by Superior HealthPlan.	N/A
S0812	PHOTOTHERAPEUTIC KERATECTOMY (PTK)	This service is not covered by Superior HealthPlan.	N/A
S0830	US PACHYMETRY CORNEAL THK W/INT/RPT	This is no longer a valid code.	N/A
S1001	DELUXE ITEM, PATIENT AWARE (LIST IN ADDITION TO CODE FOR BASIC ITEM)	This service is not covered by Superior HealthPlan.	N/A
S1002	CUSTOMIZED ITEM (LIST IN ADDITION TO CODE FOR BASIC ITEM)	This service is not covered by Superior HealthPlan.	N/A
S1015	IV TUBING EXTEN SET	No pre-authorization is required for all providers.	N/A
S1016	NON-PVC IV ADMIN SET	This service is not covered by Superior HealthPlan.	N/A
S1030	CONTINUOUS NONINVASIV GLUCOSE MONITORING DEVICE	This service is not covered by Superior HealthPlan.	N/A
S1031	CONTINUOUS NONINVASIVE GLUCOSE MONITORING	This service is not covered by Superior HealthPlan.	N/A
S1034	ART PANCREAS SYSTEM	This service is not covered by Superior HealthPlan.	N/A
S1035	ART PANCREAS INV DISP SENSOR	This service is not covered by Superior HealthPlan.	N/A
S1036	ART PANCREAS EXT TRANSMITTER	This service is not covered by Superior HealthPlan.	N/A
S1037	ART PANCREAS EXT RECEIVER	This service is not covered by Superior HealthPlan.	N/A
S1040	CRANIAL REMOULding ORTHO, PEDS, RIGID W SOFT INTERFACE MAT, CUSTOM FABR	Pre-authorization required for all providers.	Prior to 09/01/2019
S1090	MOMETASONE SINUS IMPLANT	This service is not covered by Superior HealthPlan.	N/A
S2053	TRANSPL/SMALL INTEST/LIVER ALLOGFTS	Pre-authorization is required for all providers.	Prior to 09/01/2019
S2054	TRANSPL OF MULTIVIS ORGANS	This service is not covered by Superior HealthPlan.	N/A
S2055	HARV DON MULTIVIS ORG/ALOGFTS CADAV	This service is not covered by Superior HealthPlan.	N/A
S2060	LOBAR LUNG TRANSPL	This service is not covered by Superior HealthPlan.	N/A
S2061	DONOR LOBEC/LUNG TRANS LIVING DONOR	This service is not covered by Superior HealthPlan.	N/A
S2065	SIMULTANEOUS PANCREAS KIDNEY TRANSPLANTATION	This service is not covered by Superior HealthPlan.	N/A
S2066	BRST RECON W GLUTEAL ARTERY PERF FLAP INCL HARVEST FLAP MICRO VASC TRANS	This service is not covered by Superior HealthPlan.	N/A
S2067	BRST RECN W GLUTEAL ARTRY PERF FLP INCL HRVST FLP MICRO TRNS OF DNR SITE	This service is not covered by Superior HealthPlan.	N/A
S2068	BREAST DIEP OR SIEA FLAP	Pre-authorization is required in an office, inpatient, outpatient and ambulatory surgical center locations.	Prior to 09/01/2019
S2070	CYSTOURETHROSCOPY/W URETEROSCOPY &/OR PYELOSOCOPY/W ENDSOCP LSR	This service is not covered by Superior HealthPlan.	N/A
S2075	LAPAROSCOPY SURGICAL REPAIR INCISIONAL OR VENTRAL HERNIA	This is no longer a valid code.	N/A
S2076	LAPAROSCOPY SURGICAL REPAIR UMBILICAL HERNIA	No pre-authorization is required for all providers.	N/A
S2077	LAP SURG IMPLANT OF MESH /OTH PROSTH FOR INCISIONAL /VENTR HERNIA REP	No pre-authorization is required for all providers.	N/A
S2079	LAPAROSCOPIC ESOPHAGOMYOTOMY HELLER TYPE	No pre-authorization is required for all providers.	N/A
S2080	LASER-ASSISTED UVULOPALATOPLASTY (LAUP)	This service is not covered by Superior HealthPlan.	N/A
S2082	LAP SURG; ADJ GASTRIC BAND INCL PLCMT SUBQ PORT	No pre-authorization is required for all providers.	N/A
S2083	ADJ GASTRIC BAND DIAM SUBQ PORT INJ/ASPIR SALINE	This service is not covered by Superior HealthPlan.	N/A
S2090	ABLATION, OPEN, ONE OR MORE RENAL TUMOR(S), CRYOSURGICAL	No pre-authorization is required for all providers.	N/A
S2091	ABLATION, PERCUTANIOUS, ONE OR MORE RENAL TUMOR(S), CRYOSURGICAL	No pre-authorization is required for all providers.	N/A
S2095	TRANSCATHETER OCCLUSION OR EMBOLIZATION/TUMOR DESTR/PERCUTANEOUS	No pre-authorization is required for all providers.	N/A
S2102	ISLET CELL TISS TRANSPL - PANCREAS	This service is not covered by Superior HealthPlan.	N/A
S2103	ADRENAL TISS TRANSPL TO BRAIN	This service is not covered by Superior HealthPlan.	N/A
S2107	ADOPTIVE IMMUNOTX COURSE TREATMENT	This service is not covered by Superior HealthPlan.	N/A
S2112	ARTHROSCOPY KNEE	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
S2115	OSTEOTOMY, PERIACETABULAR, WITH INTERNAL FIXATION	This service is not covered by Superior HealthPlan.	N/A
S2117	ARTHROEREISIS SUBTALAR	This service is not covered by Superior HealthPlan.	N/A
S2118	TOTAL HIP RESURFACING	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
S2120	LDL APHERESIS HEP-IND EXTRACORP LDL	This service is not covered by Superior HealthPlan.	N/A
S2135	NEUROLYSIS/INJ/METATARSAL NEUROMA/INTERDIGITAL NEURITIS	This is no longer a valid code.	N/A
S2140	CORD BLD HARVESTNG TRANS ALLOGENEIC	This service is not covered by Superior HealthPlan.	N/A
S2142	CORD BLD-DERIVED STEM-CELL TRANSPL	Pre-authorization is required for all providers.	Prior to 09/01/2019
S2150	BONE MARROW/BLOOD-DERIVED PERIPHERAL STEM CELL HARVESTING&TRNSPLNTN	This service is not covered by Superior HealthPlan.	N/A
S2152	SOLID ORGAN; TRANSPLANTATION & RELATED COMP	This service is not covered by Superior HealthPlan.	N/A
S2202	ECHOSCLEROTHAP	No pre-authorization is required for all providers.	N/A
S2205	MIN INVAS DIR CA BYPASS/1 CA GFT	This service is not covered by Superior HealthPlan.	N/A
S2206	MIN INVAS DIR CA BYPASS/2 CA GFTS	This service is not covered by Superior HealthPlan.	N/A
S2207	MIN INVAS DIR CA BYPAS/1 CV GFT	This service is not covered by Superior HealthPlan.	N/A
S2208	MIN INVAS DIR CA BYPAS/1 AV GFT	This service is not covered by Superior HealthPlan.	N/A
S2209	MIN INVAS DIR CA BYPAS/2 AV GFT	This service is not covered by Superior HealthPlan.	N/A
S2215	UGI ENDO; INJ IMPL MATL LW ESOPH SPHNCTR TX GERD	No pre-authorization is required for all providers.	N/A
S2225	MYRINGOTOMY, LASER-ASSISTED	No pre-authorization is required for all providers.	N/A
S2230	IMPLNTTN/MAGNETIC CMPNNT/SEMI-IMPLANTABLE HEARING DVC	This service is not covered by Superior HealthPlan.	N/A
S2235	IMPLANTATION OF AUDITORY BRAIN STEM IMPLANT	No pre-authorization is required for all providers.	N/A
S2260	INDUCED ABORTION, 17 TO 24 WEEKS	This service is not covered by Superior HealthPlan.	N/A
S2262	AB MATERNAL INDICATION 25 WEEKS/GT	No pre-authorization is required for all providers.	N/A
S2265	INDUCED ABORTION, 25 TO 28 WEEKS	This service is not covered by Superior HealthPlan.	N/A

S2266	INDUCED ABORTION, 29 TO 31 WEEKS	This service is not covered by Superior HealthPlan.	N/A
S2267	INDUCED ABORTION, 32 WEEKS OR GREATER	This service is not covered by Superior HealthPlan.	N/A
S2300	ARTHSCLPY SHLDR W/THERM-INDUC CAPSUL	This service is not covered by Superior HealthPlan.	N/A
S2325	HIP CORE DECOMPRESSION	No pre-authorization is required for all providers.	N/A
S2340	CHEMODENERVTN-ABDCTR MUSC/VOCAL CRD	This service is not covered by Superior HealthPlan.	N/A
S2341	CHEMODENERVATION OF ADDUCTOR MUSCLE(S) OF VOCAL CORD	This service is not covered by Superior HealthPlan.	N/A
S2342	NASAL ENDOSCOPY FOR POST OPERATIVE DEBRIMENT	This service is not covered by Superior HealthPlan.	N/A
S2348	DECOMP PERQ INTERVERT DISC RF ENERGY 1/MX LUMB	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
S2350	DISK ANT W/DECOMPRES SPINAL CORD/1	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
S2351	DISK ANT DECPRES SPINE CORD EA/ADD	If the code is related to Musculoskeletal, please contact TurningPoint, otherwise contact Superior HealthPlan.	11/01/2019
S2360	PERCUTANEOUS VERTEBROPLASTY	This is no longer a valid code.	N/A
S2361	EACH ADDITIONAL CERVICAL VERTEBRAL BODY	This is no longer a valid code.	N/A
S2362	KYPHOPLASTY, ONE VERTEBRAL BODY, UNILATERAL OR BILATERAL INJECTION	This is no longer a valid code.	N/A
S2363	KYPHOPLASTY/1 VERTEBRAL BODY, UNILATERAL OR BILATERAL INJ, EACH	This is no longer a valid code.	N/A
S2370	INTRADISCAL ELECTROTHRML THER	This is no longer a valid code.	N/A
S2371	EA ADD INTERSPACE/LST SEP IN ADD CD	This is no longer a valid code.	N/A
S2400	REPR CONGN HERN FETUS IN UTERO	This service is not covered by Superior HealthPlan.	N/A
S2401	REPAIR, URINARY TRACT OBSTRUCTION	No pre-authorization is required for all providers.	N/A
S2402	REPAIR, CONGENITAL CYSTIC ADENOMATOID	No pre-authorization is required for all providers.	N/A
S2403	REPAIR, EXTRALABOR PULMONARY SEQUESTRATION IN THE FETUS	No pre-authorization is required for all providers.	N/A
S2404	REPAIR, MYELOMENINGOCELE IN THE FETUS	This service is not covered by Superior HealthPlan.	N/A
S2405	REPR SACROCOC TRATOMA FETUS IN UTRO	No pre-authorization is required for all providers.	N/A
S2409	REPAIR, CONGENITAL MALFORMATION OF FETUS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S2411	FETOSCOPIC LASER THERAPY	No pre-authorization is required for all providers.	N/A
S2900	SRG TECHNIQUES REQ USE OF ROBOTIC SURG SYS LIST SEP IN ADDN TO PRIM CODE	This service is not covered by Superior HealthPlan.	N/A
S3000	DIABETIC INDICATOR, RETINAL EYE EXAM, DILATED, BILATERAL	This service is not covered by Superior HealthPlan.	N/A
S3005	PERFORMANCE MEASUREMENT EVALUATION OF PATIENT SELF ASSESSMENT DEPRESSION	This service is not covered by Superior HealthPlan.	N/A
S3600	STAT LABORATORY REQUEST (SITUATIONS OTHER THAN S3601)	This service is not covered by Superior HealthPlan.	N/A
S3601	EMERGENCY STAT LABORATORY CHARGE	This service is not covered by Superior HealthPlan.	N/A
S3618	FREE BETA HCG	No pre-authorization is required for all providers.	N/A
S3620	NEWBORN METABOLIC SCREENING PANEL	This service is not covered by Superior HealthPlan.	N/A
S3625	MATERNAL SERUM TRIPLE MARKER SCREEN INCLUDING ALPHA-FETOPROTEIN	This is no longer a valid code.	N/A
S3626	ESTRIOL HUMAN CHORIONIC GONADOTROPIN HCG AND INHIBIN A	This is no longer a valid code.	N/A
S3630	EOSINOPHIL COUNT, BLOOD, DIRECT	This service is not covered by Superior HealthPlan.	N/A
S3645	HIV-1 ANTIBOD TEST MUCOS TRANSUDATE	This service is not covered by Superior HealthPlan.	N/A
