

# Managing patient care



## MANAGING PATIENT CARE

[Medical management overview](#)

[Availability of providers](#)

[Accessibility of services](#)

[Admitting for inpatient stay or same-day surgery](#)

[Advance directives](#)

[Ambulatory cardiac monitoring](#)

[Behavioral Health-Mental Health and Substance Abuse Services](#)

[Children's Behavioral Health Initiative \(CBHI\) Program](#)

[Emergency Services Program Providers \(ESP\)](#)

[Community Service Agencies \(CSA\)](#)

[Care management](#)

[Disease Management](#)

[MassHealth Care Management Program](#)

[Chiropractic services](#)

[Dental benefits](#)

[FCHP MassHealth](#)

[Durable medical equipment \(DME\) and orthotic/prosthetic devices](#)

[Emergency care and urgent care](#)

[FCHP provider—definition and responsibilities](#)

[Hearing aids](#)

[Home health care providers](#)

[Hospitalization and skilled nursing facility admission](#)

[Interpreter services](#)

[Medical record standards](#)

[Network providers](#)

[Nurse Connect](#)

[Observation policy](#)

[Oral surgery](#)

[Out of area care](#)

[PCP referrals and plan prior authorization process](#)

[Peace of Mind Program™](#)

[Pharmacy](#)

[Commercial plans](#)

[FCHP MassHealth](#)

---

---

## TABLE OF CONTENTS

---

---

[Fallon Senior Plan \(Medicare Part D prescription coverage\)](#)

[Podiatry](#)

[Radiology/imaging](#)

[Sleep Management](#)

[Treatment of a Minor without Parental Consent](#)

[Treatment options](#)

[Utilization statement](#)

---

---

## MEDICAL MANAGEMENT OVERVIEW

---

---

Fallon Community Health Plan's (FCHP) care services program reviews and evaluates the health care members receive to make sure that member care is coordinated, and that appropriate levels of services are available to members. This includes prior authorization of select services, inpatient care services, complex care management and disease management.

The Care Services Department is staffed by licensed registered nurse care specialists, nurse reviewers and physician reviewers who are available to our network physicians. FCHP's Care Services uses national, evidence-based criteria that are reviewed annually by a committee of health plan and community-based physicians to determine the medical appropriateness of selected services requested by physicians. These criteria are approved as being consistent with generally accepted standards of medical practice, including prudent layperson standards for emergency room care.

FCHP also develops in-house criteria, making use of local specialist input and current medical literature, as well as guidelines from the Centers of Medicare & Medicaid Services (CMS) and the Commonwealth of Massachusetts. Criteria are available upon request.

The Care Review Department provides physician support for services requiring prior authorization (see PCP referral and plan authorization process section).

FCHP provides all physicians with the opportunity to discuss any denial decision with a physician reviewer or to obtain information about the status or outcome of any utilization issue or review decision from the plan by contacting Care Services at our toll free provider service line 1-866-ASK-FCHP, (866-275-3247) press 3 at prompt.

---

---

## AVAILABILITY OF PROVIDERS

---

---

Fallon Community Health Plan (FCHP) defines primary care providers as practitioners in Internal Medicine, Pediatrics, Family Practice, Nurse Practitioners and OB/Gyns (MassHealth members only). It is recognized that physician assistants work collaboratively with these providers, but physician assistants are not considered primary care providers for the purpose of defining geographic and numerical standards for primary care services.

### Geographic Distribution

Adult Medicine - Members will have a choice of at least two adult primary care providers (Internal Medicine, Family Practice, or Nurse Practitioner) within a 15-mile radius or 30 minutes routine driving time within all zip codes of the Health Management Organization/Managed Care Organization (HMO/MCO) service area. A MassHealth member may choose an ob/gyn as her primary care provider.

Pediatric Primary Care - Members will have access to at least two pediatric primary care providers (Pediatrics and/or Family Practice) within a 15-mile radius or 30 minutes routine driving time in all zip codes of the HMO/MCO service area.

### Cultural Needs and Preferences

FCHP assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary. FCHP utilizes the provider directory to notify members of any specialized services, including linguistic capabilities offered by network providers and handicap access.

### Population Ratios

FCHP shall continue to maintain at least one (1) adult primary care provider for every 1500 enrolled adult members. This statistic will be measured on an aggregate basis for all FCHP members and all adult primary care providers.

The ratio of pediatricians to the enrolled pediatric population (under age 18) will not be less than one (1) pediatrician for 1500 pediatric members. This shall be an aggregate calculation based on total plan members and total plan providers.

### Performance Assessment

FCHP ensures that its members are satisfied with its primary care network by conducting an annual performance assessment and measuring its performance

---

---

## AVAILABILITY OF PROVIDERS

---

---

against the standards at least annually. The methodology used to review geographic and volume of primary care physicians is the GEOACCESS® survey tool, which allows for direct measurement of performance. The Service Quality Improvement Committee also examines the results from member satisfaction surveys including the CAHPS 3.0H® (Consumer Assessment of Health plans and Providers Survey), and specific questions that include the rate of members who report no problems with obtaining access to primary care physicians. The CAHPS 3.0H survey is a rigorous methodology which includes adequate sampling, appropriate data sources and analysis.

### Availability of High Volume Specialty Practitioners

FCHP identifies within its network the following specialists as high volume specialty care providers: ophthalmologists, optometrists, orthopedists, obstetricians, cardiologists and licensed Behavioral Health professionals. FCHP defines High Volume Specialists as those specialists that account for approximately 55% of all outpatient specialty visits. The following are standards for geographic availability for FCHP's network of key specialty care providers:

#### A. Geographic distribution of specialists

FCHP shall contract with the following categories of specialists so as to maintain at least one practitioner within 15 miles or 30 minutes routine driving time, for at least 98% of enrolled members:

- Behavioral Health\*\*
- Ophthalmologists/Optometrists
- Obstetricians/Gynecologists
- Orthopedists
- Cardiologists

\*\* Note that this is overall ratio for behavioral health practitioners. FCHP shall also contract with sufficient licensed behavioral health professionals, as stipulated in Section C.

#### B. Performance Assessment

FCHP's Service Quality Improvement Committee analyzes data to measure its performance against the geographic standards for high volume specialists, including behavioral health practitioners at least annually. FCHP formally assesses its performance using the GEOACCESS® survey tools to determine adequate

---



---

## AVAILABILITY OF PROVIDERS

---



---

number and geographic distribution for specialists. The Committee identifies opportunities for improvement and decides which opportunities to pursue, and measures the effectiveness of the interventions. In addition to the geographic assessment, the committee continually monitors member satisfaction data with the annual CAHPS results with questions specific to availability of specialists. When FCHP delegates quality services to a selected vendor, the delegated entity has responsibility to conduct performance assessment and report back to FCHP's Delegation Oversight Committee. Data analysis of availability of specialists, including behavioral health practitioners must also be reported to the Delegation Oversight Committee using similar methodology approved by the plan to ensure performance compliance with FCHP's standards.

FCHP reassesses the overall distribution of specialty visits at least every other year, to determine whether the list of high volume specialists requires adjustment to include at least 50% of all outpatient specialty visits.

### C. Availability of Behavioral Health Practitioners \*

CATEGORY	STANDARD
1. Standards examining number and distribution for each Massachusetts county or region.	<ul style="list-style-type: none"> <li>• 2:15 miles or 30 minutes for adult/children/adolescents outpatient</li> <li>• 1:30 miles or 60 minutes for seniors outpatient</li> <li>• 1:30 miles or 60 minutes children/adolescent/adult/seniors inpatient</li> </ul>
2. Standards examining number and distribution for all behavioral health specialties, including those that treat:	
Children (0-12 years of age)	<ul style="list-style-type: none"> <li>• 1:30 miles 18/K members outpatient</li> <li>• 1:30 miles inpatient</li> </ul>
Adolescents (13-18 years of age)	<ul style="list-style-type: none"> <li>• 1:30 miles 34/K members outpatient</li> <li>• 1:30 miles inpatient</li> </ul>
Adults (19-65 years of age)	<ul style="list-style-type: none"> <li>• 2:15 miles 34/K members outpatient</li> <li>• 1:30 miles inpatient</li> </ul>
Elders (65+yrs)	<ul style="list-style-type: none"> <li>• 1:30 miles 4/K members outpatient</li> <li>• 1:30 miles inpatient</li> </ul>
Substance abuse	<ul style="list-style-type: none"> <li>• 1:30 miles 1.0/K members outpatient</li> <li>• 1:30 miles inpatient</li> </ul>
Eating disorders	<ul style="list-style-type: none"> <li>• 1:30 miles 0.5/K members outpatient</li> <li>• 1:30 inpatient</li> </ul>

---

---

### AVAILABILITY OF PROVIDERS

---

---

3. Standards examining number and distribution for all behavioral health provider types mandated by statute, including:	
Psychiatrists	0.5/K members
Psychologists	1.0/K members
LICSW	2.0/K members
RNCS	0.2/K members
LMHC	0.5/K members

\* Standards set by the Commonwealth of Massachusetts according to the "Managed Care Act."

---

---

## ACCESSIBILITY OF SERVICES

---

---

FCHP has established standards for accessibility to primary care, specialty care, behavioral health and customer services. These standards include regular and routine care appointments, urgent care appointments and after-hours care. In addition, FCHP has established standards for the response time of the various call centers to ensure that customers are able to inquire about information on how to access clinical care, how to resolve problems and billing issues, and how to make appointments. All of these standards are listed below.

### Performance Assessment

In order to satisfy access measurement requirements and ensure member satisfaction, FCHP's Department of Market Research and Product Development has responsibility for collecting data and conducting analysis to measure its performance against standards of accessibility on an annual basis. This is accomplished by conducting member surveys and using CAHPS® data. The Customer Service Committee monitors regular and routine care appointments, urgent care appointments and after-hours care and the call centers' statistics by using a methodology that allows for direct comparison of performance to the standards.

CAHPS 4.0H survey questions related to appointment access to specific practitioners and member complaints are routinely monitored for performance against the accessibility of services standards for appointment and after-hours care. The Committee identifies and sets priorities for opportunities for improvement; implements intervention strategies and re-measures to determine effectiveness of corrective actions.

When FCHP delegates quality services to a selected vendor, the delegated entity is responsible for monitoring accessibility of services and reporting it to FCHP. The Delegation Oversight Committee has responsibility for ensuring that the accessibility standards are met by delegated vendors. Beacon Health Strategies is the contracted vendor for behavioral health and is NCQA accredited.

Accessibility of Service	Standard
<b>A. Physical Health Service</b>	
1. Preventative and Primary Care- (Annual Physical or new patient examination)	1. Within 30 calendar days
2. Primary Care Services- Routine and Regular Care (Urgent Symptomatic, Non-Urgent Symptomatic and Non-Symptomatic Office Visit)	2. Within 48 hours of member's request for urgent care; within 10 calendar days of member's request for non-urgent symptomatic care; and within 45 calendar days of member's request for non-symptomatic care
3. Specialty Care Services	3. Within 48 hours of member's request for urgent care; within 30 calendar days of member's

---



---

## ACCESSIBILITY OF SERVICES

---



---

- |   |   |
|---|---|
| 4. Emergency Care*  | request for non-urgent symptomatic care; and within 60 calendar days of member's request for non-symptomatic care                                 |
| 5. After-Hours Care   | 4. Available 24 hours/days 7 days/week  |
| 6. After-Hours Telephone Response   | 5. 24 hours/day   |
| 7. General optometry care   | 6. Within 2 hours for the return call   |
| 8. Lab and X-ray  | 7. Within 3 weeks for regular appointments and 48 hours for urgent care   |
| 9. For members newly placed in the care or custody of the Department of Children and Families (DCF) | 8. Within 3 weeks for regular appointments and 48 hours for urgent care   |
|   | 9. Best effort to provide DCF health care screening within 7 calendar days, and initial comprehensive medical examination within 30 calendar days |

### B. Behavioral Health Services

- |   |   |
|---|---|
| 1. Emergency Services (Including Life Threatening Emergency Needs)        | 1. Immediately (24 hours/days 7days/week)   |
| 2. Non-life threatening emergency   | 2. Within 6 Hours   |
| 3. Emergency Service Programs (ESP)                                       | 3. Immediately (24 hours/days 7days/week) with unrestricted access to Enrollees who present for such services.  |
| 4. All other behavioral health services (including routine and follow-up) | 4. Within 10 business days  |
| 5. Behavioral Health URGENT Appointments                                  | 5. Within 48 hours for services that are not Emergency Services or routine services.  |
| 6. Inpatient or 24-hour Diversionary Services Discharge Plan              | 6. Non-24-Hour Diversionary Services - within 2 calendar days of discharge;<br>Medication Management – within 14 calendar days of discharge;<br>Other Outpatient Services – within seven calendar days of discharge;<br>Intensive Care Coordination Services – within the time frame directed by EOHHS. |

\*Emergency care defined by the "Prudent Layperson" definition.

---

---

## ACCESSIBILITY OF SERVICES

---

---

### Customer Service telephone accessibility

The primary role of FCHP's call centers is to promptly respond to all external customers' inquiries and to appropriately refer calls for service requests. To this end, the call centers monitor incoming calls using an automated call tracking system which provides data on the time it takes to answer calls and on the percentage of calls abandoned. FCHP has established standards and monitors customer service performance and reports findings to the Customer Service Committee on a quarterly basis.

Customer Service Telephone Accessibility:	Standard*
Abandonment Rate	<5%
% calls answered within 30 seconds	90%
Behavioral Health (Delegated Vendor)	
% calls answered within 30 seconds (Behavioral Health)	90%
Abandonment Rate (Behavioral Health)	<5%

\* Specific employer groups and government programs may require monitoring of different time intervals.

### Performance Assessment

Using an automated call center tracking system, the Customer Service department monitors its telephone performance. This includes telephone response times, call volume and abandonment rates. Findings are reported to the Customer Service Committee quarterly with evaluation of performance against the standards.

In addition, complaints about Customer Service performance are monitored continually and corrective action implemented when appropriate by the Committee.

When FCHP delegates quality services to a selected vendor, the delegated entity is responsible for monitoring customer services telephone accessibility and reporting it to FCHP. The Delegation Oversight Committee has responsibility for ensuring that the accessibility standards are met by all delegated vendors. Accessibility of behavioral health practitioners is conducted by Beacon Healthcare Strategies, an NCQA accredited vendor.

