Medicare Advantage and Dual Eligible Special Needs Plans
Prior Authorization and Notification List

We have updated our CarePlus Health Plans prior authorization and notification list for CarePlus Medicare Advantage (MA) and Dual Eligible Special Needs (D-SNP) plans.

Please note the term "prior authorization" (preauthorization, precertification, preadmission), when used in this communication, is defined as a process through which the physician or other healthcare provider is required to obtain advance approval from the plan as to whether an item or service will be covered.

"Notification" refers to the process by which the physician or other healthcare provider notifies CarePlus of the intent to provide an item or service. CarePlus requests notification, as it helps coordinate care for CarePlus-covered patients. This process is distinguished from prior authorization. CarePlus does not issue an approval or denial for notifications.

The list details services and medications (i.e., medications that are delivered in the physician's office, clinic, outpatient or home setting) that require prior authorization prior to being provided or administered. Services must be provided according to Medicare coverage guidelines established by the Centers for Medicare & Medicaid Services (CMS). According to the guidelines, all medical care, services, supplies and equipment must be medically necessary. You can review Medicare coverage guidelines on the CMS website.

To view Humana's medical coverage policies, please visit Humana's Medical and Pharmacy Coverage Policies website.

Investigational and experimental procedures and devices usually are not covered benefits. Please consult the patient's Evidence of Coverage or contact CarePlus for confirmation of coverage.

Important notes:

- **CarePlus MA health maintenance organization (HMO):** The full list of prior authorization requirements applies to your patients with CarePlus MA HMO coverage.
- For procedures or services that are investigational or experimental (or that may have limited benefit coverage), or for any service not on our prior authorization list (PAL), you can request a predetermination on behalf of the patient prior to providing the service. You may be contacted if additional information is needed.
    - Initiate a predetermination for medical services by submitting a fax or telephone request:
        - Submit by fax: **888-447-3430** (When submitting a predetermination request by fax, please write "predetermination" on your request.)
        - Submit by calling **866-220-5448**, Monday – Friday, 8 a.m. to 5 p.m., Eastern time (When requesting a predetermination by phone, please advise CarePlus you're requesting a "predetermination.")

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Please note that urgent/emergent services do not require referrals or prior authorization.

Not obtaining prior authorization for a service could result in financial penalties for the practice and reduced benefits for the patient based on the healthcare provider's contract and the patient's Evidence of Coverage. Services or medication provided without prior authorization may be subject to retrospective medical necessity review. We recommend that an individual practitioner making a specific request for services or medication verify benefits and prior authorization requirements with CarePlus prior to providing services.

New rule improves the prior authorization process:

Effective Jan. 1, 2026, CMS requires prior authorization decisions within 7 days for certain medical items/services requests. Providing supporting clinical information at the time of the prior authorization request submission helps support timely adjudication. Failure to do so may result in a delayed or adverse decision. Adherence to this process should begin immediately.

Information required for a prior authorization request or notification may include, but is not limited to, the following:

- The member's CarePlus ID number, name and date of birth
- Date of actual service or hospital admission
- Procedure codes (up to a maximum of 10 per authorization request)
- Date of proposed procedure (if applicable)
- Diagnosis codes (primary and secondary) (up to a maximum of 6 per authorization request)
- Service location
- Inpatient (e.g., acute hospital, skilled nursing)
- Outpatient (e.g., telehealth, office, home, off-campus outpatient hospital, on-campus outpatient hospital, ambulatory surgery center, etc.)
- Referral (e.g., office, off-campus outpatient hospital, on-campus outpatient hospital, ambulatory surgery center, other)
- Tax Identification Number (TIN), National Provider Identifier (NPI) number of treatment facility where service is being rendered, and TIN and NPI number of the provider performing the service
- Requester's name/phone number
- Attending physician's phone number
- Relevant clinical information
- Discharge plans

Submitting all relevant clinical information at the time of the request will help with timely processing of the determination. If additional clinical information is required, a CarePlus representative will contact the individual who submitted the prior authorization request and request the specific information needed to complete the authorization process.

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

How to request prior authorization:

Except where noted by links on the following pages, prior authorization requests for medical services may be initiated: Choose from the following options to submit a request for prior authorization:

- Submit the request on the Availity Essentials™ website.
- Complete the Health Services Prior Authorization Form and fax it (and a cover sheet) to the appropriate fax number:
  - Broward and Palm Beach counties: **866-832-2678**
  - Miami-Dade County: **888-447-3430**
  - All other counties: **888-634-3521**
- Call the CarePlus Health Plans Utilization Management department at **866-220-5448**, Monday – Friday, 8 a.m. to 5 p.m., Eastern time.