S3650	SALIVA TEST HORMONE LVL/MENOPAUSE	This service is not covered by Superior HealthPlan.	N/A
S3652	SALIVA TEST HORM LVL/PRETERM LABOR	This service is not covered by Superior HealthPlan.	N/A
S3655	ANTISPERM ANTIBODIES TEST	This service is not covered by Superior HealthPlan.	N/A
S3700	BLADDER TUMOR-ASS ANTIGEN TEST	No pre-authorization is required for all providers.	N/A
S3701	IMMUNOASSAY FOR NUCLEAR MATRIX PROTEIN 22 (NMP-22), QUANTITATIVE	This is no longer a valid code.	N/A
S3708	GASTROINTESTINAL FAT ABSORPTN STUDY	This service is not covered by Superior HealthPlan.	N/A
S3721	PCA3 TESTING	This is no longer a valid code.	N/A
S3800	GENETIC TESTING FOR AMYOTROPHIC LATERAL SCLEROSIS (ALS)	Pre-authorization is required for all providers.	Prior to 09/01/2019
S3833	COMPLETE APC GENE SEQUENCE ANAL/SUSCEPTIBILITY TO (FAP)	This is no longer a valid code.	N/A
S3834	SINGLE-MUTATION ANALYSIS /SUSCEPTIBILITY TO (FAP)&ATTENUATED FAP	This is no longer a valid code.	N/A
S3840	DNA ANALYSIS FOR GERMLINE MUTATIONS OF THE RET PROTO-ONCOGENE	This service is not covered by Superior HealthPlan.	N/A
S3841	GENETIC TESTING FOR RETINOBLASTOMA	Pre-authorization is required for all providers.	Prior to 09/01/2019
S3842	GENETIC TESTING FOR VON HIPPEL-LINDAU DISEASE	Pre-authorization is required for all providers.	Prior to 09/01/2019
S3844	DNA ANLYSS/CONNEXIN 26 GENE (GJB2)/SUSCEP/CONGENITAL, PRFND DEAFNESS	Pre-authorization is required for all providers.	Prior to 09/01/2019
S3845	GENETIC TESTING FOR ALPHA-THALASSEMIA	This service is not covered by Superior HealthPlan.	N/A
S3846	GENETCI TESTING FOR HEMOGLOBIN E BETA-THALASSEMIA	Pre-authorization is required for all providers.	Prior to 09/01/2019
S3849	GENETIC TESTING FOR NIEMANN-PICK DISEASE	Pre-authorization is required for all providers.	Prior to 09/01/2019
S3850	GENETIC TESTING FOR SICKLE CELL ANEMIA	Pre-authorization is required for all providers.	Prior to 09/01/2019
S3852	DNA ANLYS/APOE EPILSON 4 ALLELE FOR SUSCEP ALZHEIMER'S DISEASE	This service is not covered by Superior HealthPlan.	N/A
S3853	GENETIC TESTING FOR MYOTONIC MUSCULAR DYSTROPHY	Pre-authorization is required for all providers.	Prior to 09/01/2019
S3854	GENE EXPRESSION PROFILING PANEL FOR US IN MGMT OF BREAST CANCER TRTMT	This is no longer a valid code.	N/A
S3855	GENETIC TESTING FOR DETECTION OF MUTATIONS IN THE PRESENILIN - 1 GENE	This is no longer a valid code.	N/A
S3861	GENETIC TEST BRUGADA	This service is not covered by Superior HealthPlan.	N/A
S3865	COMP GENET TEST HYP CARDIOMY	This service is not covered by Superior HealthPlan.	N/A
S3866	SPEC GENE TEST HYP CARDIOMY	This service is not covered by Superior HealthPlan.	N/A
S3870	CGH MICROARRAY TEST DD ASD &/OR ID	This service is not covered by Superior HealthPlan.	N/A
S3890	DNA ANALYSIS FECAL COLORECTAL CANCER SCREENING	This is no longer a valid code.	N/A
S3900	SURFACE ELECTROMYOGRAPHY (EMG)	This service is not covered by Superior HealthPlan.	N/A
S3902	BALLISTOCARDIOGRAM	This service is not covered by Superior HealthPlan.	N/A
S3904	MASTERS TWO STEP	This service is not covered by Superior HealthPlan.	N/A
S4005	INTERIM LABOR FACILITY GLOBAL	No pre-authorization is required for all providers.	N/A
S4011	IN VIRTO FERTILIZATION	This service is not covered by Superior HealthPlan.	N/A
S4013	COMPLETE CYCLE GIFT CASE RATE	This service is not covered by Superior HealthPlan.	N/A
S4014	COMPLETE CYCLE ZIFT CASE RATE	This service is not covered by Superior HealthPlan.	N/A
S4015	COMPLETE IVF CYCLE CASE RATE NOS	This service is not covered by Superior HealthPlan.	N/A
S4016	FROZEN IN VITRO FERTILIZATION CYCLE, CASE RATE	This service is not covered by Superior HealthPlan.	N/A
S4017	INCLPL CYCL TX CANCEL D PRIOR TO STIM	This service is not covered by Superior HealthPlan.	N/A
S4018	FROZEN EMBRYO TRANSFER PROCEDURE CANCELLED BEFORE TRANSFER, CASE RATE	This service is not covered by Superior HealthPlan.	N/A
S4020	IN VITRO FERTILIZATION PROCEDURE CANCELLED BEFORE ASPIRATION, CASE RATE	This service is not covered by Superior HealthPlan.	N/A
S4021	IN VITRO FERTILIZATION PROCEDURE CANCELLED AFTER ASPIRATION, CASE RATE	This service is not covered by Superior HealthPlan.	N/A
S4022	ASSISTED OOCYTE FERTILIZATION, CASE RATE	This service is not covered by Superior HealthPlan.	N/A
S4023	DONOR EGG CYCLE INCLPL CASE RATE	This service is not covered by Superior HealthPlan.	N/A
S4025	DONOR SERVICES FOR IN VITRO FERTILIZATION (SPERM OR EMBRYO), CASE RATE	This service is not covered by Superior HealthPlan.	N/A
S4026	PROCUREMENT OF DONOR SPERM FROM SPERM BANK	This service is not covered by Superior HealthPlan.	N/A
S4027	STORAGE OF PREVIOUSLY FROZEN EMBRYOS	This service is not covered by Superior HealthPlan.	N/A
S4028	MICROSURGICAL EPIDIDYMAL SPERM ASPIRATION (MESA)	This service is not covered by Superior HealthPlan.	N/A
S4030	SPERM PROCUREMENT AND CRYOPRESERVATION SERVICES	This service is not covered by Superior HealthPlan.	N/A
S4031	SPERM PROCUREMENT AND CRYOPRESERVATION SERVICES	This service is not covered by Superior HealthPlan.	N/A
S4035	STIM INTRAUTERINE INSEMIN CASE RATE	This service is not covered by Superior HealthPlan.	N/A
S4036	INTRAVAGINAL CULTURE CASE RATE	No pre-authorization is required for all providers.	N/A
S4037	CRYOPRESERVD EMBRYO TRNSF CASE RATE	This service is not covered by Superior HealthPlan.	N/A
S4040	MON & STOR CRYOPRESRV EMBRYOS 30 DA	This service is not covered by Superior HealthPlan.	N/A
S4981	INSERTION OF LEVONORGESTREL-RELEASING INTRAUTERINE SYSTEM	This service is not covered by Superior HealthPlan.	N/A
S4989	CONTRACEPTIVE INTRAUTERINE DEVICE	This service is not covered by Superior HealthPlan.	N/A
S4990	NICOTINE PATCHES, LEGEND	This service is not covered by Superior HealthPlan.	N/A
S4991	NICOTINE PATCHES, NON-LEGEND	This service is not covered by Superior HealthPlan.	N/A
S4993	CONTRACEPTIVE PILLS BIRTH CONTROL	No pre-authorization is required for all providers.	N/A
S4995	SMOKING CESSATION GUM	This service is not covered by Superior HealthPlan.	N/A
S5000	SCRIPT DRUG GENERIC	This service is not covered by Superior HealthPlan.	N/A
S5001	SCRIPT DRUG BRAND NAME	This service is not covered by Superior HealthPlan.	N/A
S5010	5% DEXTROSE AND 45% NORM SAL 1000ML	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S5011	5% DEXTROSE-LACTATD RINGER'S 1000ML	This is no longer a valid code.	N/A
S5012	5% DEXTROSE W/POT CHLORIDE 1000 ML	This service is not covered by Superior HealthPlan.	N/A
S5013	5% DEXTROSE/45% NORM SALINE/1000ML	This service is not covered by Superior HealthPlan.	N/A
S5014	5% DEXTROSE/45% NORM SALINE/1500ML	This service is not covered by Superior HealthPlan.	N/A
S5017	ANTIBIOTIC ADMIN SUP (WO PUMP)/DA	No pre-authorization is required for all providers.	N/A
S5018	PAIN THER ADMIN SUP (PCA/CONT)/DA	No pre-authorization is required for all providers.	N/A
S5019	CHEMO ADMIN SUP (W/PUMP) / DA	No pre-authorization is required for all providers.	N/A
S5020	CHEMO ADMIN SUP (WO PUMP) /DA	No pre-authorization is required for all providers.	N/A
S5021	HYDRATION THERAP ADMIN SUP /DA	No pre-authorization is required for all providers.	N/A
S5025	INFUS PUMP RENTAL /DA	No pre-authorization is required for all providers.	N/A
S5035	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S5036	HOME INFUSION THERAPY, REPAIR OF INFUSION DEVICE (E.G. PUMP REPAIR)	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
S5100	DAY CARE SERVICES ADULT; PER 15 MIN	This service is not covered by Superior HealthPlan.	N/A
S5101	DAY CARE SRVC ADULT; PER HALF DAY	Preauthorization required for all providers	Prior to 09/01/2019
S5102	DAY CARE SERVICES, ADULT; PER DIEM	This service is not covered by Superior HealthPlan.	N/A

S5105	DAY CARE SRVC CENTER;NOT W/PROG FEE	This service is not covered by Superior HealthPlan.	N/A
S5108	HOME CARE TRAINING TO HOME CARE CLIENT, PER 15 MINUTES	This service is not covered by Superior HealthPlan.	N/A
S5109	HOME CARE TRAINING TO HOME CARE CLIENT, PER SESSION	This service is not covered by Superior HealthPlan.	N/A
S5110	HOME CARE TRAINING FAM; PER 15 MIN	This service is not covered by Superior HealthPlan.	N/A
S5111	HOME CARE TRAINING FAM; PER SESSION	This service is not covered by Superior HealthPlan.	N/A
S5115	HOME CARE TRN NON-FAM; PER 15 MIN	This service is not covered by Superior HealthPlan.	N/A
S5116	HOME CARE TRN NON-FAM; PER SESSION	This service is not covered by Superior HealthPlan.	N/A
S5120	CHORE SERVICES; PER 15 MINUTES	This service is not covered by Superior HealthPlan.	N/A
S5121	CHORE SERVICES; PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S5125	ATTENDANT CARE SERVICES; PER 15 MIN	Pre-authorization required for all providers.	Prior to 09/01/2019
S5126	ATTENDANT CARE SERVICES; PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S5130	HOMEMAKER SERVICE NOS; PER 15 MIN	This service is not covered by Superior HealthPlan.	N/A
S5131	HOMEMAKER SERVICE, NOS; PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S5135	COMPANION CARE ADULT; PER 15 MIN	This service is not covered by Superior HealthPlan.	N/A
S5136	COMPANION CARE, ADULT ; PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S5140	FOSTER CARE, ADULT; PER DIEM	Pre-authorization is required for Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
S5141	FOSTER CARE, ADULT; PER MONTH	This service is not covered by Superior HealthPlan.	N/A
S5145	FOSTER CARE THERAPEUTIC CHILD;-DIEM	This service is not covered by Superior HealthPlan.	N/A
S5146	FOSTER CARE THERAPEUTIC CHLD;-MONTH	This service is not covered by Superior HealthPlan.	N/A
S5150	UNSKL RESPITE CARE NOT HOSPICE;-15	This service is not covered by Superior HealthPlan.	N/A
S5151	UNSKL RESPITE CARE NOT HOSPICE;DIEM	Pre-authorization is required for Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