### Telephone Services and Office Wait Time Standards for Contracted Practitioners

Contracted practitioners are responsible for telephone coverage for the after hours care and responsiveness of appointment telephone lines. The practitioners are responsible for arranging coverage for evenings and weekends. The plan standards for coverage are:

Physicians shall provide 24 hour physician coverage with the availability of the covering physician to return members' calls within

---

---

## ACCESSIBILITY OF SERVICES

---

---

2 hours of the call if medically necessary. Physicians or their designees should return patients' calls received during routine business hours for active clinical problems, on a same day basis. Routine administrative requests for completion of forms, test reports, or chronic refills should generate a telephone response within one business day.

FCHP monitors this standard by soliciting feedback directly from members with a telephone survey conducted internally by the Department of Market Research and Product Development. Results of the survey are communicated to the Customer Service Committee to identify any opportunities and ensure that members receive appropriate coverage for after-hours care. In addition to the internal survey, the Committee monitors the CAHPS commercial survey Q 60 question which asks, "How long does it take for your doctor's office to return your call?" Results of the survey are also reviewed by the Customer Service Committee and any issues are addressed and forwarded to Provider Relations for follow up with the practitioners.

---

---

## ADMITTING FOR INPATIENT STAY OR SAME-DAY SURGERY

---

---

### Admissions

A Fallon Community Health Plan (FCHP) inpatient nurse care specialist will perform concurrent review on all inpatient admissions. All elective inpatient, acute hospital, acute rehabilitation and skilled nursing facility admissions must be authorized by FCHP's Care Review Department prior to admission. Selected same-day surgeries or ambulatory care procedures must be submitted to FCHP's Care Services Department.

Once a member is admitted, an inpatient nurse specialist will perform concurrent review on each case, facilitating discharge planning, assisting with disqualification of continued stay and identifying members for outpatient case management. FCHP uses nationally-recognized criteria for review.

Note: Some IPA/PHO provider network agreements differ from the procedure described below, depending on contract levels of risk. When applicable, please defer to your IPA/PHO procedures.

### Procedure:

#### *Elective admission*

1. The admitting physician's office requests authorization for the admission by completing the appropriate section of the Request for Services form and sending it to the FCHP Care Review Department or by completing the request via the Online Referral Tool. The organization makes decisions within 14 days of request for Fallon Senior Plan™ and MassHealth members or two working days of obtaining all the necessary information for commercial plan members. The organization notifies practitioners of the decisions within one day of making the decision. Specialty physicians wishing to admit a member can call, fax or send a [Request for preauthorization form](#) to FCHP's Care Review Department.
2. If authorized:
  - a.) Care Review provides the authorization number to the admitting physician indicating that the referral is authorized.
  - b.) The admitting physician books the admission.
  - c.) The admitting physician performs the history and physical, completes all preadmission tests and obtains the member's written consent.
  - d.) The admitting physician forwards copies of the member consent and results from the history, physical and preadmission testing to the hospital prior to the admission, or otherwise complies with the hospital's admission policy.
3. If not authorized:
  - a.) The Care Review Department notifies the admitting physician to discuss, if medical necessity criteria are not met. A physician medical reviewer will contact the admitting physician.

---

---

## ADMITTING FOR INPATIENT STAY OR SAME-DAY SURGERY

---

---

- b.) The Care Review Department sends the original denial letter, which includes all appeal rights, to the Member and an Authorized Appeal Representative with a copy to the primary care physician.

### Procedure:

#### *Emergency or unplanned admissions*

The admitting physician's office (the PCP or attending physician) calls the FCHP Inpatient Care Services Department to advise FCHP of the admission, reporting the member's name, date of birth and facility.

FCHP requires that the hospital notify us within 24 hours of an emergency or unplanned hospital admission or transfer to a different acute facility. Should a member be hospitalized from the emergency room with possible FCHP eligibility, it is expected that the admitting physician's office will report admission to FCHP, whether eligibility has been verified or not.

FCHP will only pay for hospital days that are medically necessary, and which are called in or faxed to us within the notification time frame, 24 hours of admission. Please note: MassHealth members can not be held financially liable.

## **ADVANCE DIRECTIVES**

Our members have certain rights relating to advance directives. Advance directives are written instructions, sometimes called a living will or durable power of attorney for health care. Advance directives are recognized under Massachusetts law to ensure a person who isn't capable of making a health care decision gets health care. If a member is no longer able to make decisions about his or her health care, having an advance directive in place can help. These written instructions tell providers what to do if their patients cannot make health care decisions. We have the authority to audit FCHP patients' records for the presence of advance directives at any time pursuant to the guidelines set forth in the [Medical Record Standards section of the Provider Manual](#).

There are different types of advance directives. They are: "health care proxy," "living will" and "durable power of attorney for health care."

### **Health Care Proxy:**

Member must be at least eighteen (18) years old and of sound mind (can make decisions on their own), and can use a health care proxy to choose someone they trust to make health care decisions for them (the "agent"). This person then will make health care decisions according to the instructions if for any reason the member becomes unable to make or communicate those decisions him/herself. A health care proxy is legally binding in Massachusetts.

### **Living Will:**

This is a document in which a person specifies the kind of life-saving and life-sustaining care and treatment he or she does or does not wish to receive in the event the person becomes both incapacitated and terminally ill. Many states have their own titles for a living will document such as "Directive to Physicians," "Declaration Concerning Health Care," etc. Massachusetts law considers the document good evidence of patient wishes; however, it is not legally binding in Massachusetts.

### **Durable Power of Attorney for Health Care:**

This is a legal document through which a person appoints someone else, an "attorney-in-fact," to act on the person's behalf in making medical treatment decisions in case of future incapacitation.

If a member decides they wish to have an advance directive, there are several ways to get this type of legal form. This form can be obtained from a lawyer or from a social worker. This form can also be printed at The Central Massachusetts Partnership to Improve Care at the End of Life, Inc., Web site: <http://www.betterending.org/>, or at the Web site of the Hospice & Palliative Care Federation of Massachusetts at: [http://www.hospicefed.org/hospice\\_pages/proxyform.htm](http://www.hospicefed.org/hospice_pages/proxyform.htm), or by sending a self addressed stamped envelope and written request to:

---

---

## ADVANCE DIRECTIVES

---

---

Commonwealth of Massachusetts  
Executive Office of Elder Affairs  
1 Ashburton Place, Room 517  
Boston, MA 02108

A member may also call FCHP's Customer Service Department at 1-800-868-5200 to request a health care proxy form.

Regardless of where the form is obtained, keep in mind that it is a very important document. One may consider having a lawyer help prepare these; however, this is not necessary in the State of Massachusetts. It is important for the member to sign this form and keep a copy at home. They should also give a copy of the form to all of their healthcare providers and to the person named on the form as the one to make decisions if they can't. It is also recommended that copies be given to close friends or family members. If a member knows ahead of time that they are going to be hospitalized, and have signed an advance directive, they should take a copy with them to the hospital.

If the member has not signed an advance directive form in advance but decides at the hospital that they want one, the hospital can provide the form to sign at that time. It is a member's right to fill out an advance directive at any time. According to law, no one can deny care or discriminate against a member based on whether or not they have signed an advance directive.

With advance directives, members also have the right to:

- Make decisions about their medical care
- Get the same level of care, and be free from any form of discrimination, whether or not they have an advance directive
- Get written information about their health care provider's advance directive policies
- Have in their medical record their advance directive, if they have one

For questions, please call FCHP's Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677), Monday through Friday, 8 a.m. to 6 p.m.

---

---

## **AMBULATORY CARDIAC MONITORING**

---

---

Ambulatory cardiac monitoring services are covered only if ordered by a plan provider. The cardiac monitoring provider agrees to abide by the following guidelines:

1. Cardiac technician-attended monitoring must be provided 24 hours a day, seven days a week.
2. All electrocardiograph transmissions must be received on a toll-free line from anywhere in the United States.
3. Cardiac technicians must be available to assist plan providers or plan members with service questions or problems.
4. Records of any transmitted information for each plan member must be retained for a minimum of ten years.
5. For any emergency arrhythmia situation, the provider will alert plan provider via fax and/or verbal notification. In addition, the provider must alert an emergency rescue team, if needed, and fax the electrocardiograph tracing to the emergency room for advanced notification. The provider will attempt to facilitate the ambulance transportation services from a contracted provider.
6. For each plan member, the provider must produce a final report. This report, along with tracings, will be mailed to the plan provider via first class mail.

All services are subject to coverage, benefits, network, and contract policies and exclusions.

---

---

## BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES

---

---

Beacon Health Strategies, LLC, a managed behavioral health care organization (MBHO) currently manages the behavioral health benefits (mental health and substance abuse) of Fallon Community Health Plan (FCHP) members.

All FCHP members can self-refer for mental health or substance abuse outpatient services by contacting a contracted provider. PCPs may also refer members directly to contracted providers. Members and PCPs may also contact Beacon Case Management at 888-421-8861, the number noted on member ID cards, for assistance in identifying contracted providers.

All members requiring inpatient or diversionary levels of care should contact Beacon Case Management at 888-421-8861 for triage and referral assistance. As with any emergent health situation, members experiencing a behavioral health emergency should be directed to the nearest emergency department, call 911, or call their local [Emergency Services Program Provider](#)

Member calls are answered by a live voice within 20 seconds. An on-call clinician is available after hours and weekends for coverage of behavioral health emergent and urgent issues. The standard for returning calls by a Beacon clinician on weekends or after hours is 20 minutes. An FCHP MassHealth member or a provider may also call the local Emergency Services Program (ESP), who provide emergency behavioral health services 24 hours a day, seven days per week. They provide assessment, treatment, stabilization, mobile crisis intervention or a combination of these services for individuals having an emergency behavioral health crisis. ESP's cover all towns across the state. A list of ESPs is provided below. Members can also access this information on line through Beacon Health Strategies, at [fchp.org](http://fchp.org) and in their Provider Directory.

Fallon Community Health Plan PCPs and nurse practitioners may obtain a brief consultation regarding specific cases of behavioral health treatment being provided in the PCP setting by calling Beacon's provider hotline at (781) 944-7556 between the hours of 8:30 a.m. and 5:00 p.m., Monday through Friday. This line is not for emergent, urgent or routine referral calls, rather it is provided as a short term consultation for PCPs and prescribers to address concerns regarding members' behavioral health issues.

---



---

## BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES

---



---

FCHP MassHealth state agency liaisons and behavioral health providers are required to coordinate with state agencies, including but not limited to the Department of Children and Families, the Department of Youth Services, the Department of Mental Health, the Department of Transitional Assistance, and local education authorities.

Additionally, FCHP MassHealth members under the age of 21, diagnosed with severe emotional disturbance, will have their behavioral health services coordinated through the Children’s Behavioral Health Initiative (CBHI) program. CBHI is an interagency undertaking by the Executive Office of Health and Human Services (EOHHS) and MassHealth whose mission is to strengthen, expand and integrate Behavioral Health Services for Enrollees under the age of 21 into a comprehensive system of community-based, culturally competent care. Incorporated into the CBHI program is a network of Community Services Agencies (CSAs) to provide Intensive Care Coordination, Family Support and Training Services (Family Support Partner) services to Enrollees who are eligible for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services. Care coordination for CSA services will be arranged by the member’s behavioral health provider.

- [Emergency Services Program Providers](#)
- [Community Service Agencies](#)
- **Specialty Community Service Agencies**

Area Offices/ Region Covered	Towns Covered	Site(s) where services will be delivered	Referral Number	Other
Boston	Allston, Boston, Brighton, Brookline, Charlestown, Chelsea, Dorchester, East Boston, Hyde Park, Jamaica Plain, Mattapan, Revere, Roslindale, Roxbury, South Boston, West Roxbury, and Winthrop	520 Dudley Street Roxbury, MA 02119	617-989-9499	Attention: Natalie Sheehan- Diaz, Salesia Hughes

---



---

**BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES**

---



---

Holyoke and Springfield	Agawam, Belchertown, Blandford, Chesterfield, Chicopee, East Longmeadow, Granby, Granville, Hampden, Holyoke, Huntington, Longmeadow, Ludlow, Monson, Montgomery, Palmer, Russell, South Hadley, Southampton, Southwick, Springfield, Tolland, Ware, West Springfield, Westfield, and Wilbraham	120 Maple Street Springfield, MA 01103	413-840-0445	Fax: 413-840-0447
Statewide, with a focus on Metropolitan Boston	Acton, Allston, Arlington, Ashland, Bedford, Belmont, Boston, Boxborough, Braintree, Brighton, Brookline, Burlington, Canton, Carlisle, Charlestown, Chelsea, Cohasset, Concord, Dedham, Dorchester, Hull, Hyde Park, Jamaica Plain, Lexington, Lincoln, Littleton, Malden, Marlborough, Mattapan, Maynard, Northborough, Norwell, Norwood, Plainville, Quincy, Randolph, Reading, Revere, Roslindale, Roxbury, Scituate, Sharon, Sherborn, Somerville, South Boston, Southborough, Stoneham, Stow, Sudbury, Wakefield, Walpole, Waltham, Watertown, Wayland, Wellesley, West Roxbury, Westborough, Weston, Westwood, Weymouth, Wilmington, Winchester, Winthrop, Woburn, and Wrentham	848 Central Street Framingham, MA 01701	Voice: 508-875-9529 VP (Videophone): 866-641-1780	Fax: 508-875-8080

**Care Management** - For all products, except MassHealth.

For FCHP MassHealth Care Management, please see section below.

Professional registered nurse care management is provided through Fallon Community Health Plan's Care Coordination Department, which includes Inpatient Care Services and Outpatient Care Services.

The Inpatient Care Services Department and inpatient nurse care specialists provide regular concurrent review of an FCHP member admitted to a hospital, acute rehabilitation facility or skilled nursing facility, using nationally recognized criteria to determine the appropriate level of care, and other case management services. Additional information is provided in the sections on **Hospitalization and Skilled Nursing Facility Admission** and **Observation Policy**. The Outpatient Care Services Department provides complex case management and disease management for FCHP members.