Please note: Online prior authorization requests are encouraged. For certain PAL services requested via Availity Essentials, healthcare providers have an option to complete a questionnaire. Answers to the questionnaire could lead to real-time approval. If approval is not provided immediately, the information on the questionnaire may help CarePlus with the review.

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

CarePlus HEALTH PLANS

Medicare Advantage and Dual Medicare-Medicaid Plans Prior Authorization and Notification List

Effective date: July 1, 2026

Revision date: November 2, 2026

Category	Details/notes	Codes
Abdominoplasty		15830, 15847
Ablation	Bone, liver, kidney and prostate cancer	20982, 20983, 47370, 47371, 47380, 47381, 47382, 47383, 47384, 50250, 50541, 50542, 50592, 50593, 51721, 52597, 53850, 53852, 53854, 55873, 55877, 55881, 55882, 0582T, 0600T, 0601T, 0947T, 0950T
	Cardiac ablation/ electrophysiology	93650, 93653, 93654, 93656
Behavioral health services	Partial hospitalization	900, 904, 910, 912, 913, 914, 915, 916, 918, 942
	Transcranial magnetic stimulation	90867, 90868, 90869, E0732
	Psychosocial rehab services, clubhouse services, targeted case management	H2017, H2030, T1017
Blepharoplasty		15820, 15821, 15822, 15823, 67900, 67903, 67904, 67908,

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Blepharoplasty (continued)		67909, 67911, 67914, 67916, 67917, 67921, 67923, 67924, 67950
Bone growth stimulators		E0747, E0748, E0760
Breast procedures	Breast cancer biopsy (excisional)	19120, 19125
	Breast lumpectomy	19301, 19302
	Other breast procedures (excludes breast reconstruction following medically necessary mastectomies for breast cancer)	11971, 19316, 19318, 19325, 19328, 19330, 19340, 19342, 19350, 19357, 19370, 19371, 19380, 0970T, 0971T, C1789, L8600
	Simple mastectomy and gynecomastia surgery (excludes radical and modified)	19300, 19303
Capsule endoscopy		91110, 91111, 91113, 0651T, 0977T
Cardiac devices	Aorta repair	33875, 33877, 33880, 33881, 33882, 33883, 33886, 34701, 34702, 34703, 34704, 34705, 34706, 34830, 34831, 34832, 34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848, 0994T, 0995T
	Cardiac implantable devices (e.g., CardioMEMS™ pacemakers, leadless pacemakers, left atrial appendage closure, defibrillators [implantable and subcutaneous] and	33206, 33207, 33208, 33212, 33213, 33214, 33216, 33217, 33221, 33224, 33225, 33227, 33228, 33229, 33230, 33231, 33233, 33234, 33235, 33240, 33241, 33244, 33249, 33262, 33263, 33264, 33270, 33271, 33272, 33273, 33274, 33275, 33289, 33340, 93264, 0408T,

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Cardiac devices (continued)	cardiac resynchronization therapy)	0409T, 0410T, 0411T, 0412T, 0413T, 0414T, 0415T, 0416T, 0417T, 0418T, 0571T, 0572T, 0573T, 0574T, 0580T, 0614T, 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, 0823T, 0824T, 0825T, 0826T, 0915T, 0916T, 0917T, 0918T, 0919T, 0920T, 0921T, 0922T, 0923T, 0924T, 0925T, 0926T, 0927T, 0933T, 0934T, 0981T, 0982T, 0983T, 1050T*, 1051T*, C1605, C1721, C1722, C1777, C1779, C1785, C1786, C1824, C1882, C1895, C1896, C1898, C1899, C1900, C2619, C2620, C2621, C2624, G0555
	Loop recorders	33285, 33286
	Implantable carotid sinus stimulator	64654, 64655, 64656, 64657, 64658, 64659, 93145, 93146, C1825
	Wearable cardiac monitoring devices	93228, 93229
Cardiac procedures/surgeries	Cardiac catheterization	93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597
	Carotid revascularization	35301, 37215, 37216, 37217, 37218
	Coronary angioplasty/stent	92920, 92924, 92928, 92930, 92933, 92937, 92943, 92945, 92972, 0913T, 0914T, C1761, C7571, C9600, C9602, C9604, C9607
	Patent foramen ovale and atrial septal defect closure	93580