S5160	EMERG RESPONSE SYSTEM; INSTL&TST	Preauthorization required for all providers	Prior to 09/01/2019
S5161	EMERG RESPONSE SYS; SRVC FEE-MONTH	Preauthorization required for all providers	Prior to 09/01/2019
S5162	EMERG RESPONSE SYS; PURCHASE ONLY	This service is not covered by Superior HealthPlan.	N/A
S5165	HOME MODIFICATIONS; PER SERVICE	Preauthorization required for all providers	Prior to 09/01/2019
S5170	HOM DELIV MEALS INCL PREP;-MEAL	Pre-authorization required for all providers.	Prior to 09/01/2019
S5175	LAUNDRY SERVICE EXT PROF;-ORDR	This service is not covered by Superior HealthPlan.	N/A
S5180	HOME HEALTH RESP TX INIT EVALUATION	This service is not covered by Superior HealthPlan.	N/A
S5181	HOME HEALTH RESP TX NOS PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S5185	MED REMINDER NON-FCE-TO-FCE;-MONTH	This service is not covered by Superior HealthPlan.	N/A
S5190	WELLNESS ASSESS PRFRM NON-PHYSICIAN	This service is not covered by Superior HealthPlan.	N/A
S5199	PERSONAL CARE ITEM, NOS, EACH	This service is not covered by Superior HealthPlan.	N/A
S5497	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S5498	HOME INFUS TX CATH CARE/MAINT SIMPLE PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S5501	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S5502	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S5503	MNT OF IMPED VAS ACCESS DEV INC SUP	No pre-authorization is required for all providers.	N/A
S5517	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S5518	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S5520	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S5521	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S5522	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S5523	HOME INFUSION THERPY, INSRV MIDLINE VENOUS CATHETER, NURSING SERV ONLY	This service is not covered by Superior HealthPlan.	N/A
S5550	INSULIN, RAPID ONSET, 5 UNITS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S5551	INSULIN, MOST RAPID ONSET (LISPRO OR ASPART), 5 UNITS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S5552	INSULIN, INTERMEDIATE ACTING (NPH OR LENTE), 5 UNITS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S5553	INSULIN, LONG ACTING, 5 UNITS	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S5560	INSULIN DELIVERY DEVICE, REUSABLE PEN, 1.5 ML SIZE	This service is not covered by Superior HealthPlan.	N/A
S5561	INSULIN DELIVERY DEVICE, REUSABLE PEN, 3 ML SIZE	This service is not covered by Superior HealthPlan.	N/A
S5565	INSULIN CARTRIDGE/IN INSULIN DLVRY DEVICE OTHER THAN PUMP, 150 UNITS	This service is not covered by Superior HealthPlan.	N/A
S5566	INSULIN CARTRIDGE/USE IN INSULIN DLVRY DEVICE OTHER THAN PUMP, 300 UNITS	This service is not covered by Superior HealthPlan.	N/A
S5570	INSULIN DELIVERY DEVICE, DISPOSABLE PEN (INCLUDING INSULIN), 1.5 ML SIZE	This service is not covered by Superior HealthPlan.	N/A
S5571	INSULIN DELIVERY DEVICE, DISPOSABLE PEN (INCLUDING INSULIN), 3.0 ML SIZE	This service is not covered by Superior HealthPlan.	N/A
S8030	SCLERAL APPLICATION OF TANTALUM	No pre-authorization is required for all providers.	N/A
S8032	LDCT LUNG CANCER SCREENIN	This service is not covered by Superior HealthPlan.	N/A
S8035	MAGNETIC SOURCE IMAG	This service is not covered by Superior HealthPlan.	N/A
S8037	MAGNETIC RESONANCE CHOLANGIOPANCREATOGRAPHY (MRCP)	This service is not covered by Superior HealthPlan.	N/A
S8040	TOPOGRAPHIC BRAIN MAPPING	This service is not covered by Superior HealthPlan.	N/A
S8042	MAGNETIC RESONANCE IMAG LOW-FIELD	This service is not covered by Superior HealthPlan.	N/A
S8055	ULTRASOUND GUIDANCE	This service is not covered by Superior HealthPlan.	N/A
S8075	COMPUTER ANALYSIS/FULL-FIELD DIGITAL MAMMO/FURTHER PHYSICIAN RVW	This is no longer a valid code.	N/A
S8080	SCINTIMAMMO UNI INC SUP RADIPHARM	This service is not covered by Superior HealthPlan.	N/A
S8085	FLUORINE-18 FLUORODEOXYGLU IMG USG	This service is not covered by Superior HealthPlan.	N/A
S8092	ELECTRON BEAM COMPUTED TOMOGRAPHY	This service is not covered by Superior HealthPlan.	N/A
S8093	CT ANGIOGRAPHY CORONARY ART W/CONTRST MATERIAL	This is no longer a valid code.	N/A
S8095	WIG (MED-INDUC HAIR LOSS)	No pre-authorization is required for all providers.	N/A
S8096	PORT PEAK FLOW METER	This service is not covered by Superior HealthPlan.	N/A
S8097	ASTHMA KIT	This service is not covered by Superior HealthPlan.	N/A
S8100	HOLDING CHAMBER OR SPACER FOR USE WITH AN INHALER OR NEBULIZER	This service is not covered by Superior HealthPlan.	N/A
S8101	HOLDING CHAMBER OR SPACER FOR USE WITH AN INHALER OR NEBULIZER	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
S8105	OXIMETER MEASR BLD O2 LVLS NONINVAS	No pre-authorization is required for all providers.	N/A
S8110	PEAK EXPIR FLOW RATE/ PHYS SERV	This service is not covered by Superior HealthPlan.	N/A
S8120	OXYGEN CONTENTS, GASEOUS, 1 UNIT EQUALS 1 CUBIC FOOT	This service is not covered by Superior HealthPlan.	N/A
S8121	OXYGEN CONTENTS, LIQUID, 1 UNIT EQUALS 1 POUND	This service is not covered by Superior HealthPlan.	N/A
S8130	INTERFERENTIAL STIM 2 CHAN	This service is not covered by Superior HealthPlan.	N/A
S8131	INTERFERENTIAL STIM 4 CHAN	This service is not covered by Superior HealthPlan.	N/A
S8180	TRACHEOSTOMY SHOWER PROTECTOR	No pre-authorization is required for all providers.	N/A
S8181	TRACHEOSTOMY TUBE HOLDER	No pre-authorization is required for all providers.	N/A
S8182	HUMIDIFIER, HEATED, USED WITH VENTILATOR, NON-SERVO-CONTROLLED	No pre-authorization is required for all providers.	N/A
S8183	HUMIDIFIER, HEATED USED WITH VENTILATOR	No pre-authorization is required for all providers.	N/A
S8185	FLUTTER DEVICE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
S8186	SWIVEL ADAPTOR	This service is not covered by Superior HealthPlan.	N/A
S8189	TRACHEOSTOMY SUPPLY, NOT OTHERWISE CLASSIFIED	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S8200	CHEST COMPRES VEST	No pre-authorization is required for all providers.	N/A
S8205	CHEST COMPRES SYST GEN/HOSES	No pre-authorization is required for all providers.	N/A
S8210	MUCUS TRAP	This service is not covered by Superior HealthPlan.	N/A
S8260	ORAL ORTHO/TX SLEEP APNEA	This is no longer a valid code.	N/A
S8262	MANDIB ORTHO REPOSITION DEVICE EACH	This is no longer a valid code.	N/A
S8265	HABERMAN FEEDER CLEFT LIP/PALATE	No pre-authorization is required for all providers.	N/A
S8270	ENURESIS ALARM USING AUDITORY BUZZER AND/OR VIBRATION DEVICE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
S8301	INFECTION CONTROL SUPPLIES NOS	Pre-authorization required for all providers.	Prior to 09/01/2019
S8400	INCONT PANTS EACH	No pre-authorization is required for all providers.	N/A
S8401	CHILD-SIZE INCONTINENCE GARMENT, DIAPER, EACH	No pre-authorization is required for all providers.	N/A
S8402	DIAPERS EACH	No pre-authorization is required for all providers.	N/A
S8403	ADULT-SIZED INCONTINENCE GARMENT, DISPOSABLE, PULL-UP BRIEF, EACH	No pre-authorization is required for all providers.	N/A
S8404	CHILD-SIZE INCONTINENCE GARMENT, DISPOSABLE, PULL-UP BRIEF, EACH	No pre-authorization is required for all providers.	N/A
S8405	INCONT LINERS EACH	No pre-authorization is required for all providers.	N/A
S8415	SUPPLIES FOR HOME DELIVERY OF INFANT	Pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
S8420	GRADIENT PRESSURE AID (SLEEVE AND GLOVE COMBINATION), CUSTOM MADE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S8421	GRADIENT PRESSURE AID (SLEEVE AND GLOVE COMBINATION), READY MADE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S8422	GRADIENT PRESSURE AID (SLEEVE), CUSTOM MADE, MEDIUM WEIGHT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S8423	GRADIENT PRESSURE AID (SLEEVE), CUSTOM MADE, HEAVY WEIGHT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S8424	GRADIENT PRESSURE AID (SLEEVE), READY MADE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S8425	GRADIENT PRESSURE AID (GLOVE), CUSTOM MADE, MEDIUM WEIGHT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S8426	GRADIENT PRESSURE AID (GLOVE), CUSTOM MADE, HEAVY WEIGHT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S8427	GRADIENT PRESSURE AID (GLOVE), READY MADE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S8428	GRADIENT PRESSURE AID (GAUNTLET), READY MADE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S8429	GRADIENT PRESSURE EXTERIOR WRAP	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S8430	PADDING FOR COMPRESSION BANDAGE, ROLL	This service is not covered by Superior HealthPlan.	N/A
S8431	COMPRESSION BANDAGE, ROLL	This service is not covered by Superior HealthPlan.	N/A
S8434	INTERIM POST-OPERATIVE ORTHOTIC DEVICE FOR UP /EXTREMITY CUSTOM MADE	No pre-authorization is required for all providers.	N/A

S8450	SPLINT, PREFABRICATED, DIGIT (SPECIFY DIGIT BY USE OF MODIFIER)	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S8451	SPLINT, PREFABRICATED, WRIST OR ANKLE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S8452	SPLINT, PREFABRICATED, ELBOW	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S8460	CAMISOLE, POST-MASTECTOMY	This service is not covered by Superior HealthPlan.	N/A
S8490	INSULIN SYRINGES (100 SYRINGES, ANY SIZE)	This service is not covered by Superior HealthPlan.	N/A
S8930	AURICULAR ELECTROSTIMULATION	This service is not covered by Superior HealthPlan.	N/A
S8940	EQUESTRIAN/HIPPOTHERAPY /SESSION	This service is not covered by Superior HealthPlan.	N/A
S8945	PHYS MED TX 30 MINS EA; PHONOPHORES	This is no longer a valid code.	N/A
S8948	APLCTN/MODALITY TO ONE OR MORE AREAS, LOW-LEVEL LASER, EA 15 MINUTES	This service is not covered by Superior HealthPlan.	N/A
S8950	COMPLX LYMPHEDEMA THERAP EA 15 MIN	This service is not covered by Superior HealthPlan.	N/A