### **Complex care management**

Complex care management is provided through the Care Management Department. Complex care management within FCHP is a multidisciplinary approach to coordinate all levels of care, focusing on complex medical and psychosocial needs to members. Nurse Care Specialists (NCS) and Social Workers assist members and families in an effort to access appropriate resources and services, which, by their presence, and accompanied by ongoing assessment and adjustment, will create improvements in the quality of life and cost-effectiveness of medical care. The Care Management team members develop and implement individualized, coordinated care plans in collaboration with the Primary Care Provider to ensure cost effective, quality outcomes focused in the ambulatory setting.

### **Complex care management program goals:**

- Assist members with multiple or complex conditions to obtain access to care and services and coordinate their care.
- Facilitate provision of care in the most appropriate community or home based setting ensuring quality of care for all members.
- Prevent fragmentation of health care services delivery through a coordinated program focus.
- Provide appropriate utilization of health care services.
- Reduce the number of hospital admissions, readmissions and associated length of stay (LOS) when appropriate.
- Educate providers and their staff with regard to the complex array of services available to manage their panel of members.

---

---

## CARE MANAGEMENT

---

---

- Provide a mechanism for the provision of health care needs from one treatment setting to another, appropriate to the needs of the members.
- Encourage and support the highest level of member and family independence possible by educating members on self-advocacy for care management.

### **Access to complex care management and member identification**

FCHP has multiple avenues for members to be considered for care management services including, but not limited to, the following referral sources: member/family, practitioner, health information line (Nurse Connect), facility discharge planner, community resources, and the FCHP Utilization Management process.

In addition, FCHP identifies members for case management via the following sources (including but not limited to): claims/encounter data, hospital discharge data, pharmacy data, and data collected through the Utilization Management process (referrals at time of inpatient facility discharge).

*Providers may refer members to Complex Care Management Programs by calling 1-800-333-2535, ext. 69301.*

### **Member qualification for complex care management**

The member must be an FCHP member and agree to care management interventions. Members have the right to decline participation or disenroll from complex care management programs and services offered by FCHP at any time.

### **Care management process**

The initial assessment of the member's health status includes the following:

- Condition specific issues
- Clinical history including medications
- Assessment of activities of daily living
- Assessment of mental health status, including cognitive functioning
- Assessment of life planning activities
- Evaluation of cultural and linguistic needs, preferences or limitations
- Evaluation of caregiver resources
- Evaluation of available benefits

There is a care management plan that is developed which includes the following:

---

---

## CARE MANAGEMENT

---

---

- Development of a care management plan, including short and long term goals
- Identification of barriers to meeting goals or complying with the plan
- Development of a schedule for follow-up and communication with the member
- Development and communication of self management plans for members

Outpatient nurse care specialists and Social Workers continually assess the member's progress against the individualized care management plan developed. Staff documents their assessments and plans in a formal documentation system and have automated prompts for follow-up, as required by the care management plan.

### **Satisfaction with care management**

FCHP annually evaluates satisfaction with the case management program by obtaining feedback from members and analyzing member complaints and inquiries.

## **Disease Management**

FCHP has several in-house, internally developed disease management programs designed to empower members with chronic health conditions to self manage their disease and achieve optimum control. The purpose of the FCHP Disease Management program is to slow disease progression, prolong periods of health and improve quality of life by focusing on healthier living.

Disease Management is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions. Disease Management supports the member-practitioner relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidence based guidelines that serve as the clinical basis for these programs and member empowerment strategies such as self-management. It continuously evaluates clinical, humanistic and economic outcomes with the goal of improving overall health.

Identification of members begins upon enrollment in FCHP with member reported information including but not limited to Health Risk Assessment and medical and pharmacy claims data. Other means of identification may include Provider referral, Customer Service referral, Self referral, Case Management referral and laboratory data.

Condition specific educational materials are provided to all members enrolled in the program. Health Educators/Nurses provide telephonic outreach to those members deemed to be “moderate risk.” They use a “coaching” model to move members through lifestyle behavior change which addresses diet, exercise, stress management and tobacco cessation to name a few. Disease specific self management is also addressed and includes medication adherence, biometric tracking and follow up medical care. Content for all disease management programs includes HEDIS® measures and is based on nationally recognized standards of care. There is no charge to the member for this program and membership is entirely voluntary.

### ***Asthma***

The National Heart Lung and Blood Institute (NHLBI) *Guidelines for the Diagnosis and Management of Asthma* serves as the clinical basis for the asthma disease management program.

The program focus is on lowering the frequency of attacks through symptom recognition, trigger identification, environmental modification and proper use of medications, as well as pathology and risk factors. Additional topics include peak flow monitoring and exercise tolerance. Smoking cessation and secondhand smoke are also discussed at length and on a regular basis. The program is available for both adults and children over five years.

### ***Diabetes***

The *Massachusetts Guidelines for Adult Diabetes Care* serves as the clinical basis for the diabetes disease management program.

Diabetes is one of our largest disease management programs. Health Educators coach members to help them control their diabetes through nutrition therapy, exercise and medication adherence. Additional topics include carbohydrate counting, increased activity, self-blood glucose monitoring, target blood glucose values and resulting HgbA1c, medications and how each plays a role in diabetes self-management.

### ***Cardiac Disease***

The clinical basis for the cardiac disease program uses a combination of evidence based guidelines:

- *The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure.*
- *The Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Executive Summary.*

Health Educators coach members about causes of their specific cardiac disease and lifestyle changes needed to prevent future cardiac events. They work with members to help them to reduce modifiable risk factors such as obesity, inactivity, high blood pressure, elevated cholesterol and LDL, and smoking. Additional topics include medication adherence and cardiac disease self management.

### ***Heart Failure***

The FCHP *Clinical Practice Guideline for the Outpatient Management of Heart Failure* serves as the clinical basis for the heart failure disease management program.

Although the Heart Failure member population tends to be small it remains a significant chronic condition in the toll it takes on the daily lives of members if left unmanaged. The Nurse Health Educator coaches members to measure their weight, blood pressure and pulse on a daily basis and to report changes to their baseline to their primary care physician. Dietary sodium content is also discussed along with the use of a sodium log to self monitor daily intake. Additional topics include medication adherence, smoking cessation, exercise and early symptom recognition and reporting.

### **Satisfaction with Disease Management**

FCHP annually evaluates satisfaction with the disease management program by obtaining feedback from members and analyzing member complaints and inquiries.

Providers may refer members to Disease Management Programs by calling 1-800-333-2535, ext. 69898 or by faxing the Disease Management/Case Management referral form located on the FCHP website: <http://www.fchp.org/providers/medical-management/forms>

### **MassHealth Care Management Program**

The MassHealth Care Management Program consists of four distinct program categories. The Programs are as follows: Complex Care Management, Case Management, Wellness and Disease Management, and Intensive Clinical Management (provided by Beacon Health Strategies).

The FCHP Utilization and Care Management Clinical programs are aligned with the FCHP Quality and Health Services program. The Programs are Member-centric and are committed to providing innovative and high quality services to our Members. Our approach is focused toward a more holistic approach to providing care to our Members, acknowledging that achieving and maintaining good health requires more than addressing a singular prominent illness or condition.

Utilizing a holistic approach focused on identifying level of health risk globally, rather than with a disease-specific lens, Members are assigned to care level groups for whom interventions range from observation to active care management to intense care management.

FCHP and Beacon Health Strategies assures the identification of Members and provides them with options and services to help meet their care needs. Care management is provided to each Member identified as eligible for care management except to the extent that the Member is unwilling or unable to receive such services.

FCHP's comprehensive Care Management Program consists of numerous clinical initiatives at varying levels of intensity. These program initiatives are for Members who are diagnosed with health conditions or chronic diseases, including behavioral health disorders. The Care Management Program provided to MassHealth Members includes the following components:

- Member identification
- Risk assessment
- Education of Members regarding their disease or condition and about the care available and the importance of proactive approaches to the management of the disease or condition (including self care)
- Outreach (telephonic and/or in person) to Members to encourage participation in the appropriate level of care and Care Management for their disease or condition
- Facilitation of prompt and easy access to care appropriate to the disease or condition in line with applicable and appropriate clinical guidelines

---

---

## CARE MANAGEMENT

---

---

- Mechanisms designed to ensure that pre-treatment protocols, such as laboratory testing and drug pre-authorization, are conducted in a timely manner to ensure that treatment regimens are implemented as expeditiously as possible
- Coordination with other health care providers as necessary and appropriate
- Coordination to ensure the provision of transportation to health care appointments, where medically necessary for the Members to access care
- Coordination with internal and external individuals and entities to secure service to support effective care including social services such as food stamps, Women, Infants and Children (WIC), and housing assistance
- Education of Providers, including, but not limited to, clinically appropriate guidelines and Member- specific information with respect to an Member's disease or condition, including relevant indications
- Evaluation of the Care Management program's effectiveness in improving the management of the disease or condition, including, but not limited to: reducing service utilization and emergency department visits, and assuring appropriate hospital admissions and health care utilization
- Assurance that in the process of coordinating care, each Member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 Subparts A and E, to the extent that they are applicable

FCHP's Care Management Programs are staffed with a dedicated team of resources including but not limited to: Care Facilitators, Nurse Case Managers (RNs), Social Workers, Behavioral Health Clinicians, Advanced Practice Clinicians (Physicians), Health Educators and other members of the Provider Network such as Care Coordination staff from Physician Offices and Community Health Centers.

FCHP Care Management staff use motivational interviewing and coaching techniques with sensitivity to cultural disparities to better foster members' understanding of their health risks and empower them to make the lifestyle/behavioral changes required to reach their goals.

Interventions are Member-specific, focused, and strategic. They consist of live communications, telephonic and face-to-face interactions, as the individuals move along the health risk continuum.

FCHP collaborates with Beacon Health Strategies to provide care management services to Members that have both medical and behavioral health care needs. Beacon Health Strategies provides several care management programs including but not limited to Depression Health Management and Intensive Case Management.

---

---

## CARE MANAGEMENT

---

---

Members are made aware of these programs via several channels including:

**FCHP Outreach:** FCHP Care Facilitators educate Members about the available care management programs during the orientation outreach call and health needs assessment process.

**Print media:** the member magazine, enrollment materials and mailed program announcements.

**Face to face:** Providers receive education regarding FCHP Care Management initiatives and are provided with materials to help them to facilitate members' involvement in programs. Education is provided by FCHP provider relations staff. FCHP staff frequently attends community based health fairs and other community events and disseminates program information as appropriate.

**Telephonic:** Other FCHP departments receive education regarding the programs offered so that they are able to discuss pertinent programs with Members with whom they may be interacting on the telephone. These departments include customer services, enrollee services, provider relations, sales and marketing, and care services. These departments receive training during their regularly scheduled departmental meetings, managers meetings and "all-employee" meetings. Entities outside of FCHP also receive training. The outside entities include FCHP's behavioral health vendor, Beacon, and the Nurse Connect staff, FCHP's 24/7 nurse information line.

---

---

## CHIROPRACTIC SERVICES

---

---

FCHP partners with American Specialty Health Network (ASHN) for chiropractic services.

### **HMO—Commercial plans**

Chiropractic benefit covers services for acute musculoskeletal conditions. The condition must be new or an exacerbation of a previous condition. (Please note: Effective July 1, 2008, chiropractic services are no longer a covered benefit for Commonwealth Care members.)

### **MassHealth**

Chiropractic benefit covers services for chiropractic manipulative treatment, office visits and radiology services for all MassHealth Members. For individuals over age 21, there is a service limit of 20 office visits or chiropractic manipulative treatments, or any combination of office visits and chiropractic manipulative treatments. NOTE: Chiropractic services are not covered for FCHP MassHealth Essential members.

### **Fallon Senior Plan<sup>™</sup>**

Chiropractic services for symptomatic musculoskeletal conditions requiring manual manipulation of the spine caused by subluxation. Symptomatic conditions include spinal aches, strains, sprains, nerve pains and functional mechanical disabilities of the spine.

### **Major Medical**

The chiropractor should bill Fallon Community Health Plan (FCHP) directly. FCHP will pay according to the rates in the current FCHP contract, minus any deductibles and/or coinsurance. FCHP will send an explanation of payment (EOP) indicating the portion of the bill for which the member is responsible. Major Medical members are identified by a purple membership card with the heading Major Medical.

### **FCHP Flex Care Select, FCHP Flex Care Direct**

#### *In-network*

FCHP Flex Care Select and FCHP Flex Care Direct members who obtain chiropractic services "in-network" have the same benefit as HMO members. When these members obtain the necessary referral for chiropractic services from FCHP and see an FCHP contracted chiropractor, services are considered in-network. Please refer to section "PCP Referral and Plan Preauthorization Process" for referral protocols.

#### *Out-of-network*

FCHP Flex Care Select and FCHP Flex Care Direct members who obtain chiropractic services "out-of-network" are covered up to a maximum of 12 chiropractic visits per calendar year combined with "in-network" visits and are responsible for deductibles and coinsurance; there are no copayments. Members may self-refer to any chiropractor's office of their choice.

---

---

## CHIROPRACTIC SERVICES

---

---

Procedure:

For a referral to participating chiropractor, the PCP must provide the member and/or the chiropractor with a written prescription. The script should include the following:

- Referring provider's name and address
- Member's name and identification number
- Referral issue date
- Primary diagnosis code

The chiropractor must submit a copy of the prescription to American Specialty Health Network (ASHN) when submitting the initial claim.

All services are subject to coverage, benefits, network, and contract policies and exclusions.

American Specialty Health Network contact information:

- To update any existing data: 1-800-972-4226, option 2,
- Fax change requests: 1-866-545-2746
- Provider applications: 1-888-511-2743, option 1
- General ASHN customer service: 1-800-848-3555

---

---

## DENTAL BENEFITS

---

---

### MASSHEALTH DENTAL BENEFIT

FCHP's contract with MassHealth only provides coverage for emergency dental services and oral surgery performed in an outpatient setting which is medically necessary to treat a medical condition. All other dental services/procedures are covered by MassHealth. For questions related to FCHP MassHealth dental benefits, please contact FCHP MassHealth Customer Service at 800-341-4848. **MassHealth** benefits are not administered by FCHP. MassHealth provides dental coverage and is contracted with DentaQuest to manage its dental program. DentaQuest has a complete customer service team, specializing in dental care. They are available to answer questions about MassHealth dental coverage and help in finding a dentist and intervention services for both members and providers.