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Cardiac procedures/surgeries (continued)	**Transcatheter valve surgeries** Transcatheter mitral valve replacement (TMVR), Transcatheter aortic valve replacement (TAVR), Transcatheter aortic valve implantation (TAVI), MitraClip	33361, 33362, 33363, 33364, 33365, 33366, 33418, 0345T, 0805T, 0806T
Cellular (including chimeric antigen receptor T-cell therapy [CAR T]), genetic, tissue and transplant therapies	Prior authorization requests will be reviewed by the **Humana National Transplant Network** • Submit by fax to **502-508-9300**. • Submit by telephone to **866-421-5663**. • Submit by email to transplant@humana.com.	38225, 38226, 38227, 38228, 38999, 60699, C9399, J3386*, J3387, J3389, J3391, J3392, J3393, J3394, J3402*, J3490, J3590, J9999, Q2041, Q2042, Q2053, Q2054, Q2055, Q2056, Q2057, Q2058
Chemotherapy agents/supportive drugs and symptom management drugs category		This list is subject to change as new prescription drugs are brought to market. View the CarePlus Medicare Part B Medication and Step Therapy List.
Cutaneous vascular lesion removal		17106, 17107, 17108
Decompression of peripheral nerve (e.g., carpal tunnel surgery)		29848, 64721, 64728
Diagnostic/cardiac imaging	Computed tomography (CT) scan	71260, 71270, 71275, 72126, 72127, 72130, 72132, 72133, 72191, 72193, 72194, 73206, 73706, 74160, 74170, 74174,

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Diagnostic/cardiac imaging (continued)		74175, 74177, 74178, 75572, 75573, 75574, 75635
	Electrophysiology (EPS) or EPS with 3D mapping	93600, 93602, 93603, 93610, 93612, 93618, 93619, 93620, 93631, 93640, 93641, 93642, 93644, 0577T
	Magnetic resonance angiography (MRA)	70544, 70545, 70546, 70547, 70548, 70549, 71555, 72159, 72198, 73225, 73725, 74185, C8900, C8901, C8902, C8909, C8910, C8911, C8912, C8913, C8914, C8918, C8919, C8920, C8931, C8932, C8933, C8934, C8935, C8936
	Magnetic resonance imaging (MRI)	70336, 70543, 70554, 70555, 71550, 71551, 71552, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72195, 72196, 72197, 73221, 73222, 73223, 73721, 73722, 73723, 74181, 74182, 74183, 75557, 75559, 75561, 75563, 77046, 77047, 77048, 77049, C8903, C8905, C8906, C8908, C9762, C9763, C9791
	Myocardial perfusion imaging single-photon emission computed tomography (MPI SPECT)	78451, 78452, A9611
	Nuclear stress test	78453, 78454, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 93350, 93351, C8928, C8930
	Peripheral angiography	36245, 36246, 36247
	Positron emission tomography (PET)	78429, 78430, 78431, 78432, 78433, 78459, 78491, 78492,

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Diagnostic/cardiac imaging (continued)	scan/National Oncology PET Registry	78608, 78811, 78812, 78813, 78814, 78815, 78816
	Prostate-specific membrane antigen (PSMA/PET CT)	A9587, A9593, A9594, A9595, A9596, A9597, A9608, A9616, A9800
	Single-photon emission computed tomography (SPECT) scan	78494
	Transesophageal echocardiogram (TEE)	93312, 93313, 93314, 93315, 93316, 93317, 93318, 93355, C8925, C8926, C8927
Electric beds		E0193, E0194, E0265, E0266, E0296, E0297
Emerging technology/new indications for existing technology		31647, 31648, 31649, 31651, 43284, 53865, 53866, 0338T, 0339T, 0446T, 0447T, 0448T, 0716T, 0745T, 0746T, 0747T, 0935T, C1735, C1736, E0738, E0739
Epidural injections (outpatient only)		62320, 62321, 62322, 62323, 64479, 64480, 64483, 64484, 64999
Esophagogastroduodenoscopy (EGD)		43235, 43237, 43238, 43239, 43242, 43252, 43253, 43259
Facet injections		64490, 64491, 64492, 64493, 64494, 64495, 64633, 64634, 64635, 64636, 64999, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T
Facility-based sleep studies (PSG)		95807, 95808, 95810, 95811
Foot surgeries: bunionectomy and hammertoe		26535, 26536, 28110, 28240, 28285, 28289, 28291, 28292,

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Foot surgeries: bunionectomy and hammertoe (continued)		28295, 28296, 28297, 28298, 28299, 28306, 28308, 28310, 28740, 28750, L8641
Gastric pacing		43647, 43648, 43881, 43882, 64590
Genicular nerve ablation and genicular nerve blocks		64454, 64624
High-frequency chest compression vests		E0483
Home health/home infusion		99512, 99600, G0151, G0152, G0153, G0155, G0156, G0157, G0158, G0159, G0160, G0161, G0162, G0299, G0300, G0493, G0494, G0495, G0496, G2168, G2169
Hyperbaric therapy		99183, G0277
Inpatient admissions	Acute hospital (includes inpatient hospice)	All
	Acute rehabilitation facilities	All
	Long-term, acute-care hospitals	All
	Mental health, substance use and residential treatment	All
	Skilled nursing facilities	All
Laparoscopic hiatal hernia repair		43280, 43281, 43282
Lung biopsy and resection		32096, 32097, 32505, 32607, 32608, 32666