S8990	PHYSICAL OR MANIPULATIVE THRYP PFRMD/MNTNC RATHER THAN RESTORATION	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
S8999	RESUSCITATION BAG	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
S9001	HOME UTERINE MONIT W/WO NRSG SERV	This service is not covered by Superior HealthPlan.	N/A
S9007	ULTRAFILTRATION MONITOR	This service is not covered by Superior HealthPlan.	N/A
S9015	AUTO EEG MONITORING	This is no longer a valid code.	N/A
S9023	XENON REG CEREBRAL BLOOD FLOW STUD	No pre-authorization is required for all providers.	N/A
S9024	PARANASAL SINUS US	This service is not covered by Superior HealthPlan.	N/A
S9025	OMNICARDIOGRAM/CARDIOINTEGRAM	This service is not covered by Superior HealthPlan.	N/A
S9034	ESWL FOR GALL STONES	This service is not covered by Superior HealthPlan.	N/A
S9035	MED EQUIP/SUP DIST BY HCP WO PRO NS	No pre-authorization is required for all providers.	N/A
S9055	PROCUREN/OTH GROWTH FAC/WOUND HEAL	This service is not covered by Superior HealthPlan.	N/A
S9056	COMA STIMULATION PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S9061	HCP DIS MED SUP/EQUIP REN;AEROSOL	This service is not covered by Superior HealthPlan.	N/A
S9083	GLOBAL FEE URGENT CARE CENTERS	This service is not covered by Superior HealthPlan.	N/A
S9088	SRVS PROV IN AN URGENT CARE CENTER	This service is not covered by Superior HealthPlan.	N/A
S9090	VERTEB AXIAL DECOMPRES PER SES	This service is not covered by Superior HealthPlan.	N/A
S9092	CANOLITH REPOSITIONING PER VISIT	This is no longer a valid code.	N/A
S9097	HOME VISIT FOR WOUND CARE	This service is not covered by Superior HealthPlan.	N/A
S9098	HOME VISIT	This service is not covered by Superior HealthPlan.	N/A
S9110	TELEMONITORING/HOME PER MNTH	No pre-authorization is required for all providers.	N/A
S9117	BACK SCHOOL, PER VISIT	This service is not covered by Superior HealthPlan.	N/A
S9122	HOME HEALTH AIDE/CNA CARE/HOME/HOUR	This service is not covered by Superior HealthPlan.	N/A
S9123	NURSING CARE, IN THE HOME, BY REGISTERED NURSE, PER HOUR	Pre-authorization is required Alere providers.	Prior to 09/01/2019
S9124	NRSG HOME CARE LPN PER HOUR	Pre-authorization required for all providers.	Prior to 09/01/2019
S9125	RESPIRE HOME CARE PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S9126	HOSPICE HOME CARE PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S9127	SOCIAL WORK VISIT HOME PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S9128	SPEECH THERAP HOME PER DIEM	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
S9129	OCCUP THERAP HOME PER DIEM	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
S9131	PHYSICAL THERAPY	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
S9140	DIAB MGMT PROG F/U VISIT NON-MD	This service is not covered by Superior HealthPlan.	N/A
S9141	DIAB MGMT PROG F/U VISIT MD PROV	This service is not covered by Superior HealthPlan.	N/A
S9145	INSULIN PUMP INIT INSTRUCT USE PUMP	This service is not covered by Superior HealthPlan.	N/A
S9150	EVALUATION BY OCCULARIST	This service is not covered by Superior HealthPlan.	N/A
S9152	SPEECH THERAPY RE-EVALUATION	Pre-authorization is required except for ECI Providers treating members 35 months of age and younger.	Prior to 09/01/2019
S9208	HOME MANAGEMENT OF PRETERM LABOR	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S9209	HOME MANAGEMENT OF PRETERM PREMATURE RUPTURE OF MEMBRANS	This service is not covered by Superior HealthPlan.	N/A
S9211	HOME MANAGEMENT OF GESTATIONAL HYPERTENSION	This service is not covered by Superior HealthPlan.	N/A
S9212	HOME MANAGEMENT OF POSTPARTUM HYPERTENSION	This service is not covered by Superior HealthPlan.	N/A
S9213	HOME MANAGEMENT OF PREECLAMPSIA	This service is not covered by Superior HealthPlan.	N/A
S9214	HOME MANAGEMENT OF GESTATIONAL DIABETES	This service is not covered by Superior HealthPlan.	N/A
S9325	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9326	HOME INFUSION THERAPY, CONTINUOUS PAIN MANAGEMENT INFUSION	This service is not covered by Superior HealthPlan.	N/A
S9327	HOME INFUSION THERAPY, INTERMITTENT	This service is not covered by Superior HealthPlan.	N/A
S9328	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9329	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9330	HOME INFUSION THERAPY, CONTINUOUS	This service is not covered by Superior HealthPlan.	N/A
S9331	HOME INFUSION THERAPY, INTERMITTENT PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S9335	HOME THERAPY, HEMODIALYSIS, ADMINISTRATIVE SERVICES	This service is not covered by Superior HealthPlan.	N/A
S9336	HOME INFUSION THERAPY	Pre-authorization is required Alere providers.	Prior to 09/01/2019
S9338	HOME THERAPY, IMMUNOTHERAPY, ADMINISTRATIVE SERVICES PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S9339	HOME THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9340	HOME THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9341	HOME THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9342	HOME THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9343	HOME THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9345	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9346	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9347	HIT UNINTRPED LNG-TERM IV/SUBQ;DIEM	This service is not covered by Superior HealthPlan.	N/A
S9348	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9349	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9351	HIT CONT ANTIEMETIC DIEM	This service is not covered by Superior HealthPlan.	N/A
S9353	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9355	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9357	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9359	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9361	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9363	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9364	HOME INFUSION THERAPY, TOTAL PARENTERAL NUTRITION (TPN)	This service is not covered by Superior HealthPlan.	N/A
S9365	HOME INFUSION THERAPY, TOTAL PARENTERAL NUTRITION (TPN), ONE LITER	This service is not covered by Superior HealthPlan.	N/A
S9366	HOME INFUSION THERAPY, TOTAL PARENTERAL NUTRITION (TPN), MORE THAN 1 LI	This service is not covered by Superior HealthPlan.	N/A
S9367	HOME INFUSION THERAPY, TOTAL PARENTERAL NUTRITION (TPN)	This service is not covered by Superior HealthPlan.	N/A
S9368	HOME INFUSION THERAPY, TOTAL PARENTERAL NUTRITION (TPN)	This service is not covered by Superior HealthPlan.	N/A
S9370	HOME THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9372	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9373	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9374	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9375	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9376	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9377	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9379	HOME INFUSION THERAPY INFUSION THERAPY NOC, DIEM	This service is not covered by Superior HealthPlan.	N/A
S9381	DELIVERY OR SVC TO HIGH RISK AREAS	This service is not covered by Superior HealthPlan.	N/A
S9401	ANTICOAGULAT CLIN NO LAB PER SESS	This service is not covered by Superior HealthPlan.	N/A
S9430	PHARM COMPOUNDING & DISPENSING SERV	This service is not covered by Superior HealthPlan.	N/A
S9433	MEDICAL FOOD ORAL 100% NUTR	No pre-authorization is required for all providers.	N/A
S9434	MODIFIED SOLID FOOD SUPPLEMENTS FOR INBORN ERRORS OF METABOLISM	This service is not covered by Superior HealthPlan.	N/A
S9435	MED FOODS FOR INBORN ERRORS OF MET	This service is not covered by Superior HealthPlan.	N/A
S9436	CHLDBRTH PREP/LAMAZE CLASS PER SESS	This service is not covered by Superior HealthPlan.	N/A
S9437	CHILDBIRTH REFRESH CLASS PER SESS	This service is not covered by Superior HealthPlan.	N/A
S9438	CESAREAN BRTH CLASS NON-MD PER SESS	This service is not covered by Superior HealthPlan.	N/A
S9439	VBAC CLASSES NON-MD PER SESSION	This service is not covered by Superior HealthPlan.	N/A
S9441	ASTHMA EDUCATION, NON-PHYSICIAN PROVIDER, PER SESSION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
S9442	BIRTHING CLASSES, NON-PHYSICIAN PROVIDER, PER SESSION	This service is not covered by Superior HealthPlan.	N/A
S9443	LACTATION CLASSES, NON-PHYSICIAN PROVIDER, PER SESSION	This service is not covered by Superior HealthPlan.	N/A
S9444	PARENTING CLASSES NON-MD PER SESS	This service is not covered by Superior HealthPlan.	N/A
S9445	PATIENT EDUCATION, INDIVIDUAL	No pre-authorization is required for all providers.	N/A
S9446	PATIENT EDUCATION	This service is not covered by Superior HealthPlan.	N/A
S9447	INFANT SAFETY CLASS NON-MD PER SESS	This service is not covered by Superior HealthPlan.	N/A
S9449	WEIGHT MGMT CLASS NON-PHYS PER SESS	This service is not covered by Superior HealthPlan.	N/A
S9451	EXERCISE CLASSES NON-PHYS PER SESS	This service is not covered by Superior HealthPlan.	N/A
S9452	NUTRITION CLASSES NON-PHYS PER SESS	This service is not covered by Superior HealthPlan.	N/A

S9453	SMOKING CESSATION CLASS NON-MD SESS	This service is not covered by Superior HealthPlan.	N/A
S9454	STRESS MGMT CLASS NON-PHYS PER SESS	This service is not covered by Superior HealthPlan.	N/A
S9455	DIAB MGMT PROG GROUP SES	This service is not covered by Superior HealthPlan.	N/A
S9460	DIAB MGMT PROG NURSE VISIT	This service is not covered by Superior HealthPlan.	N/A
S9465	DIAB MGMT PROG DIETITIAN VISIT	This service is not covered by Superior HealthPlan.	N/A
S9470	NUTR COUNSELING DIETITIAN VISIT	Pre-authorization is required except for ECI Providers treating members 0-20 years of age. All other ages will require pre-authorization.	Prior to 09/01/2019
S9472	CARD REHAB PROG NON-MD PER DIEM	No pre-authorization is required for all providers.	N/A