For eligible adults, MassHealth covers medically necessary dental services including check-ups, x-rays, cleanings, fillings, certain endodontic services (for example, root canals), and dentures. Some of the services need prior approval.

For questions call FCHP Customer Service at 1-800-341-4848 (TDD/TTY: 1-877-608-7677) Monday-Friday, 8:00 am to 6:00 pm or MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648) Monday-Friday, 8:00 am to 5:00 pm.

For a listing of dental providers, visit the web at [www.mass.gov/masshealth-dental.net](http://www.mass.gov/masshealth-dental.net) or call 1-800-207-5019 between the hours of 8:00 a.m. and 6:00 p.m.

Dental screenings and cleanings are available for children, adolescents and young adults under age 21. The child's PCP will check the child's oral health and, if the child is three years old or older, will recommend a visit to a dentist at least twice a year. No referral is required for an appointment with a MassHealth dentist. MassHealth recommends a dental checkup once per year starting at age three; and

- a dental cleaning every six (6) months starting at age three; and
- any other dental treatments needed, even before age three, if the child's primary care provider or dentist detects problems with the child's teeth or oral health.

MassHealth requires that the child's annual dental checkup should include: a complete dental exam, teeth cleaning and fluoride treatment.

### **New fluoride varnish coverage for FCHP MassHealth members:**

Physicians and other qualified health care professionals\* now may apply fluoride varnish to eligible FCHP MassHealth members under age 21. It's expected that this procedure would occur during a pediatric preventive care visit. The goal is to increase access to preventive dental treatment in an effort to prevent early childhood cavities in children at moderate to high risk for dental decay.

### **Eligible members:**

---

---

## DENTAL BENEFITS

---

---

Fluoride varnish application is primarily intended for children up to age 3, but is allowed for children up to age 21 in those instances where the member doesn't have access to a dentist. No more than one application every 180 days is recommended from first tooth eruption (usually at six months) to the third birthday. Members must meet the following three criteria to be eligible:

- 1) The member is under the age of 21;
- 2) The member is eligible for dental services; and
- 3) The service is medically necessary as determined by a Caries Assessment Tool.

Providers must bill FCHP with CDT code D1206 on the CMS 1500 form. Please refer any FCHP MassHealth member who is without a dental provider to an appropriate dental service provider for ongoing preventive care. Please call us at the number below if you need assistance in locating a dental provider.

**Required training:**

We've approved the following training programs for providers who want to apply fluoride varnish to our eligible members. You may self-administer either the American Association of Pediatric Oral Health Group's online training on Cavity Risk Assessment at <http://www.aap.org/commpeds/doch/oralhealth/cme> or the Smile for Life program at <http://www.stfm.org/oralhealth>. Providers must maintain proof of their completed training and provide FCHP with documentation upon request.

If you have any questions about this MassHealth service, please contact FCHP Provider Relations at 1-866-ASK-FCHP, option 4.

\* Physicians, physician assistants, nurse practitioners, registered nurses and licensed practical nurses who complete the required training.

---

---

## DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES

---

---

Most commercial plan members have a \$1,500 per calendar year combined benefit maximum for durable medical equipment and orthotic/prosthetic devices. Certain plan members may have nonstandard benefits. Please refer to the “Benefits Summaries” section for further descriptions.

### Durable Medical Equipment (DME)

DME is defined as equipment which (a) can withstand repeated use (e.g., could normally be rented and used by successive members, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of illness or injury and (d) is appropriate for use in a member’s home.

### Procedure:

Most DME items require preauthorization. Preauthorization is not a guarantee of payment. For most plan members, DME is subject to the \$1,500 combined DME/prosthetics and orthotics benefit maximum. FCHP maintains a list of inexpensive routinely purchased DME items that do not require preauthorization. The list of DME items that do not require preauthorization is available in the FCHP Provider Manual on pages 36 through 49.

Preauthorization for DME is coordinated through the FCHP Utilization Management Department. The Utilization Management Department will determine if the item is medically necessary for the member and will coordinate with a medical director any request that requires medical review, and will determine whether the item will be rented or purchased.

The DME supplier is responsible for obtaining preauthorization from FCHP when preauthorization is required. The DME supplier is responsible for obtaining a physician’s written order for any requested DME item and for maintaining the physician’s written order on file and available to FCHP upon request. The DME supplier calls the FCHP Utilization Department at 866-ASK-FCHP (275-3247), press 3 at the prompt, or fax the [Request for Preauthorization form](#) to 1-508-368-9700.

DME providers will be assigned an authorization number for approved items. The authorization will include: specific timeframe, codes, and rental vs. purchase. Within 48 hours from receipt of all necessary information, FCHP will communicate authorizations via fax to DME suppliers. The DME provider is responsible for ensuring that the appropriate authorization is in place prior to delivering any equipment or supplies. In instances where DME items are not authorized, the DME provider will be notified via fax of the denial decision. The PCP and member will receive a determination letter. The decision will include the denial reason(s). A DME provider may not appeal this decision. The member may appeal according to [FCHP’s member appeals policy](#).

### **Orthotic/prosthetic devices**

Orthotics are defined as rigid or semi-rigid devices that are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

Prosthetics are defined as devices that replace all or part of an internal body organ (other than dental) or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ.

### **Procedure:**

Most orthotics/prosthetic items require preauthorization. Preauthorization is not a guarantee of payment. For most plan members, orthotics/prosthetic items are subject to the \$1,500 combined DME/prosthetics and orthotics benefit maximum. FCHP maintains a list of inexpensive routinely purchased orthotics/prosthetic items that do not require preauthorization. The list of orthotics/prosthetic items that do not require preauthorization is available below.

On January 1, 2007, the benefit for prosthetic limbs changed for most commercial plan members. Prosthetic limbs (arms and legs and parts thereof) are not subject to the combined DME/prosthetics and orthotics benefit maximum. Most commercial plan members will be responsible for 20% coinsurance for prosthetic limbs. Prosthetic limbs will require preauthorization by FCHP Utilization Management. [See a list of prosthetic limbs subject to 20% coinsurance.](#)

### **Preauthorization for orthotics/prosthetics**

Orthotics/prosthetics providers will be assigned an authorization number for approved items. The authorization will include: specific timeframe, codes, and rental vs. purchase. Within 48 hours from receipt of all necessary information, FCHP will communicate authorizations via fax to Orthotics/prosthetics providers. The DME provider is responsible for ensuring that the appropriate authorization is in place prior to delivering any equipment or supplies.

*In instances where DME items are not authorized, the DME provider will be notified via fax of the denial decision. The decision will include the denial reason(s). A DME provider may not appeal this decision. The member may appeal according to [FCHP's member appeals policy.](#)*

---



---

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

---



---

### Insulin Pumps and Insulin Pump Supplies

*This table applies to the majority of plan members. Some plan members have different cost-sharing.*

	Commercial Plans (HMO) and MassHealth		Fallon Senior Plan™	
	Coverage Category	Member Cost-Sharing*	Coverage Category	Member Cost-Sharing
Insulin pumps  Preauthorization is required**	DME	Covered in full (not subject to DME/prosthetics and orthotics benefit limit)	DME	Covered in full
Insulin pump supplies (includes infusion sets and syringe-type cartridge or reservoir)	Medical supplies	Covered in full	Medical supplies	Covered in full
Insulin for insulin pumps***	Prescription drugs	Prescription copayment, deductible and/or coinsurance per 30-day supply	Prescription drugs	Prescription Copayment per 30-day supply
Insulin pump batteries (quantity limits apply <sup>1</sup> )	Medical supplies	Covered in full	Medical supplies	Covered in full

\* Members of qualified high deductible plans must meet their deductible prior to receiving coverage for insulin pumps and insulin pump supplies.

\*\* Insulin pumps require preauthorization through Care Services. Refer to *Insulin Pumps and Insulin Pump Supplies* medical policy for criteria.

\*\*\* Insulin for insulin pumps is obtained at a plan pharmacy. A prescription is required. Commercial plan members who do not have prescription drug coverage do not have Coverage for insulin for insulin pumps.

---

<sup>1</sup> Excerpt from Medical Supplies Payment Policy:

---



---

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

---



---

Code	Brief description	No. per month or episode	No. per 3 months (90-day supply)	No. per 6 or 12 months
K0601	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, SILVER OXIDE, 1.5 VOLT, EACH	3 per month	N/A	N/A
K0602	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, SILVER OXIDE, 3.0 VOLT, EACH	N/C	N/C	N/C
K0603	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, ALKALINE, 1.5 VOLT, EACH	2 per month	N/A	N/A
K0604	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, LITHIUM, 3.6 VOLT, EACH	N/A	2 per 3 months	N/A
K0605	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP OWNED BY PATIENT, LITHIUM, 4.5 VOLT, EACH	N/C	N/C	N/C

---



---

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

---



---

**Prosthetic devices (artificial limbs, additions and repairs) requiring coverage**

<b>Partial Foot</b>	
L5000	Partial foot, shoe insert with longitudinal arch, toe filler
L5010	Partial foot, molded socket, ankle height, with toe filler
L5020	Partial foot, molded socket, tibial tubercle height, with toe filler
<b>Ankle</b>	
L5050	Ankle, Symes, molded socket, SACH foot
L5060	Ankle, Symes, metal frame, molded leather socket, articulated ankle/foot
<b>Below Knee</b>	
L5100	Below knee, molded socket, shin, SACH foot
L5105	Below knee, plastic socket, joints and thigh lacer, SACH foot
<b>Knee Disarticulation</b>	
L5150	Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot
L5160	Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin, SACH foot
<b>Above Knee</b>	
L5200	Above knee, molded socket, single axis constant friction knee, shin, SACH foot
L5210	Above knee, short prosthesis, no knee joint (stubbies), with foot blocks, no ankle joints, each
L5220	Above knee, short prosthesis, no knee joint (stubbies), with articulated ankle/foot, dynamically aligned, each
L5230	Above knee, for proximal femoral focal deficiency, constant friction knee, shin, SACH foot
<b>Hip Disarticulation</b>	
L5250	Hip disarticulation, canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot
L5270	Hip disarticulation, tilt table type; molded socket, locking hip joint, single axis constant friction knee, shin, SACH foot
<b>Hemipelvectomy</b>	
L5280	Hemipelvectomy, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot
L5301	Below knee, molded socket, shin, SACH foot, endoskeletal system
L5311	Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot, endoskeletal system
L5321	Above knee, molded socket, open end, SACH foot, endoskeletal system, single axis knee
L5331	Hip disarticulation, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot
L5341	Hemipelvectomy, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot
<b>Immediate Post-Surgical or Early Fitting Procedures</b>	
L5400	Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment, suspension, and one cast change, below knee
L5410	Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, below knee, each additional cast change and realignment
L5420	Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension and one cast change AK or knee disarticulation
L5430	Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, AK or knee disarticulation, each additional cast change and realignment
L5450	Immediate postsurgical or early fitting, application of nonweight-bearing rigid dressing, below knee

---



---

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

---



---

L5460	Immediate postsurgical or early fitting, application of nonweight-bearing rigid dressing, above knee
<b>Initial Prosthesis</b>	
L5500	Initial, below knee PTB type socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, direct formed
L5505	Initial, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot plaster socket, direct formed
<b>Preparatory Prosthesis</b>	
L5510	Preparatory, below knee PTB type socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, molded to model
L5520	Preparatory, below knee PTB type socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed
L5530	Preparatory, below knee PTB type socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model
L5535	Preparatory, below knee PTB type socket, non-alignable system, pylon, no cover, SACH foot, prefabricated, adjustable open end socket
L5540	Preparatory, below knee PTB type socket, non-alignable system, pylon, no cover, SACH foot, laminated socket, molded to model
L5560	Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, molded to model
L5570	Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed
L5580	Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model
L5585	Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, prefabricated adjustable open end socket
L5590	Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, laminated socket, molded to model
L5595	Preparatory, hip disarticulation - hemipelvectomy, pylon, no cover, SACH foot, thermoplastic or equal, molded to patient model
L5600	Preparatory, hip disarticulation - hemipelvectomy, pylon, no cover, SACH foot, laminated socket, molded to patient model
<b>Additions: Lower Extremity</b>	
L5610	Addition to lower extremity, endoskeletal system, above knee, hydracadence system
L5611	Addition to lower extremity, endoskeletal system, above knee - knee disarticulation, 4-bar linkage, with friction swing phase control
L5613	Addition to lower extremity, endoskeletal system, above knee - knee disarticulation, 4-bar linkage, with hydraulic swing phase control
L5614	Addition to lower extremity, endoskeletal system, above knee - knee disarticulation, 4-bar linkage, with pneumatic swing phase control
L5616	Addition to lower extremity, endoskeletal system, above knee, universal multiplex system, friction swing phase control
L5617	Addition to lower extremity, quick change self-aligning unit, above or below knee, each
<b>Additions: Test Sockets</b>	
L5618	Addition to lower extremity, test socket, Symes
L5620	Addition to lower extremity, test socket, below knee
L5622	Addition to lower extremity, test socket, knee disarticulation
L5624	Addition to lower extremity, test socket, above knee
L5626	Addition to lower extremity, test socket, hip disarticulation
L5628	Addition to lower extremity, test socket, hemipelvectomy
L5629	Addition to lower extremity, below knee, acrylic socket
<b>Additions: Socket Variations</b>	

## DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES

L5630	Addition to lower extremity, Symes type, expandable wall socket
L5631	Addition to lower extremity, above knee or knee disarticulation, acrylic socket
L5632	Addition to lower extremity, Symes type, PTB brim design socket
L5634	Addition to lower extremity, Symes type, posterior opening (canadian) socket
L5636	Addition to lower extremity, Symes type, medial opening socket
L5637	Addition to lower extremity, below knee, total contact
L5638	Addition to lower extremity, below knee, leather socket
L5639	Addition to lower extremity, below knee, wood socket
L5640	Addition to lower extremity, knee disarticulation, leather socket
L5642	Addition to lower extremity, above knee, leather socket
L5643	Addition to lower extremity, hip disarticulation, flexible inner socket, external frame
L5644	Addition to lower extremity, above knee, wood socket
L5645	Addition to lower extremity, below knee, flexible inner socket, external frame
L5646	Addition to lower extremity, below knee, air, fluid, gel or equal, cushion socket
L5647	Addition to lower extremity, below knee, suction socket
L5648	Addition to lower extremity, above knee, air, fluid, gel or equal, cushion socket
L5649	Addition to lower extremity, ischial containment/narrow M-L socket
L5650	Addition to lower extremity, total contact, above knee or knee disarticulation socket
L5651	Addition to lower extremity, above knee, flexible inner socket, external frame
L5652	Addition to lower extremity, suction suspension, above knee or knee disarticulation socket
L5653	Addition to lower extremity, knee disarticulation, expandable wall socket
<b>Additions: Socket Insert and Suspension</b>	
L5654	Addition to lower extremity, socket insert, Symes (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5655	Addition to lower extremity, socket insert, below knee (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5656	Addition to lower extremity, socket insert, knee disarticulation (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5658	Addition to lower extremity, socket insert, above knee (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5661	Addition to lower extremity, socket insert, multidurometer, Symes
L5665	Addition to lower extremity, socket insert, multidurometer, below knee
L5666	Addition to lower extremity, below knee, cuff suspension
L5668	Addition to lower extremity, below knee, molded distal cushion
L5670	Addition to lower extremity, below knee, molded supracondylar suspension (PTS or similar)
L5671	Addition to lower extremity, below knee/above knee suspension locking mechanism (shuttle, lanyard or equal), excludes socket insert
L5672	Addition to lower extremity, below knee, removable medial brim suspension
L5673	Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism
L5676	Addition to lower extremity, below knee, knee joints, single axis, pair
L5677	Addition to lower extremity, below knee, knee joints, polycentric, pair
L5678	Addition to lower extremity, below knee joint covers, pair
L5679	Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism
L5680	Addition to lower extremity, below knee, thigh lacer, nonmolded
L5681	Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code I5673 or I5679)
L5682	Addition to lower extremity, below knee, thigh lacer, gluteal/ischial, molded

---



---

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

---



---

L5683	Addition to lower extremity, below knee/above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code I5673 or I5679)
L5684	Addition to lower extremity, below knee, fork strap
L5685	Addition to lower extremity prosthesis, below knee, suspension/sealing sleeve, with or without valve, any material, each
L5686	Addition to lower extremity, below knee, back check (extension control)
L5688	Addition to lower extremity, below knee, waist belt, webbing
L5690	Addition to lower extremity, below knee, waist belt, padded and lined
L5692	Addition to lower extremity, above knee, pelvic control belt, light
L5694	Addition to lower extremity, above knee, pelvic control belt, padded and lined
L5695	Addition to lower extremity, above knee, pelvic control, sleeve suspension, neoprene or equal, each
L5696	Addition to lower extremity, above knee or knee disarticulation, pelvic joint
L5697	Addition to lower extremity, above knee or knee disarticulation, pelvic band
L5698	Addition to lower extremity, above knee or knee disarticulation, Silesian bandage
L5699	All lower extremity prostheses, shoulder harness
<b>Replacements</b>	
L5700	Replacement, socket, below knee, molded to patient model
L5701	Replacement, socket, above knee/knee disarticulation, including attachment plate, molded to patient model
L5702	Replacement, socket, hip disarticulation, including hip joint, molded to patient model
L5703	Ankle, Symes, molded to patient model, socket without solid ankle cushion heel (SACH) foot, replacement only
L5704	Custom shaped protective cover, below knee
L5705	Custom shaped protective cover, above knee
L5706	Custom shaped protective cover, knee disarticulation
L5707	Custom shaped protective cover, hip disarticulation
<b>Additions: Exoskeletal Knee-Shin System</b>	
L5710	Addition, exoskeletal knee-shin system, single axis, manual lock
L5711	Addition, exoskeletal knee-shin system, single axis, manual lock, ultra-light material
L5712	Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)
L5714	Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control
L5716	Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock
L5718	Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control
L5722	Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control
L5724	Addition, exoskeletal knee-shin system, single axis, fluid swing phase control
L5726	Addition, exoskeletal knee-shin system, single axis, external joints, fluid swing phase control
L5728	Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control
L5780	Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control
L5781	Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system
L5782	Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system, heavy duty
<b>Component Modification</b>	
L5785	Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)
L5790	Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)

---



---

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

---



---

L5795	Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)
<b>Additions: Endoskeletal Knee-Shin System</b>	
L5810	Addition, endoskeletal knee-shin system, single axis, manual lock
L5811	Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material
L5812	Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)
L5814	Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock
L5816	Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock
L5818	Addition, endoskeletal knee-shin system, polycentric, friction swing and stance phase control
L5822	Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control
L5824	Addition, endoskeletal knee-shin system, single axis, fluid swing phase control
L5826	Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame
L5828	Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control
L5830	Addition, endoskeletal knee-shin system, single axis, pneumatic/swing phase control
L5840	Addition, endoskeletal knee-shin system, 4-bar linkage or multiaxial, pneumatic swing phase control
L5845	Addition, endoskeletal knee-shin system, stance flexion feature, adjustable
L5848	Addition to endoskeletal, knee-shin system, hydraulic stance extension, dampening feature, with or without adjustability
L5850	Addition, endoskeletal system, above knee or hip disarticulation, knee extension assist
L5855	Addition, endoskeletal system, hip disarticulation, mechanical hip extension assist
L5856	Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor(s), any type
L5857	Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing phase only, includes electronic sensor(s), any type
L5858	Addition to lower extremity prosthesis, endoskeletal knee shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type
L5910	Addition, endoskeletal system, below knee, alignable system
L5920	Addition, endoskeletal system, above knee or hip disarticulation, alignable system
L5925	Addition, endoskeletal system, above knee, knee disarticulation or hip disarticulation, manual lock
L5930	Addition, endoskeletal system, high activity knee control frame
L5940	Addition, endoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)
L5950	Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)
L5960	Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)
L5962	Addition, endoskeletal system, below knee, flexible protective outer surface covering system
L5964	Addition, endoskeletal system, above knee, flexible protective outer surface covering system
L5966	Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system
L5968	Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature
L5670	All lower extremity prostheses, foot, external keel, SACH foot
L5971	All lower extremity prostheses, solid ankle cushion heel (SACH) foot, replacement only
L5972	All lower extremity prostheses, flexible keel foot (safe, sten, bock dynamic or equal)
L5974	All lower extremity prostheses, foot, single axis ankle/foot
L5975	All lower extremity prosthesis, combination single axis ankle and flexible keel foot
L5976	All lower extremity prostheses, energy storing foot (Seattle carbon copy ii or equal)

---



---

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

---



---

L5978	All lower extremity prostheses, foot, multi-axial ankle/foot
L5979	All lower extremity prostheses, multi-axial ankle, dynamic response foot, one piece system
L5980	All lower extremity prostheses, flex-foot system
L5981	All lower extremity prostheses, flex-walk system or equal
L5982	All exoskeletal lower extremity prostheses, axial rotation unit
L5984	All endoskeletal lower extremity prosthesis, axial rotation unit, with or without adjustability
L5985	All endoskeletal lower extremity prostheses, dynamic prosthetic pylon
L5986	All lower extremity prostheses, multi-axial rotation unit (MCP or equal)
L5987	All lower extremity prosthesis, shank foot system with vertical loading pylon
L5988	Addition to lower limb prosthesis, vertical shock reducing pylon feature
L5990	Addition to lower extremity prosthesis, user adjustable heel height
L5995	Addition to lower extremity prosthesis, heavy duty feature (for patient weight 300 lbs)
L5999	Lower extremity prosthesis, not otherwise specified
<b>Upper Limb</b>	
L6000	Partial hand, robin-aids, thumb remaining (or equal)
L6010	Partial hand, robin-aids, little and/or ring finger remaining (or equal)
L6020	Partial hand, robin-aids, no finger remaining (or equal)
L6025	Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device
L6050	Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad
L6055	Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps pad
<b>Below Elbow</b>	
L6100	Below elbow, molded socket, flexible elbow hinge, triceps pad
L6110	Below elbow, molded socket (Muenster or Northwestern suspension types)
L6120	Below elbow, molded double wall split socket, step-up hinges, half cuff
L6130	Below elbow, molded double wall split socket, stump activated locking hinge, half cuff
<b>Elbow Disarticulation</b>	
L6200	Elbow disarticulation, molded socket, outside locking hinge, forearm
L6205	Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm
<b>Above Elbow</b>	
L6250	Above elbow, molded double wall socket, internal locking elbow, forearm
<b>Shoulder Disarticulation</b>	
L6300	Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm
L6310	Shoulder disarticulation, passive restoration (complete prosthesis)
L6320	Shoulder disarticulation, passive restoration (shoulder cap only)
<b>Interscapular Thoracic</b>	
L6350	Interscapular thoracic, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm
L6360	Interscapular thoracic, passive restoration (complete prosthesis)
L6370	Interscapular thoracic, passive restoration (shoulder cap only)
<b>Immediate and Early Postsurgical Procedures</b>	
L6380	Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, wrist disarticulation or below elbow

---



---

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

---



---

L6382	Immediate postsurgical or early fitting, application of initial rigid dressing including fitting alignment and suspension of components, and one cast change, elbow disarticulation or above elbow
L6384	Immediate postsurgical or early fitting, application of initial rigid dressing including fitting alignment and suspension of components, and one cast change, shoulder disarticulation or interscapular thoracic
L6386	Immediate postsurgical or early fitting, each additional cast change and realignment
L6388	Immediate postsurgical or early fitting, application of rigid dressing only
<b>Endoskeletal: Below Elbow</b>	
L6400	Below elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping
<b>Endoskeletal: Elbow Disarticulation</b>	
L6450	Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping
<b>Endoskeletal: Above Elbow</b>	
L6500	Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping
<b>Endoskeletal: Shoulder Disarticulation</b>	
L6550	Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping
<b>Endoskeletal: Interscapular Thoracic</b>	
L6570	Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6580	Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC or equal pylon, no cover, molded to patient model
L6582	Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC or equal pylon, no cover, direct formed
L6584	Preparatory, elbow disarticulation or above elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC or equal pylon, no cover, molded to patient model
L6586	Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC or equal pylon, no cover, direct formed
L6588	Preparatory, shoulder disarticulation or interscapular thoracic, single wall plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, USMC or equal pylon, no cover, molded to patient model
L6590	Preparatory, shoulder disarticulation or interscapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, USMC or equal pylon, no cover, direct formed
<b>Additions: Upper Limb</b>	
L6600	Upper extremity additions, polycentric hinge, pair
L6605	Upper extremity additions, single pivot hinge, pair
L6610	Upper extremity additions, flexible metal hinge, pair
L6615	Upper extremity addition, disconnect locking wrist unit
L6616	Upper extremity addition, additional disconnect insert for locking wrist unit, each
L6620	Upper extremity addition, flexion/extension wrist unit, with or without friction
L6621	Upper extremity prosthesis addition, flexion/extension wrist with or without friction, for use with external powered terminal device
L6623	Upper extremity addition, spring assisted rotational wrist unit with latch release
L6625	Upper extremity addition, rotation wrist unit with cable lock
L6628	Upper extremity addition, quick disconnect hook adapter, Otto Bock or equal

---



---

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

---



---

L6629	Upper extremity addition, quick disconnect lamination collar with coupling piece, Otto Bock or equal
L6630	Upper extremity addition, stainless steel, any wrist
L6632	Upper extremity addition, latex suspension sleeve, each
L6635	Upper extremity addition, lift assist for elbow
L6637	Upper extremity addition, nudge control elbow lock
L6638	Upper extremity addition to prosthesis, electric locking feature, only for use with manually powered elbow
L6640	Upper extremity additions, shoulder abduction joint, pair
L6641	Upper extremity addition, excursion amplifier, pulley type
L6642	Upper extremity addition, excursion amplifier, lever type
L6645	Upper extremity addition, shoulder flexion-abduction joint, each
L6646	Upper extremity addition, shoulder joint, multipositional locking, flexion, adjustable abduction friction control, for use with body powered or external powered system
L6647	Upper extremity addition, shoulder lock mechanism, body powered actuator
L6648	Upper extremity addition, shoulder lock mechanism, external powered actuator
L6650	Upper extremity addition, shoulder universal joint, each
L6655	Upper extremity addition, standard control cable, extra
L6660	Upper extremity addition, heavy duty control cable
L6665	Upper extremity addition, Teflon, or equal, cable lining
L6670	Upper extremity addition, hook to hand, cable adapter
L6672	Upper extremity addition, harness, chest or shoulder, saddle type
L6675	Upper extremity addition, harness, (e.g. figure of eight type), single cable design
L6676	Upper extremity addition, harness, (e.g. figure of eight type), dual cable design
L6677	Upper extremity addition, harness, triple control, simultaneous operation of terminal device and elbow
L6680	Upper extremity addition, test socket, wrist disarticulation or below elbow
L6682	Upper extremity addition, test socket, elbow disarticulation or above elbow
L6684	Upper extremity addition, test socket, shoulder disarticulation or interscapular thoracic
L6686	Upper extremity addition, suction socket
L6687	Upper extremity addition, frame type socket, below elbow or wrist disarticulation
L6688	Upper extremity addition, frame type socket, above elbow or elbow disarticulation
L6689	Upper extremity addition, frame type socket, shoulder disarticulation
L6690	Upper extremity addition, frame type socket, interscapular-thoracic
L6691	Upper extremity addition, removable insert, each
L6692	Upper extremity addition, silicone gel insert or equal, each
L6693	Upper extremity addition, locking elbow, forearm counterbalance
L6694	Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism
L6695	Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism
L6696	Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, Use code L6694 or L6695)
L6697	Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695)