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Microinvasive glaucoma surgery (MIGS)		66989, 66991, 0253T, 0449T, 0450T, 0660T, 0661T, 0671T
Molecular diagnostic/genetic testing		81105, 81112, 81120, 81121, 81161, 81162, 81163, 81165, 81166, 81167, 81168, 81175, 81176, 81177, 81178, 81179, 81180, 81181, 81182, 81183, 81184, 81185, 81187, 81189, 81191, 81192, 81193, 81194, 81195, 81200, 81201, 81203, 81204, 81205, 81212, 81216, 81218, 81219, 81220, 81223, 81225, 81226, 81227, 81229, 81230, 81231, 81233, 81234, 81236, 81240, 81241, 81242, 81243, 81244, 81247, 81249, 81250, 81251, 81255, 81257, 81259, 81260, 81265, 81266, 81269, 81272, 81273, 81275, 81276, 81277, 81278, 81279, 81283, 81284, 81286, 81287, 81290, 81291, 81292, 81294, 81295, 81297, 81298, 81300, 81302, 81305, 81306, 81307, 81308, 81309, 81310, 81311, 81312, 81314, 81317, 81319, 81320, 81321, 81323, 81324, 81325, 81328, 81329, 81330, 81333, 81334, 81335, 81336, 81338, 81339, 81343, 81344, 81345, 81347, 81348, 81350, 81351, 81352, 81354, 81355, 81357, 81361, 81364, 81376, 81400, 81401, 81402, 81403, 81404, 81405, 81406, 81407, 81408, 81410, 81411, 81412, 81413, 81414, 81415, 81416, 81418, 81419, 81422, 81425, 81426, 81430, 81431, 81432, 81434, 81435, 81437, 81439, 81440, 81443, 81445, 81448, 81449, 81450, 81451, 81455, 81456, 81457, 81458, 81459,

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Molecular diagnostic/genetic testing (continued)		81460, 81462, 81463, 81464, 81465, 81471, 81479, 81490, 81503, 81518, 81519, 81520, 81521, 81522, 81524, 81525, 81529, 81540, 81546, 81554, 81558, 81599, 83080, 0020M, 0005U, 0018U, 0026U, 0037U, 0045U, 0089U, 0090U, 0118U, 0172U, 0211U, 0212U, 0213U, 0214U, 0216U, 0217U, 0239U, 0242U, 0245U, 0250U, 0299U, 0313U, 0315U, 0326U, 0329U, 0333U, 0334U, 0340U, 0345U, 0347U, 0349U, 0355U, 0356U, 0358U, 0359U, 0378U, 0379U, 0388U, 0411U, 0419U, 0422U, 0433U, 0434U, 0437U, 0449U, 0473U, 0475U, 0485U, 0486U, 0487U, 0489U, 0493U, 0510U, 0532U, 0533U, 0534U, 0537U, 0538U, 0539U, 0543U, 0549U, 0552U, 0553U, 0554U, 0555U, 0560U, 0561U, 0562U, 0565U, 0566U, 0567U, 0569U, 0571U, 0572U, 0578U, 0602U, 0605U, 0611U, 0612U, 0613U, 0616U, 0617U*, 0618U, 0619U, 0620U, 0622U, 0623U, 0624U, 0625U, 0626U, 0627U, 0628U, 0630U, 0631U*, 0633U*, 0634U*, 0635U*, 0641U*, 0642U*, 0643U*, 0644U*, 0645U*, 0646U*, 0647U*, 0648U*, 0649U*, 0650U*, 0651U*, 0652U*, 0653U*, 0657U*, 0658U*, 0659U*, 0668U*, 0686U*, 0688U*, 0689U*, 0693U*, 0695U*
Negative pressure wound therapy (NPWT)		97605, 97606, A6550, E2402, K0743
Neuromuscular stimulators		A4593, A4594, C9807, E0764, E0770