S9473	PULM REHAB PROG NON-MD PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S9474	RN CERT ENTEROSTOMAL THERAP/DIEM	This service is not covered by Superior HealthPlan.	N/A
S9475	AMB SET SUB ABUSE TX/DETOX/PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S9476	VESTIBULAR REHABILITATION PROGRAM, NON-PHYSICIAN PROVIDER, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S9480	INTENSIVE OUTPT PSYCH SERV PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S9482	FAMILY STABILIZATION SERVICES PER 15 MINUTES	This service is not covered by Superior HealthPlan.	N/A
S9484	CRISIS INTERVEN MENTL HLTH SRVC-HR	This service is not covered by Superior HealthPlan.	N/A
S9485	CRISIS INTERV MENTAL HEALTH/DIEM	This service is not covered by Superior HealthPlan.	N/A
S9490	HIT CORTICOSTEROID INFUS; PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S9494	HOME INFUSION THERAPY, ANTIBIOTIC, ANTIVIRAL, OR ANTIFUNGAL THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9497	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9500	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9501	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9502	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9503	HOME INFUSION THERAP	This service is not covered by Superior HealthPlan.	N/A
S9504	HOME INFUSION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9524	NRSRG SERV RELAT HOME IV THERAP/DIEM	This is no longer a valid code.	N/A
S9529	ROUTINE VENIPUNCTURE	This service is not covered by Superior HealthPlan.	N/A
S9537	HOME THERAPY, HEMATOPOIETIC HORMONE INJECTION THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9538	HOME TRANSFUSION BLOOD	This service is not covered by Superior HealthPlan.	N/A
S9542	HOME INJECTABLE THERAPY, NOT OTHERWISE CLASSIFIED, INCL ADMINI SVC	This service is not covered by Superior HealthPlan.	N/A
S9558	HOME INJECTABLE THERAPY, GROWTH HORMONE, INCLUDING ADMIN SVC	This service is not covered by Superior HealthPlan.	N/A
S9559	HOME INJECTABLE THERAPY, INTERFERON, INCL ADM SVC	This service is not covered by Superior HealthPlan.	N/A
S9560	HOME INJECTABLE THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9562	HOM INJ TX PALIVIZUMAB-PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S9590	HOM TX IRRIG TX; W/ADMN-PER DIEM	This service is not covered by Superior HealthPlan.	N/A
S9810	HOME THERAPY	This service is not covered by Superior HealthPlan.	N/A
S9900	CHRISTIAN SCI PRACT VISIT	This service is not covered by Superior HealthPlan.	N/A
S9901	CHRISTIAN SCI NURSE VISIT	This service is not covered by Superior HealthPlan.	N/A
S9960	AIR AMBULANC NONEMERG FIXE	This service is not covered by Superior HealthPlan.	N/A
S9961	AIR AMBULANC NONEMERG ROTAR	This service is not covered by Superior HealthPlan.	N/A
S9970	HEALTH CLUB MEMBERSHIP ANNUAL	This service is not covered by Superior HealthPlan.	N/A
S9975	TPLNT REL LODG MEALS & TRNSPRT DIEM	This service is not covered by Superior HealthPlan.	N/A
S9976	LODGING PER DIEM NOT OTHERWISE SPECIFIED	This service is not covered by Superior HealthPlan.	N/A
S9977	MEALS PER DIEM NOT OTHERWISE SPECIFIED	This service is not covered by Superior HealthPlan.	N/A
S9981	MEDICAL RECORDS COPYING FEE, ADMINISTRATIVE	This service is not covered by Superior HealthPlan.	N/A
S9982	MEDICAL RECORDS COPYING FEE, PER PAGE	This service is not covered by Superior HealthPlan.	N/A
S9986	NOT MEDICALLY NECESSARY SERVICES	This service is not covered by Superior HealthPlan.	N/A
S9988	SERV PROVIDED AS PART OF PHASE I CLINICAL TRIAL	This service is not covered by Superior HealthPlan.	N/A
S9989	SVCS PROVIDED OUTSIDE OF THE USA	This service is not covered by Superior HealthPlan.	N/A
S9990	SERV PROVID/PHASE II CLIN TRIAL	This service is not covered by Superior HealthPlan.	N/A
S9991	SERV PROVID/PHASE III CLIN TRIAL	This service is not covered by Superior HealthPlan.	N/A
S9992	TRANS/TRIAL LOC/PARTIC/CARE GIVER	This service is not covered by Superior HealthPlan.	N/A
S9994	LODG/CLIN TRIAL PARTIC/CAREGIVER	This service is not covered by Superior HealthPlan.	N/A
S9996	MEALS CLIN TRIAL PARTIC/CAREGIVER	This service is not covered by Superior HealthPlan.	N/A
S9999	SALES TAX	This service is not covered by Superior HealthPlan.	N/A
T1000	PRIVATE DUTY/INDEPENDEND NURSING LICENSED UP TO 15 MIN	Preauthorization required for all providers	Prior to 09/01/2019
T1001	NURSING ASSESSMENT / EVALUATION	Pre-authorization is required if the service is rendered by an Advanced Practice Nurse. For all other members, pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
T1002	RN SERVICES, UP TO 15 MINUTES	Pre-authorization is required if the service is rendered by an Advanced Practice Nurse. For all other members, pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
T1003	LPN/LVN SERVICES, UP TO 15 MINUTES	Pre-authorization is required if the service is rendered by an Advanced Practice Nurse. For all other members, pre-authorization is required for Home Visits by Home Health, Home Infusion, Physical, Occupational and Speech Therapist.	Prior to 09/01/2019
T1004	SERVICES OF A QUALIFIED NURSING AIDE, UP TO 15 MINUTES	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
T1005	RESPIRE CARE SERVICES, UP TO 15 MINUTES	Preauthorization required for all providers	Prior to 09/01/2019
T1006	ALCOHOL AND/OR SUBSTANCE ABUSE SERVICES, FAMILY/COUPLE COUNSELING	This service is not covered by Superior HealthPlan.	N/A
T1007	ALCOHOL AND/OR SUB ABUSE SVCS, TREATMENT PLAN DEVELOPMENT	No pre-authorization is required for all providers.	N/A
T1009	CHILD SITTING	This service is not covered by Superior HealthPlan.	N/A
T1010	MEALS FOR INDIVIDUALS RECEIVING ALCOHOL OR SUB ABUSE SVCS	This service is not covered by Superior HealthPlan.	N/A
T1012	ALCOHOL AND/OR SUBSTANCE ABUSE SERVICES, SKILLS DEVELOPMENT	This service is not covered by Superior HealthPlan.	N/A
T1013	SIGN LANGE/ORAL INTEPR SRVC-15 MIN	No pre-authorization is required for all providers.	N/A
T1014	TELEHEALTH TRANSMISSION	This service is not covered by Superior HealthPlan.	N/A
T1015	CLINIC VISIT/ENCOUNTER, ALL-INCLUSIVE	No pre-authorization is required for all providers.	N/A
T1016	CASE MANAGEMENT EACH 15 MINS	This service is not covered by Superior HealthPlan.	N/A
T1017	TARGETED CASE MANAGEMENT EA 15 MINS	No pre-authorization is required for all providers.	N/A
T1018	SCHOOL-BASD IND ED PROG SERV BUNDLD	This service is not covered by Superior HealthPlan.	N/A
T1019	PERSONAL CARE SERVICES PER 15 MINS	Preauthorization required for all providers	Prior to 09/01/2019
T1020	PERSONAL CARE SERVICES PER DIEM	This service is not covered by Superior HealthPlan.	N/A
T1021	HOME HLTH AIDE/CERT NURSE ASST VST	This service is not covered by Superior HealthPlan.	N/A
T1022	CONTRACT HOME HEALTH AGCY SRVC DAY	This service is not covered by Superior HealthPlan.	N/A
T1023	SCR IND PARTICIP SPEC PROG PROJ/TX	Pre-authorization required for all providers.	Prior to 09/01/2019
T1024	EVAL&TX TEAM MX/SEV HANDICAP CHILD	This service is not covered by Superior HealthPlan.	N/A
T1025	MXDISCIPLIN CHILD CMLPX IMPAIR DIEM	Preauthorization required for all providers	Prior to 09/01/2019
T1026	MXDISCIPLIN CHILD W/CMLPX IMPAIR HR	Preauthorization required for all providers	Prior to 09/01/2019
T1027	FAM TRAIN & CNSL CHILD DVLP 15 MINS	This service is not covered by Superior HealthPlan.	N/A
T1028	ASSESS HOME PHYSICAL & FAMILY ENVIR	This service is not covered by Superior HealthPlan.	N/A
T1029	COMP ENVIR LEAD INVESTIGAT-DWELL	This service is not covered by Superior HealthPlan.	N/A
T1030	NRS CARE HOME REGISTERED NURSE-DIEM	This service is not covered by Superior HealthPlan.	N/A
T1031	NURSING CARE THE HOME LPN PER DIEM	This service is not covered by Superior HealthPlan.	N/A
T1040	COMM BH CLINIC SVC PER DIEM	No pre-authorization is required for all providers.	N/A
T1041	COMM BH CLINIC SVC PER MONTH	No pre-authorization is required for all providers.	N/A
T1500	DIAPER/INCONT PANT REUSBL/WASHBL EA	No pre-authorization is required for all providers.	N/A
T1501	REUSABLE UNDERPAD	No pre-authorization is required for all providers.	N/A
T1502	ADMN ORL IM&SUBQ MED HLTH PROF	This service is not covered by Superior HealthPlan.	N/A
T1505	ELEC MED COMP DEV, NOC	This service is not covered by Superior HealthPlan.	N/A
T1999	MISC TX ITEMS&SUPPLIES RETAIL NOC	Pre-authorization required for all providers.	Prior to 09/01/2019
T2001	N-EMERG TRNSPRT; PT ATTENDNT/ESCORT	This service is not covered by Superior HealthPlan.	N/A
T2002	NON-EMERG TRANSPORTATION; PER DIEM	Preauthorization required for all providers	Prior to 09/01/2019
T2003	NON-EMERG TRNSPRT; ENCOUNTER/TRIP	This service is not covered by Superior HealthPlan.	N/A
T2004	N-EMERG TRNSPRT;COMMER CARR MX-PASS	This service is not covered by Superior HealthPlan.	N/A
T2005	N-EMRG TRNSPRT;NON-AMB STRETCH VAN	This service is not covered by Superior HealthPlan.	N/A
T2006	AMBULANCE RESPONSE&TX NO TRANSPORT	No pre-authorization is required for all providers.	N/A
T2007	TRNSPRT WAIT TIME NON-ER VEH 1/2 HR	This service is not covered by Superior HealthPlan.	N/A
T2010	PREADMIS SCRNG&RESIDENT REVIEW (PASRR) LEVEL I IDNTFCTN	This service is not covered by Superior HealthPlan.	N/A
T2011	PREADMIS SCR&RESIDENT REVIEW (PASRR) LEVEL II IDNTFCTN	This service is not covered by Superior HealthPlan.	N/A
T2012	HABILITATION, EDUCATIONAL, WAIVER, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
T2013	HABILITATION, EDUCATIONAL, WAIVER, PER HOUR	This service is not covered by Superior HealthPlan.	N/A
T2014	HABILITATION, PREVOCAIONAL, WAIVER, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
T2015	HABILITATION, PREVOCAIONAL, WAIVER, PER HOUR	This service is not covered by Superior HealthPlan.	N/A
T2016	HABILITATION, RESIDENTIAL, WAIVER, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
T2017	HABILITATION, RESIDENTIAL, WAIVER, PER 15 MINUTES	This service is not covered by Superior HealthPlan.	N/A