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

L6698	Addition to upper extremity prosthesis, below elbow/above elbow, Lock mechanism, excludes socket insert
<b>Terminal Devices - Hooks</b>	
L6700	Terminal device, hook, Dorrance or equal, model #3
L6703	Terminal device, passive hand/mitt, any material, any size
L6704	Terminal device, sport/recreational/work attachment, any material, any size
L6705	Terminal device, hook, Dorrance or equal, model #5
L6706	Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined
L6707	Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined
L6708	Terminal device, hook, mechanical, voluntary opening, any material, any size
L6709	Terminal device, hook, mechanical, voluntary closing, any material, any size
L6710	Terminal device, hook, Dorrance or equal, model #5X
L6715	Terminal device, hook, Dorrance or equal, model #5XA
L6720	Terminal device, hook, Dorrance or equal, model #6
L6725	Terminal device, hook, Dorrance or equal, model #7
L6730	Terminal device, hook, Dorrance or equal, model #7LO
L6735	Terminal device, hook, Dorrance or equal, model #8
L6740	Terminal device, hook, Dorrance or equal, model #8X
L6745	Terminal device, hook, Dorrance or equal, model #88X
L6750	Terminal device, hook, Dorrance or equal, model #10P
L6755	Terminal device, hook, Dorrance or equal, model #10P
L6765	Terminal device, hook, Dorrance or equal, model #12P
L6770	Terminal device, hook, Dorrance or equal, model #99X
L6775	Terminal device, hook, Dorrance or equal, model #555
L6780	Terminal device, hook, Dorrance or equal, model #SS555
L6790	Terminal device, hook, Accu hook or equal
L6795	Terminal device, hook, 2 load or equal
L6800	Terminal device, hook, APRL VC or equal
L6805	Terminal device, modifier wrist flexion unit
L6806	Terminal device, hook, trs grip, grip iii, vc, or equal
L6807	Terminal device, hook, grip i, grip ii, vc, or equal
L6808	Terminal device, hook, trs adept, infant or child, vc, or equal
L6809	Terminal device, hook, trs super sport, passive
L6810	Terminal device, pincher tool, Otto Bock or equal
<b>Terminal Devices - Hands</b>	
L6825	Terminal device, hand, Dorrance, vo
L6830	Terminal device, hand, APRL, vc
L6835	Terminal device, hand, Sierra, vo
L6840	Terminal device, hand, Becker Imperial
L6845	Terminal device, hand, Becker Lock Grip
L6850	Terminal device, hand, Becker Plylite
L6855	Terminal device, hand, Robin-Aids, vo
L6860	Terminal device, hand, Robin-Aids, vo soft
L6865	Terminal device, hand, passive hand
L6867	Terminal device, hand, Detroit infant hand (mechanical)
L6868	Terminal device, hand, passive infant hand, Steeper, Hosmer or equal
L6870	Terminal device, hand, child mitt
L6872	Terminal device, hand, NYU child hand

---



---

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

---



---

L6873	Terminal device, hand, mechanical infant hand, Steeper or equal
L6875	Terminal device, hand, Bock, vc
L6880	Terminal device, hand, Bock, vo
L6881	Automatic grasp feature, addition to upper limb prosthetic terminal device
L6882	Microprocessor control feature, addition to upper limb prosthetic terminal device
L6883	Replacement socket, below elbow/wrist disarticulation, molded to patient model, for use with or without external power
L6884	Replacement socket, above elbow disarticulation, molded to patient model, for use with or without external power
L6885	Replacement socket, shoulder disarticulation/interscapular thoracic, molded to patient model, for use with or without external power
L6890	Addition to upper extremity prosthesis, glove for terminal device, any material, prefabricated, includes fitting and adjustment
L6895	Addition to upper extremity prosthesis, glove for terminal device, any material, custom fabricated
<b>Hand Restoration</b>	
L6900	Hand restoration (casts, shading and measurements included), partial hand, with glove, thumb or one finger remaining
L6905	Hand restoration (casts, shading and measurements included), partial hand, with glove, multiple fingers remaining
L6910	Hand restoration (casts, shading and measurements included), partial hand, with glove, no fingers remaining
L6915	Hand restoration (shading and measurements included), replacement glove for above
<b>External Power - Base Devices</b>	
L6920	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6925	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6930	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6935	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6940	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6945	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6950	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6955	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6960	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6965	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device

---



---

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

---



---

L6970	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6975	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L7007	Electric hand, switch or myoelectric controlled, adult
L7008	Electric hand, switch or myoelectric controlled, pediatric
L7009	Electric hook, switch or myoelectric controlled, adult
L7010	Electronic hand, Otto Bock, Steeper or equal, switch controlled
L7015	Electronic hand, System Teknik, Variety Village or equal, switch controlled
L7020	Electronic greifer, Otto Bock or equal, switch controlled
L7025	Electronic hand, Otto Bock or equal, myoelectronically controlled
L7030	Electronic hand, System Teknik, Variety Village or equal, myoelectronically controlled
L7035	Electronic greifer, Otto Bock or equal, myoelectronically controlled
L7040	Prehensile actuator, hosmer or equal, switch controlled
L7045	Electronic hook, child, Michigan or equal, switch controlled
<b>External Power – Elbow</b>	
L7170	Electronic elbow, Hosmer or equal, switch controlled
L7180	Electronic elbow, microprocessor sequential control of elbow and terminal device
L7181	Electronic elbow, microprocessor simultaneous control of elbow and terminal device
L7185	Electronic elbow, adolescent, Variety Village or equal, switch controlled
L7186	Electronic elbow, child, Variety Village or equal, switch controlled
L7190	Electronic elbow, adolescent, Variety Village or equal, myoelectronically controlled
L7191	Electronic elbow, child, Variety Village or equal, myoelectronically controlled
L7260	Electronic wrist rotator, Otto Bock or equal
L7261	Electronic wrist rotator, for Utah arm
L7266	Servo control, Steeper or equal
L7272	Analogue control, UNB or equal
L7274	Proportional control, 6-12 volt, liberty, Utah or equal
<b>Battery Components</b>	
L7360	Six volt battery, Otto Bock or equal, each
L7362	Battery charger, six volt, Otto Bock or equal
L7364	Twelve volt battery, Utah or equal, each
L7366	Battery charger, twelve volt, Utah or equal
L7367	Lithium ion battery, replacement
L7368	Lithium ion battery charger
L7400	Addition to upper extremity prosthesis, below elbow/wrist disarticulation, ultralight material (titanium, carbon fiber or equal)
L7401	Addition to upper extremity prosthesis, above elbow disarticulation, ultralight material (titanium, carbon fiber or equal)
L7402	Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoracic, ultralight material (titanium, carbon fiber or equal)
L7403	Addition to upper extremity prosthesis, below elbow/wrist disarticulation, acrylic material
L7404	Addition to upper extremity prosthesis, above elbow disarticulation, acrylic material
L7405	ADD TO UPPER EXTREMITY PROSTHESIS SHOULDER DISARTICULATION/INTERSCAPULAR THORA Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoracic, acrylic material
L7499	Upper extremity prosthesis, NOS

---



---

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

---



---

<b>Repairs</b>	
L7500	Repair of prosthetic device, hourly rate
L7510	Repair of prosthetic device, repair or replace minor parts
L7520	Repair prosthetic device, labor component, per 15 minutes
L7600	Prosthetic donning sleeve, any material, each
<b>Prosthetic socks</b>	
L8400	Prosthetic sheath, below knee, each
L8410	Prosthetic sheath, above knee, each
L8415	Prosthetic sheath, upper limb, each
L8417	Prosthetic sheath/sock, including a gel cushion layer, below knee or above knee, each
L8420	Prosthetic sock, multiple ply, below knee, each
L8430	Prosthetic sock, multiple ply, above knee, each
L8435	Prosthetic sock, multiple ply, upper limb, each
L8440	Prosthetic shrinker, below knee, each
L8460	Prosthetic shrinker, above knee, each
L8465	Prosthetic shrinker, upper limb, each
L8470	Prosthetic sock, single ply, below knee, each
L8480	Prosthetic sock, single ply, above knee, each
L8485	Prosthetic sock, single ply, upper limb, each
L8499	Unlisted procedure for miscellaneous prosthetic services

---



---

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

---



---

**Fallon Community Health Plan**

**DME items that do not require preauthorization (updated 9/1/2011)**

Current HCPCS Code	Description	Quantity Alert
E0100	CANE, INCLUDES CANES OF ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIP	
E0105	CANE, QUAD OR THREE PRONG, INCLUDES CANES OF ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIPS	
E0110	CRUTCHES, FOREARM, INCLUDES CRUTCHES OF VARIOUS MATERIALS, ADJUSTABLE OR FIXED, PAIR, COMPLETE WITH TIPS AND HANDGRIPS	
E0111	CRUTCH FOREARM, INCLUDES CRUTCHES OF VARIOUS MATERIALS, ADJUSTABLE OR FIXED, EACH, WITH TIP AND HANDGRIPS	
E0112	CRUTCHES UNDERARM, WOOD, ADJUSTABLE OR FIXED, PAIR, WITH PADS, TIPS AND HANDGRIPS	
E0113	CRUTCH UNDERARM, WOOD, ADJUSTABLE OR FIXED, EACH, WITH PAD, TIP AND HANDGRIP	
E0114	CRUTCHES UNDERARM, OTHER THAN WOOD, ADJUSTABLE OR FIXED, PAIR, WITH PADS, TIPS AND HANDGRIPS	
E0116	CRUTCH UNDERARM, OTHER THAN WOOD, ADJUSTABLE OR FIXED, EACH, WITH PAD, TIP AND HANDGRIP	
E0130	WALKER, RIGID (PICKUP), ADJUSTABLE OR FIXED HEIGHT	
E0135	WALKER, FOLDING (PICKUP), ADJUSTABLE OR FIXED HEIGHT	
E0141	RIGID WALKER, WHEELED, ADJUSTABLE OF FIXED HEIGHT	
E0143	FOLDING WALKER, WHEELED, WITHOUT SEAT	
*E0144	ENCLOSED, FRAMED FOLDING WALKER, WHEELED, WITH POSTERIOR SEAT	
*E0147	HEAVY DUTY, MULTIPLE BREAKING SYSTEM, VARIABLE WHEEL RESISTANCE WALKER	
E0148	WALKER, HEAVY DUTY, WITHOUT WHEELS, RIGID OR FOLDING, ANY TYPE, EACH	
E0149	WALKER, HEAVY DUTY, WHEELED, RIGID OR FOLDING, ANY TYPE, EACH	
E0153	PLATFORM ATTACHMENT, FOREARM CRUTCH, EACH	
E0154	PLATFORM ATTACHMENT, WALKER, EACH	
E0155	WHEEL ATTACHMENT, RIGID PICK-UP WALKER, PER PAIR	
E0156	SEAT ATTACHMENT, WALKER	
E0157	CRUTCH ATTACHMENT, WALKER, EACH	
E0158	LEG EXTENSIONS FOR WALKER, PER SET OF FOUR (4)	
E0159	BRAKE ATTACHMENT FOR WHEELED WALKER, REPLACEMENT, EACH	
E0160	SITZ TYPE BATH OR EQUIPMENT, PORTABLE, USED WITH OR WITHOUT COMMUNE	
E0161	SITZ TYPE BATH OR EQUIPMENT, PORTABLE, USED WITH OR WITHOUT COMMUNE, WITH FAUCET ATTACHMENT/S	
E0163	COMMUNE CHAIR, STATIONARY, WITH FIXED ARMS	
E0167	PAIL OR PAN FOR USE WITH COMMUNE CHAIR	
E0175	FOOT REST, FOR USE WITH COMMUNE CHAIR, EACH	
E0188	SYNTHETIC SHEEPSKIN PAD	
E0189	LAMBSWOOL SHEEPSKIN PAD, ANY SIZE	
E0275	BED PAN, STANDARD, METAL OR PLASTIC	

---



---

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

---



---

E0276	BED PAN, FRACTURE, METAL OR PLASTIC	
*E0280	BED CRADLE, ANY TYPE	
*E0305	BED SIDE RAILS, HALF LENGTH	
*E0310	BED SIDE RAILS, FULL LENGTH	
E0325	URINAL; MALE, JUG-TYPE, ANY MATERIAL	
E0326	URINAL; FEMALE, JUG-TYPE, ANY MATERIAL	
E0570	NEBULIZER WITH COMPRESSOR	
E0574	US/ELEC AROSL GEN W/SM VOLUME NEB	
E0580	NEBULIZR GLASS/AUTOCLVBL PLST BOTTL	
E0585	NEBULIZER W/COMPRESSOR AND HEATER	
E0606	POSTURAL DRAINAGE BOARD	
*E0621	SLING OR SEAT, PATIENT LIFT, CANVAS OR NYLON	
E0700	SAFETY EQUIPMENT (E.G., BELT, HARNESS OR VEST)	
E0710	RESTRAINTS, ANY TYPE (BODY, CHEST, WRIST OR ANKLE)	
E0720	TENS, TWO LEAD, LOCALIZED STIMULATION	
E0730	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION DEVICE, FOUR OR MORE LEADS, FOR MULTIPLE NERVE STIMULATION	
E0731	FORM-FITTING CONDUCTIVE GARMENT FOR DELIVERY OF TENS OR NMES (WITH CONDUCTIVE FIBERS SEPARATED FROM THE PATIENT'S SKIN BY LAYERS OF FABRIC)	
E0745	NEUROMUSCULAR STIMULATOR, ELECTRONIC SHOCK UNIT	
*E0910	TRAPEZE BARS, A/K/A PATIENT HELPER, ATTACHED TO BED, WITH GRAB BAR	
E0911	TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 POUNDS, ATTACHED TO BED, WITH GRAB BAR	
E0912	TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 POUNDS, FREE STANDING, COMPLETE WITH GRAB BAR	
*E0940	TRAPEZE BAR, FREE STANDING, COMPLETE WITH GRAB BAR	
E0942	CERVICAL HEAD HARNESS/HALTER	
E0950	WHEELCHAIR TRAY	QUANTITY ALERT
E0951	LOOP HEEL, EACH (WHEELCHAIR ACCESSORY)	QUANTITY ALERT
E0952	TOE LOOP, EACH	QUANTITY ALERT
*E0958	WHEELCHAIR ATTACHMENT TO CONVERT ANY WHEELCHAIR TO ONE ARM DRIVE	
E0959	WHEELCHAIR ADAPTER FOR AMPUTEE, PAIR (DEVICE USED TO COMPENSATE FOR TRANSFER OF WEIGHT DUE TO LOST LIMBS TO MAINTAIN PROPER BALANCE)	QUANTITY ALERT
E0961	WHEEL LOCK EXTENSION, PAIR	QUANTITY ALERT
E0966	HOOK ON HEAD REST EXTENSION	
E0967	WHEELCHAIR HAND RIMS WITH 8 VERTICAL RUBBER TIPPED PROJECTIONS, PAIR	QUANTITY ALERT
E0968	COMMODE SEAT, WHEELCHAIR	
E0971	ANTI-TIPPING DEVICE WHEELCHAIRS	
E0973	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, COMPLETE ASSEMBLY, EACH	