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Neurostimulators		1013T, 1014T, 1015T, 1027T*, 1028T*, 1029T*, 61860, 61863 61867, 61885, 61886, 61889 61891, 61892, 64553, 64555 64561, 64566, 64567, 64568 64575, 64581, 64590,64596, 64597, 64598, 0587T,0588T, 0783T, 0786T, 0787T, 0816T, 0817T, 0818T, 0819T, 0908T, 0909T, 0910T, 0911T, 0912T, 0956T, 0957T, 0958T, 0959T, 0960T, 0968T, 0969T, 0988T, 0989T, C1607, C1767, C1787, C1826, C9807, E0721, E0734, E0735, E0736, E0737, E0743, L8683
Noninvasive home ventilators		E0466, E0468
Obesity surgeries		0813T, 43290, 43291, 43631, 43632, 43633, 43634, 43644, 43645, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888, 43889, C9785
Observation	Observation notification required	All
Oral, orthognathic temporomandibular joint (TMJ) surgeries		20910, 21010, 21050, 21070, 21085, 21100, 21110, 21125, 21127, 21141, 21142, 21143, 21145, 21146, 21147, 21150, 21151, 21154, 21155, 21159, 21160, 21188, 21193, 21194, 21195, 21196, 21198, 21199, 21206, 21208, 21210, 21215, 21240, 21242, 21243, 21244, 21247, 29800, 29804

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Orthotics		L0452, L0456, L0457, L0458, L0460, L0462, L0464, L0480, L0482, L0484, L0486, L0488, L0624, L0629, L0631, L0632, L0634, L0635, L0636, L0637, L0638, L0639, L0640, L0700, L0710, L0999, L1000, L1200, L1499, L1680, L1685, L1686, L1690, L1700, L1730, L1834, L1840, L1843, L1844, L1845, L1846, L1848, L1851, L1852, L1860, L1907, L1932, L1945, L1950, L1951, L1960, L1970, L2000, L2005, L2006, L2010, L2020, L2030, L2034, L2036, L2037, L2038, L2106, L2108, L2128, L2136, L2350, L2525, L2526, L2627, L2999, L3671, L3674, L3720, L3730, L3740, L3763, L3764, L3765, L3766, L3900, L3901, L3904, L3905, L3961, L3971, L3973, L3977, L3999, L4631, L8683, L8701, L8702
Orthopedic surgeries: hip, knee and shoulder arthroscopy		23929, 27299, 27412, 27599, 29805, 29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, 29826, 29827, 29828, 29850, 29851, 29860, 29861, 29862, 29863, 29866, 29867, 29870, 29871, 29873, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886, 29887, 29888, 29889, 29914, 29915, 29916, 29999, C9781, J7330
Orthopedic surgeries: hip, knee and shoulder arthroplasty		23472, 23473, 23474, 27125, 27130, 27132, 27134, 27137, 27138, 27437, 27438, 27440, 27441, 27442, 27443, 27446, 27447, 27486, 27487, C8003

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Other durable medical equipment (DME)		A4238, A4239, A9274, E0277, E0301, E0302, E0303, E0304, E0469, E0481, E0482, E0486, E0490, E0491, E0492, E0493, E0650, E0651, E0652, E0658, E0659, E0660, E0665, E0666, E0667, E0668, E0669, E0670, E0671, E0672, E0673, E0675, E0676, E0677, E0678, E0679, E0680, E0681, E0682, E0683, E0691, E0692, E0693, E0694, E0762, E0766, E0784, E2102, E2103, E2402, E2508, E2510, E2599, E3000, K0743, K0900, K1007, K1027, L0720, L1933, L1952
Pain infusion pump		62324, 62325, 62326, 62327, 62350, 62351, 62360, 62361, 62362, 64999, C1772, C1891, C2626, C9804, C9806, E0782, E0783, E0785, E0786
Penile implant		54405
Percutaneous lumbar intravertebral disc injection		0627T, 0628T, 0629T, 0630T
Peripheral revascularization (atherectomy, angioplasty)		37236, 37238, 37242, 37243, 37254, 37256, 37258, 37260, 37262*, 37263, 37265, 37267, 37269, 37271, 37273, 37275, 37277, 37279*, 37280, 37282, 37284, 37286, 37288, 37290, 37292, 37294, 37296, 37298, 0234T, 0235T, 0236T, 0237T, 0238T, 0505T, C9764, C9765, C9766, C9767, C9772, C9773, C9774, C9775
Prostate surgeries (prostatectomy)		55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845, 55866, 55867, 55868, 55869, 55880