T2018	HABILITATION, SUPPORTED EMPLOYMENT, WAIVER, PER DIEM	This service is not covered by Superior HealthPlan.	N/A

T2019	HABILITATION, SUPPORTED EMPLOYMENT, WAIVER, PER 15 MINUTES	This service is not covered by Superior HealthPlan.	N/A
T2020	DAY HABILITATION, WAIVER, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
T2021	DAY HABILITATION, WAIVER, PER 15 MINUTES	This service is not covered by Superior HealthPlan.	N/A
T2022	CASE MANAGEMENT, PER MONTH	This service is not covered by Superior HealthPlan.	N/A
T2023	TARGETED CASE MANAGEMENT, PER MONTH	This service is not covered by Superior HealthPlan.	N/A
T2024	SERVICE ASSESSMENT/PLAN OF CARE DEVELOPMENT, WAIVER	This service is not covered by Superior HealthPlan.	N/A
T2025	WAIVER SERVICES, NOT OTHERWISE SPECIFIED (NOS)	This service is not covered by Superior HealthPlan.	N/A
T2026	SPECIALIZED CHILDCARE, WAIVER, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
T2027	SPECIALIZED CHILDCARE, WAIVER, PER 15 MINUTES	Preauthorization required for all providers	Prior to 09/01/2019
T2028	SPECIALIZED SUPPLY, NOT OTHERWISE SPECIFIED, WAIVER	This service is not covered by Superior HealthPlan.	N/A
T2029	SPECIALIZED MEDICAL EQUIPMENT, NOT OTHERWISE SPECIFIED, WAIVER	This service is not covered by Superior HealthPlan.	N/A
T2030	ASSISTED LIVING, WAIVER, PER MONTH	This service is not covered by Superior HealthPlan.	N/A
T2031	ASSISTED LIVING, WAIVER, PER DIEM	Pre-authorization is required for Dual STAR+PLUS and STAR+PLUS members.	Prior to 09/01/2019
T2032	RESIDENTIAL CARE, NOT OTHERWISE SPECIFIED (NOS), WAIVER, PER MONTH	This service is not covered by Superior HealthPlan.	N/A
T2033	RESIDENTIAL CARE, NOT OTHERWISE SPECIFIED (NOS), WAIVER, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
T2034	CRISIS INTERVENTION WAIVER, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
T2035	UTILITY SVS/SUPPORT MEDICAL EQUIP&ASSISTIVE TECHNOLOGY/DEVICES, WAIVER	This service is not covered by Superior HealthPlan.	N/A
T2036	THERAPEUTIC CAMPING, OVERNIGHT, WAIVER, EACH SESSION	This service is not covered by Superior HealthPlan.	N/A
T2037	THERAPEUTIC CAMPING, DAY, WAIVER, EACH SESSION	This service is not covered by Superior HealthPlan.	N/A
T2038	COMMUNITY TRANSITION, WAIVER, PER SERVICE	Preauthorization required for all providers	Prior to 09/01/2019
T2039	VEHICLE MODIFICATIONS, WAIVER, PER SERVICE	Preauthorization required for all providers	Prior to 09/01/2019
T2040	FINANCIAL MANAGEMENT, SELF-DIRECTED, WAIVER, PER 15 MINUTES	Preauthorization required for all providers	Prior to 09/01/2019
T2041	SUPPORTS BROKERAGE, SELF-DIRECTED, WAIVER, PER 15 MINUTES	This service is not covered by Superior HealthPlan.	N/A
T2042	HOSPICE ROUTINE HOME CARE, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
T2043	HOSPICE CONTINUOUS HOME CARE, PER HOUR	This service is not covered by Superior HealthPlan.	N/A
T2044	HOSPICE INPATIENT RESPITE CARE, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
T2045	HOSPICE GENERAL INPATIENT CARE, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
T2046	HOSPICE Long-term CARE, ROOM AND BOARD ONLY, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
T2048	BHVRL HLTH/Long-term CARE RESDNTL, PER DIEM	This service is not covered by Superior HealthPlan.	N/A
T2049	NOT OTHERWISE CLASSIFIED HEAD, INCISION AND EXCISION	This service is not covered by Superior HealthPlan.	N/A
T2101	HUMAN BREAST MILK PROCESSING, STORAGE AND DISTRIBUTION ONLY	This service is not covered by Superior HealthPlan.	N/A
T3303	IMPLANT/HEPARIN PUMP/SUBCLAVICULAR FOSSA W/DELIVERY CATHETER THREADED IN	No pre-authorization is required for all providers.	N/A
T3305	CUTDOWN PLACEMENT OF PERMANENT SUBCLAVIAN CATHETER FOR HEMODIALYSIS.	No pre-authorization is required for all providers.	N/A
T4521	ADLT SIZED DISPBL INCONT PROD BRFDIAPER SM EA	Pre-authorization required for all providers.	Prior to 09/01/2019
T4522	ADLT SIZED DISPBL INCONT PROD BRFDIAPER MED EA	Pre-authorization required for all providers.	Prior to 09/01/2019
T4523	ADLT SIZED DISPBL INCONT PROD BRFDIAPER LG EA	Pre-authorization required for all providers.	Prior to 09/01/2019
T4524	ADLT SZD DISPBL INCONT PROD BRFDIAPER X-LG EA	Pre-authorization required for all providers.	Prior to 09/01/2019
T4525	ADLT SZD DISPBL INCONT PROD UNDWEAR/PULLON SM EA	Pre-authorization required for all providers.	Prior to 09/01/2019
T4526	ADLT SZD DISPBL INCONT PROD UNDWEAR MED EA	Pre-authorization required for all providers.	Prior to 09/01/2019
T4527	ADLT SZD DISPBL INCONT PROD UNDWEAR/PULLON LG EA	Pre-authorization required for all providers.	Prior to 09/01/2019
T4528	ADLT SZD DISPBL INCONT PROD UNDWEAR XTRA LG EA	Pre-authorization required for all providers.	Prior to 09/01/2019
T4529	PED SZD DISPBL INCONT PROD BRFDIAPER SM/MED EA	Pre-authorization required for all providers.	Prior to 09/01/2019
T4530	PED SZD DISPBL INCONT PROD BRFDIAPER LG SZ EA	Pre-authorization required for all providers.	Prior to 09/01/2019
T4531	PED SZD DISPBL INCONT PROD UNDWEAR SM/MED EA	Pre-authorization required for all providers.	Prior to 09/01/2019
T4532	PED SZD DISPBL INCONT PROD UNDWEAR/PULLON LG EA	Pre-authorization required for all providers.	Prior to 09/01/2019
T4533	YOUTH SIZED DISPBL INCONT PRODUCT BRFDIAPER EA	Pre-authorization required for all providers.	Prior to 09/01/2019
T4534	YOUTH SZD DISPBL INCONT PROD UNDWEAR/PULLON EA	Pre-authorization required for all providers.	Prior to 09/01/2019
T4535	DISPBL LINER/SHIELD/GUARD/PAD/UNDGRMNT INCONT EA	Pre-authorization required for all providers.	Prior to 09/01/2019
T4536	INCONT PROD PROTVE UNDWEAR/PULLON REUSBL SIZE EA	This service is not covered by Superior HealthPlan.	N/A
T4537	INCONT PROD PROTVE UNDPAD REUSABLE BED SIZE EA	This service is not covered by Superior HealthPlan.	N/A
T4538	DIAPER SERVICE REUSABLE DIAPER EACH DIAPER	This service is not covered by Superior HealthPlan.	N/A
T4539	INCONTINENCE PRODUCT DIAPER/BRF REUSABLE SIZE EA	This service is not covered by Superior HealthPlan.	N/A
T4540	INCONT PROD PROTVE UNDPAD REUSABLE CHAIR SIZE EA	This service is not covered by Superior HealthPlan.	N/A
T4541	INCONTINENCE PRODUCT DISPOSABLE UNDPAD LARGE EA	This service is not covered by Superior HealthPlan.	N/A
T4542	INCONTINENCE PRODUCT DISPBL UNDPAD SMALL SIZE EA	This service is not covered by Superior HealthPlan.	N/A
T4543	DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, BARIATRIC, EACH	Pre-authorization required for all providers.	Prior to 09/01/2019
T4544	ADLT DISP UNDPAD/PULL ON ABV X	Pre-authorization required for all providers.	Prior to 09/01/2019
T4545	INCONTINENCE PRODUCT DISPOSABLE PENILE WRAP EACH	This service is not covered by Superior HealthPlan.	N/A
T5001	POSITIONING SEAT FOR PERSONS WITH SPECIAL ORTHOPEDIC NEEDS	This service is not covered by Superior HealthPlan.	N/A
T5905	VAGINAL DELIVERY ONLY (W/WO FORCEPS AND/OR EPIS) EXCLUDES INHOSP POSTPAR	No pre-authorization is required for all providers.	N/A
T5909	CESAREAN SECTION LOW CERVICAL, INCLUDING IN HOSPITAL ANTEPARTUM CARE.	No pre-authorization is required for all providers.	N/A
T5999	SUPPLY NOT OTHERWISE SPECIFIED	This service is not covered by Superior HealthPlan.	N/A
T6005	SPINAL PUNCTURE, LUMBAR DIAGNOSTIC, FOR DECOMPRESSION INCLUDING HYDRODYN	No pre-authorization is required for all providers.	N/A
U0001	CDC 2019 NOVEL CORONAVIRUS RT RT-PCR DX PANEL	No pre-authorization is required for all providers.	N/A
U0002	2019-NCOV CORONAVIRUS SARS-COV-2/2019-NCOV	No pre-authorization is required for all providers.	N/A
V2020	FRAMES PURCHASES	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2025	DELUXE FRAME	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2100	SPHERE 1VIS PLANO +/- 4.00 PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2101	SPHERE 1VIS +/- 4.12-7.00D PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2102	SPHERE 1VIS +/- 7.12-20.00D PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2103	SPHEROCYLINDER 1VIS PLANO +/-4.0S .12-2.00C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2104	SPHEROCYLINDER 1VIS PLANO +/-4.0S 2.12-4.0C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2105	SPHEROCYLINDER 1VIS PLANO +/-4.0S 4.25-6.0C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2106	SPHEROCYLINDER 1VIS PLANO +/-4.0S OVER 6.0C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2107	SPHEROCYLINDER 1VIS +/- 4.25-7.00S .12-2.00C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2108	SPHEROCYLINDER 1VIS +/- 4.25-7.00S 2.12-4.00C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2109	SPHEROCYLINDER 1VIS +/- 4.25-7.00S 4.25-6.00D EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2110	SPHEROCYLINDER 1VIS +/- 4.25-7.00S 4.25-6.00C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2111	SPHEROCYLINDER 1VIS 4.25-7.00S OVER 6.00C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2112	SPHEROCYLINDER 1VIS +/- 7.25-12.0S .25-2.25C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2113	SPHEROCYLINDER 1VIS +/- 7.25-12.0S 2.25-4.00C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2114	SPHEROCYLINDER 1VIS SPHERE OVER +/- 12.00E EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2115	LENTICULAR (MYODISC) PER LENS SINGLE VIS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2116	LENTICULAR LENS NONASPHERIC PER LENS SINGLE VIS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2117	LENTICULAR ASPHERIC PER LENS SINGLE VIS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2118	ANISEIKONIC LENS SINGLE VIS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2121	LENTICULAR LENS, PER LENS, SINGLE	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2199	NOT OTHERWISE CLASSIFIED SINGLE VIS LENS	This service is not covered by Superior HealthPlan.	N/A