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

E0974	ANTI-ROLLBACK DEVICE, PAIR	QUANTITY ALERT
E0978	SAFETY BELT/PELVIC STRAP, EACH	QUANTITY ALERT
*E0980	SAFETY VEST, WHEELCHAIR	
E0990	WHEELCHAIR ACCESSORY, ELEVATING LEG REST, EACH	
E0992	SOLID SEAT INSERT, PLANAR SEAT, SINGLE DENSITY FOAM	
E0994	ARM REST, EACH	
E0995	CALF PAD, EACH	QUANTITY ALERT
E2208	WHEELCHAIR ACCESSORY, CYLINDER TANK CARRIER, EACH	
E2209	WHEELCHAIR ACCESSORY, ARM TROUGH, EACH	
E2210	WHEELCHAIR ACCESSORY, BEARINGS, ANY TYPE, REPLACEMENT ONLY, EACH	
E2211	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	
E2212	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	
E2213	MANUAL WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC PROPULSION TIRE (REMOVABLE), ANY TYPE, ANY SIZE, EACH	
E2214	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, EACH	
E2215	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, EACH	
E2216	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED PROPULSION TIRE, ANY SIZE, EACH	
E2217	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, EACH	
E2218	MANUAL WHEELCHAIR ACCESSORY, FOAM PROPULSION TIRE, ANY SIZE, EACH	
E2219	MANUAL WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, EACH	
E2220	MANUAL WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) PROPULSION TIRE, ANY SIZE, EACH	
E2221	MANUAL WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE (REMOVABLE), ANY SIZE, EACH	
E2222	MANUAL WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATED WHEEL, ANY SIZE, EACH	
E2224	MANUAL WHEELCHAIR ACCESSORY, PROPULSION WHEEL EXCLUDES TIRE, ANY SIZE, EACH	
E2225	MANUAL WHEELCHAIR ACCESSORY, CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	
E2226	MANUAL WHEELCHAIR ACCESSORY, CASTER FORK, ANY SIZE, REPLACEMENT ONLY, EACH	
E2227	MANUAL WHEELCHAIR ACCESSORY, GEAR REDUCTION DRIVE WHEEL, EACH	
E2228	MANUAL WHEELCHAIR ACCESSORY, WHEEL BRAKING SYSTEM AND LOCK, COMPLETE, EACH	
E2230	MANUAL WHEELCHAIR ACCESSORY, MANUAL STANDING SYSTEM	
E2231	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT), INCLUDES ANY TYPE MOUNTING HARDWARE	

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

E2295	MANUAL WHEELCHAIR ACCESSORY, FOR PEDIATRIC SIZE WHEELCHAIR, DYNAMIC SEATING FRAME, ALLOWS COORDINATED MOVEMENT OF MULTIPLE POSITIONING FEATURES	
E2312	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, MINI-PROPORTIONAL REMOTE JOYSTICK, PROPORTIONAL, INCLUDING FIXED MOUNTING HARDWARE	
E2313	POWER WHEELCHAIR ACCESSORY, HARNESS FOR UPGRADE TO EXPANDABLE CONTROLLER, INCLUDING ALL FASTENERS, CONNECTORS AND MOUNTING HARDWARE, EACH	
E2360	22 NF NON-SEALED LEAD ACID BATTERY, EACH	QUANTITY ALERT
E2361	22 NF SEALED LEAD ACID BATTERY, EACH, (E.G., GEL CELL ABSORBED GLASS MAT)	QUANTITY ALERT
E2362	GROUP 24 NON-SEALED LEAD ACID BATTERY, EACH	QUANTITY ALERT
E2363	GROUP 24 SEALED LEAD ACID BATTERY, EACH, (E.G., GEL CELL ABSORBED GLASS MAT)	QUANTITY ALERT
E2364	U-1 NON-SEALED LEAD ACID BATTERY, EACH	QUANTITY ALERT
E2365	U-1 SEALED LEAD ACID BATTERY, EACH (GEL)	QUANTITY ALERT
E2366	BATTERY CHARGER, SINGLE MODE, FOR USE W/ ONLY 1 BATTERY TYPE - SEALED OR NON-SEALED	
E2367	BATTERY CHARGER, DUAL MODE	
E2371	POWER WHEELCHAIR ACCESSORY, GROUP 27 SEALED LEAD ACID BATTERY, (E.G. GEL CELL, ABSORBED GLASSMAT), EACH	
E2372	POWER WHEELCHAIR ACCESSORY, GROUP 27 NON-SEALED LEAD ACID BATTERY, EACH	
E2373	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, MINI-PROPORTIONAL, COMPACT, OR SHORT THROW REMOTE JOYSTICK OR TOUCHPAD, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE	
E2374	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, STANDARD REMOTE JOYSTICK (NOT INCLUDING CONTROLLER), PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE, REPLACEMENT ONLY	
E2375	POWER WHEELCHAIR ACCESSORY, NON-EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY	
E2376	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY	
E2377	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, UPGRADE PROVIDED AT INITIAL ISSUE	
E2381	POWER WHEELCHAIR ACCESSORY, PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	
E2382	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	
E2383	POWER WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC DRIVE WHEEL TIRE (REMOVABLE), ANY TYPE, ANY SIZE, REPLACEMENT ONLY, EACH	

---



---

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

---



---

E2384	POWER WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	
E2385	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	
E2386	POWER WHEELCHAIR ACCESSORY, FOAM FILLED DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	
E2387	POWER WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	
E2388	POWER WHEELCHAIR ACCESSORY, FOAM DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	
E2389	POWER WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	
E2390	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	
E2391	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE (REMOVABLE), ANY SIZE, REPLACEMENT ONLY, EACH	
E2392	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATED WHEEL, ANY SIZE, REPLACEMENT ONLY, EACH	
E2394	POWER WHEELCHAIR ACCESSORY, DRIVE WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	
E2395	POWER WHEELCHAIR ACCESSORY, CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	
E2396	POWER WHEELCHAIR ACCESSORY, CASTER FORK, ANY SIZE, REPLACEMENT ONLY, EACH	
E2397	POWER WHEELCHAIR ACCESSORY, LITHIUM-BASED BATTERY, EACH	
E2622	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 IN, ANY DEPTH	
E2623	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 IN OR GREATER, ANY DEPTH	
E2624	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 IN, ANY DEPTH	
E2625	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 IN OR GREATER, ANY DEPTH	
K0017	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, BASE, EACH	QUANTITY ALERT
K0018	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, UPPER PORTION, EACH	QUANTITY ALERT
K0019	ARM PAD, EACH	QUANTITY ALERT
K0020	FIXED, ADJUSTABLE HEIGHT ARMREST, PAIR	QUANTITY ALERT
K0037	HIGH MOUNT FLIP-UP FOOTREST, EACH	QUANTITY ALERT
K0038	LEG STRAP, EACH	QUANTITY ALERT
K0039	LEG STRAP, H STYLE, EACH	QUANTITY ALERT
K0040	ADJUSTABLE ANGLE FOOTPLATE, EACH	QUANTITY ALERT

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

K0041	LARGE SIZE FOOTPLATE, EACH	QUANTITY ALERT
K0042	STANDARD SIZE FOOTPLATE, EACH	QUANTITY ALERT
K0043	FOOTREST, LOWER EXTENSION TUBE, EACH	QUANTITY ALERT
K0044	FOOTREST, UPPER HANGER BRACKET, EACH	QUANTITY ALERT
K0045	FOOTREST, COMPLETE ASSEMBLY	
K0046	ELEVATING LEGREST, LOWER EXTENSION TUBE, EACH	QUANTITY ALERT
K0047	ELEVATING LEGREST, UPPER HANGER BRACKET, EACH	QUANTITY ALERT
K0050	RATCHET ASSEMBLY	
K0051	CAM RELEASE ASSEMBLY, FOOTREST OR LEGREST, EACH	QUANTITY ALERT
K0052	SWINGAWAY, DETACHABLE FOOTRESTS, EACH	QUANTITY ALERT
K0053	ELEVATING FOOTRESTS, ARTICULATING (TELESCOPING), EACH	QUANTITY ALERT
K0065	SPOKE PROTECTORS, EACH	QUANTITY ALERT
K0069	REAR WHEEL ASSEMBLY, COMPLETE, WITH SOLID TIRE, SPOKES OR MOLDED, EACH	QUANTITY ALERT
K0070	REAR WHEEL ASSEMBLY, COMPLETE, WITH PNEUMATIC TIRE, SPOKES OR MOLDED, EACH	QUANTITY ALERT
K0071	FRONT CASTER ASSEMBLY, COMPLETE, WITH PNEUMATIC TIRE, EACH	QUANTITY ALERT
K0072	FRONT CASTER ASSEMBLY, COMPLETE, WITH SEMI-PNEUMATIC TIRE, EACH	QUANTITY ALERT
K0073	CASTER PIN LOCK,EACH	QUANTITY ALERT
K0077	FRONT CASTER ASSEMBLY, COMPLETE, WITH SOLID TIRE, EACH	QUANTITY ALERT
K0098	DRIVE BELT FOR POWER WHEELCHAIR	
K0105	IV HANGER, EACH	QUANTITY ALERT
*K0195	ELEVATING LEG RESTS, PAIR (FOR USE WITH CAPPED RENTAL WHEELCHAIR BASE)	
K0462	TEMP REPL PT EQUIP REPR ANY TYPE	
L0113	CRANIAL CERVICAL ORTHOSIS, TORTICOLLIS TYPE, WITH OR WITHOUT JOINT, WITH OR WITHOUT SOFT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L0120	CERVICAL, FLEXIBLE, NON-ADJUSTABLE (FOAM COLLAR)	
L0130	CERVICAL, FLEXIBLE, THERMOPLASTIC COLLAR, MOLDED TO PATIENT	
L0140	CERVICAL, SEMI-RIGID, ADJUSTABLE (PLASTIC COLLAR)	
L0150	CERVICAL, SEMI-RIGID, ADJUSTABLE MOLDED CHIN CUP (PLASTIC COLLAR WITH MANDIBULAR/OCCIPITAL PIECE)	
L0160	CERVICAL, SEMI-RIGID, WIRE FRAME OCCIPITAL/MANDIBULAR SUPPORT	
L0170	CERVICAL, COLLAR, MOLDED TO PATIENT MODEL	

---



---

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

---



---

L0172	CERVICAL, COLLAR, SEMI-RIGID THERMOPLASTIC FOAM, TWO PIECE	QUANTITY ALERT
L0174	CERVICAL, COLLAR, SEMI-RIGID, THERMOPLASTIC FOAM, TWO PIECE WITH THORACIC EXTENSION	QUANTITY ALERT
L0180	CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE	
L0190	CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE CERVICAL BARS (SOMI, GUILFORD, TAYLOR TYPES)	
L0200	CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE CERVICAL BARS, AND THORACIC EXTENSION	
L0491	TLSO, SAGITTAL-CORONAL CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, TWO RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE XIPHOID, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL AND CORONAL PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L0492	TLSO, SAGITTAL-CORONAL CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, THREE RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE XIPHOID, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL AND CORONAL PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L0621	SACROILIAC ORTHOSIS, FLEXIBLE, PROVIDES PELVIC-SACRAL SUPPORT, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L0623	SACROILIAC ORTHOSIS, PROVIDES PELVIC-SACRAL SUPPORT, WITH RIGID OR SEMI-RIGID PANELS OVER THE SACRUM AND ABDOMEN, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L0625	LUMBAR ORTHOSIS, FLEXIBLE, PROVIDES LUMBAR SUPPORT, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, SHOULDER STRAPS, STAYS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L0626	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	

---



---

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

---



---

L0627	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L0628	LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVIDES LUMBO-SACRAL SUPPORT, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L0630	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L0631	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L0633	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L0635	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, LUMBAR FLEXION, RIGID POSTERIOR FRAME/PANEL(S), LATERAL ARTICULATING DESIGN TO FLEX THE LUMBAR SPINE, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANEL(S), PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, ANTERIOR PANEL, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L0637	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND 'POSTERIOR FRAME/PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L0638	LUMBAR-SACRAL ORTHOSIS SAGITTAL-CORONAL CONTROL WITH RIGID ANTERIOR AND POSTER	

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

L0639	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, OVERALL STRENGTH IS PROVIDED BY OVERLAPPING RIGID MATERIAL AND STABILIZING CLOSURES, INCLUDES STRAPS, CLOSURES, MAY INCLUDE SOFT INTERFACE, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L0859	ADDITION TO HALO PROCEDURE, MAGNETIC RESONANCE IMAGE COMPATIBLE SYSTEMS, RINGS AND PINS, ANY MATERIAL	
L0970	THORACIC-LUMBAR-SACRAL ORTHOSIS (TLSO), CORSET FRONT	
L0972	LUMBAR-SACRAL ORTHOSIS (LSO), CORSET FRONT	
L0974	TLSO, FULL CORSET	
L0976	LSO, FULL CORSET	
L0978	AXILLARY CRUTCH EXTENSION	
L0980	PERONEAL STRAPS, PAIR	QUANTITY ALERT
L0982	STOCKING SUPPORTER GRIPS, SET OF FOUR (4)	QUANTITY ALERT
L1010	ADDITION TO CERVICAL-THORACIC-LUMBAR-SACRAL ORTHOSIS (CTLSO) OR SCOLIOSIS ORTHOSIS, AXILLA SLING	
L1020	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, KYPHOSIS PAD	
L1025	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, KYPHOSIS PAD, FLOATING	
L1030	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, LUMBAR BOLSTER PAD	
L1040	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, LUMBAR OR LUMBAR RIB PAD	
L1050	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, STERNAL PAD	
L1060	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, THORACIC PAD	
L1070	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, TRAPEZIUS SLING	
L1080	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, OUTRIGGER	
L1085	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, OUTRIGGER, BILATERAL WITH VERTICAL EXTENSIONS	
L1090	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, LUMBAR SLING	
L1100	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, RING FLANGE, PLASTIC OR LEATHER	
L1110	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, RING FLANGE, PLASTIC OR LEATHER, MOLDED TO PATIENT MODEL	
L1120	ADDITION TO CTLSO, SCOLIOSIS ORTHOSIS, COVER FOR UPRIGHT, EACH	
L1210	ADDITION TO TLSO, (LOW PROFILE), LATERAL THORACIC EXTENSION	
L1220	ADDITION TO TLSO, (LOW PROFILE), ANTERIOR THORACIC EXTENSION	
L1230	ADDITION TO TLSO, (LOW PROFILE), MILWAUKEE TYPE SUPERSTRUCTURE	
L1240	ADDITION TO TLSO, (LOW PROFILE), LUMBAR DEROTATION PAD	
L1250	ADDITION TO TLSO, (LOW PROFILE), ANTERIOR ASIS PAD	
L1260	ADDITION TO TLSO, (LOW PROFILE), ANTERIOR THORACIC DEROTATION PAD	
L1270	ADDITION TO TLSO, (LOW PROFILE), ABDOMINAL PAD	
L1280	ADDITION TO TLSO, (LOW PROFILE), RIB GUSSET (ELASTIC), EACH	
L1290	ADDITION TO TLSO, (LOW PROFILE), LATERAL TROCHANTERIC PAD	
L1650	HIP ORTHOSIS ABDUCT CNTRL-STATC ADJ	