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Prosthetics		21081, 21082, 21084, A9282, L5000, L5010, L5020, L5050, L5060, L5100, L5105, L5150, L5160, L5200, L5210, L5220, L5230, L5250, L5270, L5280, L5301, L5312, L5321, L5331, L5341, L5420, L5500, L5505, L5510, L5520, L5530, L5535, L5540, L5560, L5570, L5580, L5585, L5590, L5595, L5600, L5610, L5611, L5613, L5614, L5615, L5616, L5617, L5618, L5620, L5622, L5624, L5626, L5628, L5629, L5630, L5631, L5632, L5634, L5636, L5637, L5638, L5639, L5640, L5642, L5643, L5644, L5645, L5646, L5647, L5648, L5649, L5650, L5651, L5652, L5653, L5654, L5655, L5656, L5657, L5658, L5661, L5665, L5666, L5668, L5670, L5671, L5672, L5673, L5676, L5677, L5678, L5679, L5681, L5682, L5683, L5684, L5685, L5686, L5688, L5690, L5692, L5694, L5695, L5696, L5697, L5698, L5699, L5700, L5701, L5702, L5703, L5704, L5705, L5706, L5707, L5710, L5711, L5712, L5714, L5716, L5718, L5722, L5724, L5726, L5728, L5780, L5781, L5782, L5783, L5785, L5790, L5795, L5810, L5811, L5812, L5814, L5816, L5818, L5822, L5824, L5826, L5827, L5828, L5830, L5840, L5841, L5845, L5848, L5850, L5855, L5856, L5857, L5858, L5859, L5910, L5920, L5925, L5926, L5930, L5940, L5950, L5960, L5961, L5962, L5964, L5966, L5968, L5969, L5970, L5971, L5972, L5973, L5974, L5975, L5976, L5978, L5979, L5980, L5981, L5982,

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Prosthetics (continued)		L5984, L5985, L5986, L5987, L5988, L5991, L5999, L6026, L6028, L6029, L6030, L6031, L6032, L6033, L6037, L6050, L6055, L6100, L6110, L6120, L6130, L6200, L6205, L6250, L6300, L6310, L6320, L6350, L6360, L6370, L6400, L6450, L6500, L6550, L6570, L6580, L6582, L6584, L6586, L6588, L6590, L6600, L6605, L6610, L6611, L6615, L6616, L6620, L6621, L6623, L6624, L6625, L6628, L6629, L6630, L6632, L6635, L6637, L6638, L6640, L6641, L6642, L6645, L6646, L6647, L6648, L6650, L6655, L6660, L6665, L6670, L6672, L6675, L6676, L6677, L6680, L6682, L6684, L6686, L6687, L6688, L6689, L6690, L6691, L6692, L6693, L6694, L6695, L6696, L6697, L6698, L6700, L6703, L6704, L6706, L6707, L6708, L6709, L6711, L6712, L6713, L6714, L6715, L6721, L6722, L6805, L6810, L6880, L6881, L6882, L6883, L6884, L6885, L6895, L6900, L6905, L6910, L6915, L6920, L6925, L6930, L6935, L6940, L6945, L6950, L6955, L6960, L6965, L6970, L6975, L7007, L7008, L7009, L7040, L7045, L7170, L7180, L7181, L7259, L7400, L7401, L7402, L7403, L7404, L7405, L7406, L7499, L7510, L7520, L8035, L8499, L8720, L8721
Radiation therapy		32701, 61796, 61798, 63620, 77280, 77290, 77295, 77301, 77338, 77371, 77372, 77373, 77387*, 77402, 77407, 77412, 77423, 77424, 77425, 77436, 77437, 77438, 77439, 77520,

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Radiation therapy (continued)		77522, 77523, 77525, 77750, 77761, 77762, 77763, 77767, 77768, 77770, 77771, 77772, 77778, G0339, G0340, G0458
Radiofrequency ablation for the sacroiliac (SI) joint		64625
Rhinoplasty		30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, 30468, 30469
SI joint injections		27096
Skin and tissue substitutes		A2001, A2002, A2004, A2005, A2006, A2007, A2008, A2009, A2010, A2011, A2012, A2013, A2014, A2015, A2016, A2017, A2018, A2019, A2020, A2021, A2022, A2023, A2024, A2025, A2026, A2027, A2028, A2029, A2030, A2031, A2032, A2033, A2034, A2035, A2036, A2037, A2038, A2039, A4100, C1832, C8002, C9354, C9358, C9360, C9361, C9363, C9364, Q4101, Q4102, Q4103, Q4104, Q4105, Q4107, Q4108, Q4110, Q4111, Q4112, Q4113, Q4114, Q4115, Q4116**, Q4117, Q4118, Q4121, Q4122**, Q4123, Q4124, Q4125, Q4126, Q4127, Q4128**, Q4130, Q4132, Q4133, Q4134, Q4135, Q4136, Q4137, Q4138, Q4139, Q4140, Q4141, Q4142, Q4143, Q4145, Q4146, Q4147, Q4148, Q4149, Q4150, Q4151, Q4152, Q4153, Q4154, Q4155, Q4156, Q4157, Q4158, Q4159, Q4160, Q4161, Q4162, Q4163, Q4164, Q4165, Q4166, Q4167, Q4168, Q4169, Q4170, Q4171, Q4173, Q4174, Q4175, Q4176, Q4177, Q4178, Q4179, Q4180, Q4181, Q4182, Q4183, Q4184, Q4185,

