Payer Coverage: [Service Name (CPT/HCPCS Codes)]

***Coverage Disclaimer:*** *In order to be charged, billed, and reimbursed; all services must be provided by an individual who is appropriately licensed, operating within his/her scope of practice, privileged by the institution, enrolled with the payers, and adequately supervised, when applicable, according to federal, state, third party payer, and intuitional requirements. These determinations are the responsibility of the clinical departments, and out of the scope of this coverage review.*

***Prior Authorization Disclaimer:*** *Prior authorization requirements can vary by payer, plan, diagnosis, and employer/group. Authorization requirements are frequently updated by the payers. Use the below as a general guideline for prior authorization requirements; however, it’s best practice to verify authorization requirements directly with the payer/portal for each patient prior to scheduling.*

Coding and RVU Summary

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CPT** | **CPT Description** | **wRVU** | **FAC PE RVU** | **MP RVU** | **MPFS Status Indicator** | **Global Surgery Indicator** | **PC/TC Indicator** | **Multiple Surgery Indicator** | **Bilateral Surgery Indicator** | **Assistant at Surgery Indicator** | **Two (co) Surgeon Indicator** | **Team Surgery Indicator** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |

Coverage Summary (Medicare/ Medicaid)

| **Payer** | **Medicare**  **(Local contractor: NGS)** | **Tricare East** | **MassHealth** | **United Healthcare Community Plan** |
| --- | --- | --- | --- | --- |
| **Coverage** |  |  |  |  |
| **Medical Necessity Criteria Summary** |  |  |  |  |
| **Prior Authorization Requirements** |  |  |  |  |
| **Clinical Documentation Requirements** |  |  |  |  |
| **Full Policy Link** |  |  |  |  |

Coverage Summary (Commercial/Private Payer)

| **Payer** | **Aetna** | **BCBS MA** | **Cigna** | **Fallon Health** | **Point32Health (Harvard Pilgrim and Tufts Health Plan)** | **United Healthcare/ UHC Community Plan** |
| --- | --- | --- | --- | --- | --- | --- |
| **Coverage** |  |  |  |  |  |  |
| **Medical Necessity Criteria Summary** |  |  |  |  |  |  |
| **Prior Authorization Requirements** |  |  |  |  |  |  |
| **Clinical Documentation Requirements** |  |  |  |  |  |  |
| **Full Policy Link** |  |  |  |  |  |  |