V2200	SPHERE BIFOC PLANO TO +/- 4.00D PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2201	SPHERE BIFOC +/- 4.12-7.00D PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2202	SPHERE BIFOC +/- 7.12-20.00C PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2203	SPHEROCYLINDER BIFOC PLANO +/- 4.0S .12-2.0C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2204	SPHEROCYLINDER BIFOC PLANO +/-4.0S 2.12-4.0C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2205	SPHEROCYLINDER BIFOC PLANO +/-04.0S 4.25-6.0C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2206	SPHEROCYLINDER BIFOC PLANO +/-4.0S OVER 6.0C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2207	SPHEROCYLINDER BIFOC +/-4.25-7.0S .12-2.00C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2208	SPHEROCYLINDER BIFOC +/- 4.25-7.0S 2.12-4.00C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2209	SPHEROCYLINDER BIFOC +/-4.25-7.0S 4.25-6.00C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2210	SPHEROCYLINDER BIFOC +/-4.25-7.0S OVER 6.00C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2211	SPHEROCYLINDER BIFOC +/-7.25-12.0S .25-2.25C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2212	SPHEROCYLINDER BIFOC +/-7.25-12.0S 2.25-4.00C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2213	SPHEROCYLINDER BIFOC +/-7.25-12.0S 4.25-6.00C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2214	SPHEROCYLINDER BIFOC SPHERE OVER +/- 12.00E EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2215	LENTICULAR (MYODISC) PER LENS BIFOCAL	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2216	LENTICULAR NONASPHERIC PER LENS BIFOCAL	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2217	LENTICULAR ASPHERIC LENS BIFOCAL	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2218	ANISEIKONIC PER LENS BIFOCAL	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2219	BIFOCAL SEG WIDTH OVER 28MM	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2220	BIFOCAL ADD OVER 3.25D	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2221	LENTICULAR LENS, PER LENS, BIFOCAL	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2299	SPECIALTY BIFOCAL (BY REPORT)	This service is not covered by Superior HealthPlan.	N/A
V2300	SPHERE TRIFOC PLANO +/-4.00D PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A

V2301	SPHERE TRIFOC +/- 4.12-7.00D PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2302	SPHERE TRIFOC +/- 7.12-20.00D PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2303	SPHEROCYLINDER TRIFOC PLANO +/-4.0S .12-2.0C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2304	SPHEROCYLINDER TRIFOC PLANO +/-4.0S 2.25-4.0C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2305	SPHEROCYLINDER TRIFOC PLANO +/-4.0S 4.25-6.0C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2306	SPHEROCYLINDER TRIFOC PLANO +/-4.0S OVER 6.0C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2307	SPHEROCYLINDER TRIFOC +/-4.25-7.0W .12-2.0C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2308	SPHEROCYLINDER TRIFOC +/-4.25-7.0 S 2.12-4.0C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2309	SPHEROCYLINDER TRIFOC +/-4.25-7.0S 4.25-6.0C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2310	SPHEROCYLINDER TRIFOC +/-4.25-7.0S OVER 6.0C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2311	SPHEROCYLINDER TRIFOC +/-7.25-12.0S .25-2.25C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2312	SPHEROCYLINDER TRIFOC +/-7.25-12.0S 2.25-4.0C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2313	SPHEROCYLINDER TRIFOC +/-7.25-12.0S 4.25-6.0C EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2314	SPHEROCYLINDER TRIFOC SHPERE OVER +/-12.00D EA	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2315	LENTICULAR MYODISC PER LENS TRIFOCAL	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2316	LENTICULAR NONASPHERIC PER LENS TRIFOCAL	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2317	LENTICULAR ASPHERIC LENS TRIFOCAL	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2318	ANISEIKONIC LENS TRIFOCAL	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2319	TRIFOCL SEG WIDTH OVER 28 MM	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2320	TRIFOCAL ADD OVER 3.25 D	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2321	LENTICULAR LENS, PER LENS, TRIFOCAL	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2399	SPECIALTY TRIFOCAL (BY REPORT)	This service is not covered by Superior HealthPlan.	N/A
V2410	VARY ASPHERICITY LENS SINGLE FULL FIELD PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2430	VARY ASPHERICITY BIFOCAL FULL FIELD PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2499	VARY SPHERICITY LENS OTHER TYPE	This service is not covered by Superior HealthPlan.	N/A
V2500	CONTACT LENS PMMA SPHERICAL PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2501	CONTACT LENS PMMA TORIC/PRISM BALLAST PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2502	CONTACT LENS PMMA BIFOCAL PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2503	CONTACT LENS COLOR VISION DEFICIT PER LENS	This service is not covered by Superior HealthPlan.	N/A
V2510	CONTACT LENS GAS PERMEABLE SPHERICAL PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2511	CONTACT LENS GAS PERMEABLE TORIC/PRISM PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2512	CONTACT LENS GAS PERMEABLE BIFOCAL PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2513	CONTACT LENS GAS PERMEABLE EXTEND WEAR PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2520	CONTACT LENS HYDROPHILIC SPHERICAL PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2521	CONTACT LENS HYDROPHILIC TORIC/PRISM PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2522	CONTACT LENS HYDROPHILIC BIFOCAL PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2523	CONTACT LENS HYDROPHILIC EXTENDED WEAR PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2530	CNTCT LENS SCLERAL/GAS IMPERMBL LENS (SEE 92325)	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2531	CONTACT LENS, SCLERAL, GAS PERMEABLE, PER LENS	Pre-authorization required for all providers.	Prior to 09/01/2019
V2599	CONTACT LENS OTHER TYPE	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2600	HAND HELD LOW VISION/NON SPECTACLE MOUNTED AIDS	This service is not covered by Superior HealthPlan.	N/A
V2610	SINGLE LENS SPECTACLE MOUNT LOW VISION AID	This service is not covered by Superior HealthPlan.	N/A
V2615	TELESCOPIC/OTHER COMPOUND LES SYSTEM	This service is not covered by Superior HealthPlan.	N/A
V2623	PROSTHETIC EYE PLASTIC CUSTOM	Pre-authorization required for all providers.	Prior to 09/01/2019
V2624	POLISHING/RESURFACING OF OCULAR PROSTHESIS	No pre-authorization is required for all providers.	N/A
V2625	ENLARGEMENT OF OCULAR PROSTHESIS	No pre-authorization is required for all providers.	N/A
V2626	REDUCTION OF OCULAR PROSTHESIS	No pre-authorization is required for all providers.	N/A
V2627	SCLERAL COVER SHELL	Pre-authorization required for all providers.	Prior to 09/01/2019
V2628	FABRICATION AND FITTING OF OCULAR CONFORMER	No pre-authorization is required for all providers.	N/A
V2629	PROSTHETIC EYE OTHER TYPE	This service is not covered by Superior HealthPlan.	N/A
V2630	ANTERIOR CHAMBER INTRAOCULAR LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2631	IRIS SUPPORTED INTRAOCULAR LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2632	POSTERIOR CHAMBER INTRAOCULAR LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2700	BALANCE LENS PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2702	DELUXE LENS FEATURE	This service is not covered by Superior HealthPlan.	N/A
V2710	SLAB OFF PRISM GLASS OR PLASTIC PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2715	PRISM PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2718	PRESS ON LENS FRESNELL PRISM PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2730	SPECIAL BASE CURVE GLASS OR PLASTIC PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2740	TINT PLASTIC ROSE 1 OR 2 PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2741	TINT PLASTIC OTHER THAN ROSE 1-2 PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2742	TINT GLASS ROSE 1 OR 2 PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2743	TINT GLASS OTHER THAN ROSE 1 OR 2 PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2744	TINT PHOTOCHROMATIC PER LENS	This service is not covered by Superior HealthPlan.	N/A
V2745	ADDTN TO LENS/TINT/ANY COLOR/SOLID/GRADIENT/OR EQUAL	This service is not covered by Superior HealthPlan.	N/A
V2750	ANTI-REFLECTIVE COATING PER LENS	This service is not covered by Superior HealthPlan.	N/A
V2755	U-V LENS PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2756	EYE GLASS CASE	This service is not covered by Superior HealthPlan.	N/A
V2760	SCRATCH RESISTANT COATING PER LENS	This service is not covered by Superior HealthPlan.	N/A
V2761	MIRROR COATING, ANY TYPE, SOLID, GRADIENT OR EQUAL	This service is not covered by Superior HealthPlan.	N/A
V2762	POLARIZATION, ANY LENS MATERIAL, PER LENS	This service is not covered by Superior HealthPlan.	N/A
V2770	OCCLUDER LENS PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2780	OVERSIZE LENS PER LENS	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V2781	PROGRESSIVE LENS, PER LENS	This service is not covered by Superior HealthPlan.	N/A
V2782	LENS/INDEX 1.54 TO 1.65 PLSTC/1.60 TO 1.79 GLASS, EXCL POLYCARBONATE	This service is not covered by Superior HealthPlan.	N/A
V2783	LENS/INDEX >OR EQUAL TO 1.66 OR >OR EQUAL TO 1.80 GLASS, EXCL PLYCRBNT	This service is not covered by Superior HealthPlan.	N/A
V2784	LENS, POLYCARBONATE OR EQUAL, ANY INDEX, PER LENS	Pre-authorization is required for all providers.	Prior to 09/01/2019
V2785	PROCESSING PRESERVING TRANSPORT CORNEAL TISSUE	This service is not covered by Superior HealthPlan.	N/A