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Skin and tissue substitutes (continued)		Q4186, Q4187, Q4188, Q4189, Q4190, Q4191, Q4192, Q4193, Q4194, Q4195, Q4196, Q4197, Q4198, Q4199, Q4200, Q4201, Q4202, Q4203, Q4204, Q4205, Q4206, Q4208, Q4209, Q4211, Q4212, Q4213, Q4214, Q4215, Q4216, Q4217, Q4218, Q4219, Q4220, Q4221, Q4222, Q4224, Q4225, Q4226, Q4227, Q4229, Q4230, Q4232, Q4233, Q4234, Q4235, Q4236, Q4237, Q4238, Q4239, Q4240, Q4241, Q4242, Q4245, Q4246, Q4247, Q4248, Q4249, Q4250, Q4251, Q4252, Q4253, Q4254, Q4255, Q4256, Q4257, Q4258, Q4259, Q4260, Q4261, Q4262, Q4263, Q4264, Q4265, Q4266, Q4267, Q4268, Q4269, Q4270, Q4271, Q4272, Q4273, Q4274, Q4275, Q4276, Q4278, Q4279, Q4280, Q4281, Q4282, Q4283, Q4284, Q4285, Q4286, Q4287, Q4288, Q4289, Q4290, Q4291, Q4292, Q4293, Q4294, Q4295, Q4296, Q4297, Q4298, Q4299, Q4300, Q4301, Q4302, Q4303, Q4304, Q4305, Q4306, Q4307, Q4308, Q4309, Q4310, Q4311, Q4312, Q4313, Q4314, Q4315, Q4316, Q4317, Q4318, Q4319, Q4320, Q4321, Q4322, Q4323, Q4324, Q4325, Q4326, Q4327, Q4328, Q4329, Q4330, Q4331, Q4332, Q4333, Q4334, Q4335, Q4336, Q4337, Q4338, Q4339, Q4340, Q4341, Q4342, Q4343, Q4344, Q4345, Q4346, Q4347, Q4348, Q4349, Q4350, Q4351, Q4352, Q4353, Q4354, Q4355, Q4356, Q4357, Q4358, Q4359, Q4360, Q4361, Q4362, Q4363, Q4364, Q4365, Q4366, Q4367, Q4368, Q4369,

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Skin and tissue substitutes (continued)		Q4375, Q4376, Q4377, Q4378, Q4379, Q4380, Q4382, Q4383, Q4384, Q4385, Q4386, Q4387, Q4399, Q4400, Q4401, Q4402, Q4403, Q4404, Q4405, Q4406, Q4407, Q4408, Q4409, Q4410, Q4411, Q4412, Q4413, Q4414, Q4415, Q4416, Q4417, Q4418, Q4419, Q4420, Q4421, Q4422, Q4423, Q4424, Q4425, Q4426, Q4427, Q4428, Q4429, Q4431, Q4432, Q4433, Q4435, Q4436, Q4437, Q4438, Q4439, Q4440 **For codes Q4116, Q4122 and Q4128, no prior authorization is required for breast reconstruction following medically necessary mastectomies for breast cancer.
Spinal cord stimulators		63650, 63655, 63663, 63664, 63685, 63688, 64999, C1816, C1820, C1822, L8679, L8682
Spinal fusion, decompression, kyphoplasty and vertebroplasty		20999, 22100, 22101, 22102, 22103, 22510, 22511, 22512, 22513, 22514, 22515, 22526, 22527, 22532, 22533, 22534, 22548, 22551, 22552, 22554, 22556, 22558, 22585, 22586, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22633, 22634, 22800, 22802, 22804, 22808, 22810, 22812, 22818, 22819, 22830, 22836, 22837, 22838, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 22853, 22854, 22856, 22857, 22858, 22859, 22860, 22861, 22862, 22867, 22868, 22869, 22870, 22899, 27278, 27279, 27280, 62287, 62330, 62331,

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Spinal fusion, decompression, kyphoplasty and vertebroplasty (continued)		62380, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63032, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63050, 63051, 63052, 63053, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103, 63170, 63172, 63173, 63185, 63190, 63191, 63197, 63200, 63250, 63251, 63252, 63265, 63266, 63267, 63268, 63270, 63271, 63272, 63273, 63275, 63276, 63277, 63278, 63280, 63281, 63282, 63283, 63285, 63286, 63287, 63290, 63295, 63300, 63301, 63302, 63303, 63304, 63305, 63306, 63307, 63308, 64628, 64629, 0095T, 0098T, 0164T, 0165T, 0202T, 0219T, 0220T, 0221T, 0222T, 0274T, 0656T, 0657T, 0719T, 0784T, 0785T, 0790T, C1821, C2614, C9757
Surgery for obstructive sleep apnea		21685, 33276, 33277, 33278, 33279, 33280, 33281, 33287, 33288, 41512, 41530, 41599, 42140, 42145, 42299, 42950, 64582, 93150, 93151, 93152, 93153
Surgical nasal/sinus endoscopic procedures and balloon sinus ostial dilation	Excludes diagnostic nasal/sinus endoscopies	31237, 31240, 31242, 31243, 31253, 31254, 31255, 31256, 31257, 31259, 31267, 31276, 31287, 31288, 31295, 31296, 31297, 31298, 69705, 69706
Therapy (physical and occupational)		97010, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034,

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Therapy (physical and occupational) (continued)		97035, 97036, 97037, 97039, 97110, 97112, 97113, 97116, 97124, 97129, 97130, 97139, 97140, 97150, 97164, 97168, 97530, 97533, 97535, 97537, 97542, 97545, 97546, 97550, 97551, 97552, 97750, 97755, 97760, 97761, 97763, 97799, G0281, G0283
Transplant surgeries	Prior authorization requests will be reviewed by the **Humana National Transplant Network** • Submit by fax to 502-508-9300. • Submit by phone to 866-421-5663, Monday – Friday, 8 a.m. to 8 p.m., Eastern time. • Submit by email to transplant@humana.com	32850, 32851, 32852, 32853, 32854, 33927, 33928, 33929, 33935, 33945, 38205, 38206, 38230, 38232, 38240, 38241, 38243, 44135, 47133, 47135, 48160, 48550, 48554, 48556, 50300, 50320, 50340, 50360, 50365, 50370, 50547, 81370, 81371, 81372, 81373, 81375, 81376, 81377, 81378, 81379, 81380, 81381, 81382, 81383, 81595, 0087U, 0088U, 0540U, 0575U, 0576U, 0584T, 0585T, 0586T, G0341, G0342, G0343, L8698, 02WA3QZ, 02WA4QZ
Transplant evaluation	Notification only	99199*
Varicose vein: surgical treatment and sclerotherapy		36465, 36466, 36468, 36470, 36471, 36473, 36474, 36475, 36476, 36478, 36479, 36482, 36483, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766, 37780, 37785, 0524T
Ventricular assist devices (VADs)	Percutaneous VADs Prior authorization requests will be reviewed by the **Humana National Transplant Network** • Submit by fax to 502-508-9300. • Submit by phone to 866-421-5663, Monday – Friday,	33990, 33991, 33995

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Ventricular assist devices (VADs) (continued)	8 a.m. to 8 p.m., Eastern time. • Submit by email to transplant@humana.com	
	VADs Prior authorization requests will be reviewed by the **Humana National Transplant Network** • Submit by fax to 502-508-9300. • Submit by phone to 866-421-5663, Monday – Friday, 8 a.m. to 8 p.m., Eastern time. • Submit by email to transplant@humana.com	33975, 33976, 33979, 33981, 33982, 33983
Wearable cardioverter defibrillators		K0606
Wheelchairs/scooters		E0986, E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1009, E1010, E1012, E1161, E1220, E1234, E1235, E1239, E2207, E2298, E2310, E2311, E2312, E2321, E2322, E2325, E2327, E2328, E2329, E2330, E2331, E2343, E2351, E2358, E2359, E2360, E2362, E2364, E2368, E2369, E2375, E2376, E2383, E2398, K0005, K0008, K0009, K0013, K0669, K0800, K0801, K0802, K0806, K0807, K0808, K0812, K0813, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0830, K0831, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864, K0868, K0869, K0870, K0871,

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement

Category	Details/notes	Codes
Wheelchairs/scooters (continued)		K0877, K0878, K0879, K0880, K0884, K0885, K0886, K0890, K0891, K0898, K0899

To prevent disruption of care, CarePlus does not require prior authorization for basic Medicare benefits during the first 90 days of a new member's enrollment for active courses of treatment that started prior to the enrollment. CarePlus may review the services furnished during that active course of treatment against permissible coverage criteria when determining payment.

* New prior authorization requirement