V2786	SPECIALTY OCCUPATIONAL MULTIFOCAL LENS, PER LENS	This service is not covered by Superior HealthPlan.	N/A
V2787	ASTIGMATISM-CORRECT FUNCTION	This service is not covered by Superior HealthPlan.	N/A
V2788	PRESBYOPIA CORRECTING FUNCTION OF INTRAOCULAR LENS	This service is not covered by Superior HealthPlan.	N/A
V2790	AMNIOTIC MEMBRN SURG RECON P/PROC	Pre-authorization is required for all providers.	Prior to 09/01/2019
V2797	VISION SPLY, ACSRY &/OR SVC COMPONENT OF ANOTHER HCPCS VISION CODE	This service is not covered by Superior HealthPlan.	N/A
V2799	MISC VISION ITEM OR SERVICE	No prior authorization is required. Routine vision services administered by Envolve Vision services.	N/A
V5008	HEARING SCREENING	This service is not covered by Superior HealthPlan.	N/A
V5010	ASSESSMENT FOR HEARING AID	No authorization is required for Par Providers unless over the benefits limitation.	N/A
V5011	FITTING/ORIENTATION/CHECKING OF HEARING AID	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
V5014	REPAIR/MODIFICATION OF A HEARING AID	Pre-authorization required for all providers.	Prior to 09/01/2019
V5020	CONFORMITY EVALUATION	This service is not covered by Superior HealthPlan.	N/A
V5030	HEARING AID MONAURAL BODY WORN AIR CONDUCTION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5040	HEARING AID MONAURAL BODY WORN BONE CONDUCTION	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5050	HEARING AID MONAURAL IN THE EAR	This service is not covered by Superior HealthPlan.	N/A
V5060	HEARING AID MONAURAL BEHIND THE EAR	This service is not covered by Superior HealthPlan.	N/A
V5070	GLASSES AIR CONDUCTION	No pre-authorization is required for all providers.	N/A
V5080	GLASSES BONE CONDUCTION	No pre-authorization is required for all providers.	N/A
V5090	DISPENSING FEE UNSPECIFIED HEARING AID	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
V5095	SEMI-IMPL MID EAR HEARING PROSTH	This service is not covered by Superior HealthPlan.	N/A
V5100	HEARING AID BILATERAL BODY WORN	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5110	DISPENSING FEE BILATERAL	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
V5120	BINAURAL BODY	This service is not covered by Superior HealthPlan.	N/A
V5130	BINAURAL IN THE EAR	This service is not covered by Superior HealthPlan.	N/A
V5140	BINAURAL BEHIND THE EAR	This service is not covered by Superior HealthPlan.	N/A
V5150	BINAURAL GLASSES	No pre-authorization is required for all providers.	N/A
V5160	DISPENSING FEE BINAURAL	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
V5170	HEARING AID CROS IN THE EAR	This is no longer a valid code.	N/A
V5171	HEARING AID CONTRALAT ROUT DEVICE MONAURAL ITE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5172	HEARING AID CONTRALAT ROUT DEVICE MONAURAL ICT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5180	HEARING AID CROS BEHIND THE EAR	This is no longer a valid code.	N/A
V5181	HEARING AID CONTRALATERAL ROUT DVC MONAURAL BTE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5190	HEARING AID CONTRALATERAL RTE MONAURAL GLASSES	No pre-authorization is required for all providers.	N/A
V5200	DISPENSING FEE CONTRALATERAL MONAURAL	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
V5210	HEARING AID BICROS IN THE EAR	This is no longer a valid code.	N/A

V5211	HEARING AID CONTRALAT ROUT SYS BINAURAL ITE/ITE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5212	HEARING AID CONTRALAT ROUT SYS BINAURAL ITE/ITC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5213	HEARING AID CONTRALAT ROUT SYS BINAURAL ITE/BTE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5214	HEARING AID CONTRALAT ROUT SYS BINAURAL ITC/ITC	No pre-authorization is required for all providers.	N/A
V5215	HEARING AID CONTRALAT ROUT SYS BINAURAL ITC/BTE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5220	HEARING AID BICROS BEHIND THE EAR	This is no longer a valid code.	N/A
V5221	HEARING AID CONTRALAT ROUT SYS BINAURAL BTE/BTE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5230	HEARING AID CONTRALAT RTE SYS BINAURAL GLASSES	No pre-authorization is required for all providers.	N/A
V5240	DISPENSING FEE CONTRALATERAL RTE SYSTEM BINAURAL	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
V5241	DISPENSING FEE, MONAURAL HEARING AID, ANY TYPE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
V5242	HEARING AID, ANALOG, MONAURAL, CIC (COMPLETELY IN THE EAR CANAL)	This service is not covered by Superior HealthPlan.	N/A
V5243	HEARING AID, ANALOG, MONAURAL, ITC (IN THE CANAL)	This service is not covered by Superior HealthPlan.	N/A
V5244	HEARING AID, DIGITALLY PROGRAMMABLE ANALOG, MONAURAL, CIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5245	HEARING AID, DIGITALLY PROGRAMMABLE, ANALOG, MONAURAL, ITC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5246	HEARING AID, DIGITALLY PROGRAMMABLE ANALOG, MONAURAL, ITE (IN THE EAR)	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5247	HEARING AID DIGITALLY PROGRAMMABLE ANALOG MONAURAL	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5248	HEARING AID, ANALOG, BINAURAL, CIC	This service is not covered by Superior HealthPlan.	N/A
V5249	HEARING AID, ANALOG, BINAURAL, ITC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5250	HEARING AID, DIGITALLY PROGRAMMABLE ANALOG, BINAURAL, CIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5251	HEARING AID, DIGITALLY PROGRAMMABLE ANALOG, BINAURAL, ITC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5252	HEARING AID, DIGITALLY PROGRAMMABLE, BINAURAL, ITE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5253	HEARING AID, DIGITALLY PROGRAMMABLE, BINAURAL, BTE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5254	HEARING AID, DIGITAL, MONAURAL, CIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5255	HEARING AID, DIGITAL, MONAURAL, ITC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5256	HEARING AID, DIGITAL, MONAURAL, ITE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5257	HEARING AID, DIGITAL, MONAURAL, BTE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5258	HEARING AID, DIGITAL, BINAURAL, CIC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5259	HEARING AID, DIGITAL, BINAURAL, ITC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5260	HEARING AID, DIGITAL, BINAURAL, ITE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5261	HEARING AID, DIGITAL, BINAURAL, BTE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5262	HEARING AID, DISPOSABLE, ANY TYPE, MONAURAL	This service is not covered by Superior HealthPlan.	N/A
V5263	HEARING AID, DISPOSABLE, ANY TYPE, BINAURAL	This service is not covered by Superior HealthPlan.	N/A
V5264	EAR MOLD/INSERT, NOT DISPOSABLE, ANY TYPE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
V5265	EAR MOLD/INSERT, DISPOSABLE, ANY TYPE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
V5266	BATTERY FOR USE IN HEARING DEVICE	Pre-authorization is not required unless it exceeds benefit limitation.	Prior to 09/01/2019
V5267	HEARING AID SUP/ACCESS/DEV	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5268	ASSISTIVE LISTENING DEVICE, TELEPHONE AMPLIFIER, ANY TYPE	This service is not covered by Superior HealthPlan.	N/A
V5269	ASSISTIVE LISTENING DEVICE, ALERTING, ANY TYPE	This service is not covered by Superior HealthPlan.	N/A
V5270	ASSISTIVE LISTENING DEVICE, TELEVISION AMPLIFIER, ANY TYPE	This service is not covered by Superior HealthPlan.	N/A
V5271	ASSISTIVE LISTENING DEVICE, TELEVISION CAPTION DECODER	This service is not covered by Superior HealthPlan.	N/A
V5272	ASSISTIVE LISTENING DEVICE, TDD	This service is not covered by Superior HealthPlan.	N/A
V5273	ASSISTIVE LISTENING DEVICE, FOR USE WITH COCHLEAR IMPLANT	This service is not covered by Superior HealthPlan.	N/A
V5274	ASSISTIVE LISTENING DEVICE, NOT OTHERWISE SPECIFIED	This service is not covered by Superior HealthPlan.	N/A
V5275	EAR IMPRESSION, EACH	No authorization is required for Par Providers unless over the benefits limitation.	N/A
V5281	ALD FM/DM SYSTEM, MONAURAL	This service is not covered by Superior HealthPlan.	N/A
V5282	ALD FM/DM SYSTEM BINAURAL	This service is not covered by Superior HealthPlan.	N/A
V5283	ALD NECK, LOOP IND RECEIVER	This service is not covered by Superior HealthPlan.	N/A
V5284	ALD FM/DM EAR LEVEL RECEIVER	This service is not covered by Superior HealthPlan.	N/A
V5285	ALD FM/DM AUD INPUT RECEIVER	This service is not covered by Superior HealthPlan.	N/A
V5286	ALD BLU TOOTH FM/DM RECEIVER	This service is not covered by Superior HealthPlan.	N/A
V5287	ALD FM/DM RECEIVER, NOS	This service is not covered by Superior HealthPlan.	N/A
V5288	ALD FM/DM TRANSMITTER ALD	This service is not covered by Superior HealthPlan.	N/A
V5289	ALD FM/DM ADAPT/BOOT COUPLIN	This service is not covered by Superior HealthPlan.	N/A
V5290	ALD TRANSMITTER MICROPHONE	This service is not covered by Superior HealthPlan.	N/A
V5298	HEARING AID NOC	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5299	HEARING SERVICE MISCELLANEOUS	This service is not covered by Superior HealthPlan.	N/A
V5336	REPAIR MODIFY AUGMENT COMMUNICATION SYS/DEVICE	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
V5362	SPEECH SCREENING	This service is not covered by Superior HealthPlan.	N/A
V5363	LANGUAGE SCREENING	This service is not covered by Superior HealthPlan.	N/A
V5364	DYSPHAGIA SCREENING	This service is not covered by Superior HealthPlan.	N/A
Y4190	PUNCTUM PLUG KIT	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Y5911	MASK	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Y6103	EXTRA CHARGE ADDITIONAL ATTENDANT.	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019
Y7114	CONTINUOUS AMBULATORY PERITONEAL DIALYSIS SUPPLY KIT, PER MONTH.	Please contact Superior HealthPlan for pre-authorization requirements.	Prior to 09/01/2019