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

L1652	HIP ORTHOSIS, BILATERAL THIGH CUFFS WITH ADJUSTABLE ABDUCTOR SPREADER BAR, ADULT SIZE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT, ANY TYPE	
L1810	KO ELAST W/JNT PREFAB INCL FIT&ADJ	
L1830	KNEE ORTHOSIS, IMMOBILIZER, CANVAS LONGITUDINAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L1832	KNEE ORTHOSIS, ADJUSTABLE KNEE JOINTS, POSITIONAL ORTHOSIS, RIGID SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L1847	KNEE ORTHOSIS, DOUBLE UPRIGHT WITH ADJUSTABLE JOINT, WITH INFLATABLE AIR SUPPORT CHANBER(S), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L1902	AFO ANK GAUNTLT PREFAB W/FIT & ADJ	
L1906	ANKLE-FOOT ORTHOSIS, MULTILIGAMENTUS ANKLE SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L1930	ANKLE-FOOT ORTHOSIS, PLASTIC OR OTHER MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L2035	KAFO FULL PLSTC STAT PED SZ PRFAB	
L2180	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, PLASTIC SHOE INSERT W/ ANKLE JOINTS	
L2182	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, DROP LOCK KNEE JOINT	
L2184	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, LIMITED MOTION KNEE JOINT	
L2186	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, ADJUSTABLE MOTION KNEE JOINT, LERMAN TYPE	
L2188	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, QUADRILATERAL BRIM	
L2190	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, WAIST BELT	
L2192	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, HIP JOINT, PELVIC BAND, THIGH FLANGE, AND PELVIC BELT	
L2200	ADDITION TO LOWER EXTREMITY, LIMITED ANKLE MOTION, EACH JOINT	QUANTITY ALERT
L2210	ADDITION TO LOWER EXTREMITY, DORSIFLEXION ASSIST (PLANTAR FLEXION RESIST), EACH JOINT	QUANTITY ALERT
L2220	ADDITION TO LOWER EXTREMITY, DORSIFLEXION AND PLANTAR FLEXION ASSIST/RESIST, EACH JOINT	QUANTITY ALERT
L2230	ADDITION TO LOWER EXTREMITY, SPLIT FLAT CALIPER STIRRUPS AND PLATE ATTACHMENT	
L2240	ADDITION TO LOWER EXTREMITY, ROUND CALIPER AND PLATE ATTACHMENT	
L2250	ADDITION TO LOWER EXTREMITY, FOOT PLATE, MOLDED TO PATIENT MODEL, STIRRUP ATTACHMENT	
L2260	ADDITION TO LOWER EXTREMITY, REINFORCED SOLID STIRRUP (SCOTT-CRAIG TYPE)	
L2265	ADDITION TO LOWER EXTREMITY, LONG TONGUE STIRRUP	
L2270	ADDITION TO LOWER EXTREMITY, VARUS/VALGUS CORRECTION ('T') STRAP, PADDED/LINED OR MALLEOLUS PAD	
L2275	ADDITION TO LOWER EXTREMITY, VARUS/VALGUS CORRECTION, PLASTIC MODIFICATION, PADDED/LINED	
L2280	ADDITION TO LOWER EXTREMITY, MOLDED INNER BOOT	

---



---

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

---



---

L2300	ADDITION TO LOWER EXTREMITY, ABDUCTION BAR (BILATERAL HIP INVOLVEMENT), JOINTED, ADJUSTABLE	
L2310	ADDITION TO LOWER EXTREMITY, ABDUCTION BAR-STRAIGHT	
L2320	ADDITION TO LOWER EXTREMITY, NON-MOLDED LACER	
L2330	ADDITION TO LOWER EXTREMITY, LACER MOLDED TO PATIENT MODEL	
L2335	ADDITION TO LOWER EXTREMITY, ANTERIOR SWING BAND	
L2340	ADDITION TO LOWER EXTREMITY, PRE-TIBIAL SHELL, MOLDED TO PATIENT MODEL	
L2350	ADDITION TO LOWER EXTREMITY, PROSTHETIC TYPE, (BK) SOCKET, MOLDED TO PATIENT MODEL, (USED FOR 'PTB' 'AFO' ORTHOSES)	
L2360	ADDITION TO LOWER EXTREMITY, EXTENDED STEEL SHANK	
L2370	ADDITION TO LOWER EXTREMITY, PATTEN BOTTOM	
L2375	ADDITION TO LOWER EXTREMITY, TORSION CONTROL, ANKLE JOINT AND HALF SOLID STIRRUP	
L2380	ADDITION TO LOWER EXTREMITY, TORSION CONTROL, STRAIGHT KNEE JOINT, EACH JOINT	QUANTITY ALERT
L2385	ADDITION TO LOWER EXTREMITY, STRAIGHT KNEE JOINT, HEAVY DUTY, EACH JOINT	QUANTITY ALERT
L2390	ADDITION TO LOWER EXTREMITY, OFFSET KNEE JOINT, EACH JOINT	QUANTITY ALERT
L2395	ADDITION TO LOWER EXTREMITY, OFFSET KNEE JOINT, HEAVY DUTY, EACH JOINT	QUANTITY ALERT
L2397	ADDITION TO LOWER EXTREMITY ORTHOSIS, SUSPENSION SLEEVE	
L2405	ADDITION TO KNEE JOINT, DROP LOCK, EACH JOINT	QUANTITY ALERT
L2415	ADDITION TO KNEE JOINT, CAM LOCK (SWISS, FRENCH, BAIL TYPES) EACH JOINT	QUANTITY ALERT
L2425	ADDITION TO KNEE JOINT, DISC OR DIAL LOCK FOR ADJUSTABLE KNEE FLEXION, EACH JOINT	QUANTITY ALERT
L2430	ADDITION TO KNEE JOINT, RATCHET LOCK FOR ACTIVE AND PROGRESSIVE KNEE EXTENSION, EACH JOINT	QUANTITY ALERT
L2492	ADDITION TO KNEE JOINT, LIFT LOOP FOR DROP LOCK RING	
L2500	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, GLUTEAL/ ISCHIAL WEIGHT BEARING, RING	
L2510	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, QUADRILATERAL BRIM, MOLDED TO PATIENT MODEL	
L2520	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, QUADRILATERAL BRIM, CUSTOM FITTED	
L2525	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, ISCHIAL CONTAINMENT/NARROW M-L BRIM MOLDED TO PATIENT MODEL	
L2526	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, ISCHIAL CONTAINMENT/NARROW M-L BRIM, CUSTOM FITTED	
L2530	ADDITION TO LOWER EXTREMITY, THIGH-WEIGHT BEARING, LACER, NON-MOLDED	
L2540	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, LACER, MOLDED TO PATIENT MODEL	
L2550	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, HIGH ROLL CUFF	
L2570	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, CLEVIS TYPE TWO POSITION JOINT, EACH	QUANTITY ALERT

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

L2580	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, PELVIC SLING	
L2600	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, CLEVIS TYPE, OR THRUST BEARING, FREE, EACH	QUANTITY ALERT
L2610	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, CLEVIS OR THRUST BEARING, LOCK, EACH	QUANTITY ALERT
L2620	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, HEAVY DUTY, EACH	QUANTITY ALERT
L2622	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, ADJUSTABLE FLEXION, EACH	QUANTITY ALERT
L2624	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, ADJUSTABLE FLEXION, EXTENSION, ABDUCTION CONTROL, EACH	QUANTITY ALERT
L2627	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, PLASTIC, MOLDED TO PATIENT MODEL, RECIPROCATING HIP JOINT AND CABLES	
L2628	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, METAL FRAME, RECIPROCATING HIP JOINT AND CABLES	
L2630	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, BAND AND BELT, UNILATERAL	
L2640	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, BAND AND BELT, BILATERAL	
L2650	ADDITION TO LOWER EXTREMITY, PELVIC AND THORACIC CONTROL, GLUTEAL PAD, EACH	QUANTITY ALERT
L2660	ADDITION TO LOWER EXTREMITY, THORACIC CONTROL, THORACIC BAND	
L2670	ADDITION TO LOWER EXTREMITY, THORACIC CONTROL, PARASPINAL UPRIGHTS	
L2680	ADDITION TO LOWER EXTREMITY, THORACIC CONTROL, LATERAL SUPPORT UPRIGHTS	
L2750	ADDITION TO LOWER EXTREMITY ORTHOSIS, PLATING CHROME OR NICKEL, PER BAR	QUANTITY ALERT
L2755	ADDITION TO LOWER EXTREMITY ORTHOSIS, CARBON GRAPHITE LAMINATION	
L2760	ADDITION TO LOWER EXTREMITY ORTHOSIS, EXTENSION, PER EXTENSION, PER BAR (FOR LINEAL ADJUSTMENT FOR GROWTH)	QUANTITY ALERT
L2768	ORTHOTICS SIDE-BAR DISCONNECT DEVICE, PER BAR	QUANTITY ALERT
L2780	ADDITION TO LOWER EXTREMITY ORTHOSIS, NON-CORROSIVE FINISH, PER BAR	QUANTITY ALERT
L2785	ADDITION TO LOWER EXTREMITY ORTHOSIS, DROP LOCK RETAINER, EACH	QUANTITY ALERT
L2795	ADDITION TO LOWER EXTREMITY ORTHOSIS, KNEE CONTROL, FULL KNEECAP	
L2800	ADDITION TO LOWER EXTREMITY ORTHOSIS, KNEE CONTROL, KNEE CAP, MEDIAL OR LATERAL PULL	
L2810	ADDITION TO LOWER EXTREMITY ORTHOSIS, KNEE CONTROL, CONDYLAR PAD	
L2820	ADDITION TO LOWER EXTREMITY ORTHOSIS, SOFT INTERFACE FOR MOLDED PLASTIC, BELOW KNEE SECTION	
L2830	ADDITION TO LOWER EXTREMITY ORTHOSIS, SOFT INTERFACE FOR MOLDED PLASTIC, ABOVE KNEE SECTION	
L2840	ADDITION TO LOWER EXTREMITY ORTHOSIS, TIBIAL LENGTH SOCK, FRACTURE OR EQUAL, EACH	QUANTITY ALERT

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

L2850	ADDITION TO LOWER EXTREMITY ORTHOSIS, FEMORAL LENGTH SOCK, FRACTURE OR EQUAL, EACH	QUANTITY ALERT
L3650	SO FIG 8 DESN ABDUCT RESTRNER PRFAB	
L3674	SHOULDER ORTHOTIC (SO), ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, WITH OR WITHOUT NONTORSION JOINT/TURNBuckle, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L3760	ELBOW ORTHOSIS, WITH AJUSTABLE POSITION LOCKING JOINT(S), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENTS, ANY TYPE	
L3807	WRIST-HAND-FINGER ORTHOSIS (WHFO), WITHOUT JOINT(S), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENTS, ANY TYPE	
L3908	WHO, WRIST EXTENTION CONTROL COCK-UP, NON-MOLDED, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L3929	HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBuckles, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L3931	WRIST HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBuckles, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L3956	ADDITION OF JOINT TO UPPER EXTREMITY ORTHOSIS, ANY MATERIAL; PER JOINT	QUANTITY ALERT
L3970	SHOULDER-ELBOW ORTHOSIS (SE0), ADDITION TO MOBILE ARM SUPPORT, ELEVATING PROXIMAL ARM	
L3972	SEO, ADDITION TO MOBILE ARM SUPPORT, OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE CONTROL	
L3974	SEO, ADDITION TO MOBILE ARM SUPPORT, SUPINATOR	
L3980	UPPER EXTREMITY FRACTURE ORTHOSIS, HUMERAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L3984	UP EXTRM FX ORTHOSF WRST PRFAB	
L3995	ADDITION TO UPPER EXTREMITY ORTHOSIS, SOCK, FRACTURE OR EQUAL, EACH	
L4000	REPLACE GIRDLE FOR MILWAUKEE ORTHOSIS	
L4002	REPL STRAP ANY ORTHOSIS ALL CMPNTS	
L4010	REPLACE TRILATERAL SOCKET BRIM	
L4205	REPAIR OF ORTHOTIC DEVICE, LABOR COMPONENT, PER 15 MINUTES	QUANTITY ALERT
L4210	REPAIR OF ORTHOTIC DEVICE, REPAIR OR REPLACE MINOR PARTS	
L4360	WALKING BOOT, PNEUMATIC, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	
L4386	WALK BOOT NON-PNEUMATC PRFAB	
L4392	REPLACEMENT, SOFT INTERFACE MATERIAL, STATIC ANKLE-FOOT ORTHOSIS (AFO)	
L4394	REPLACE SOFT INTERFACE MATERIAL, FOOT DROP SPLINT	
L4396	STATIC ANKLE FOOT ORTHOSIS, INCLUDING SOFT INTERFACE MATERIAL, ADJUSTABLE FOR FIT, FOR POSITIONING, PRESSURE REDUCTION, MAY BE USED FOR MINIMAL AMBULATION, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	

---



---

**DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

---



---

L4631	ANKLE-FOOT ORTHOTIC (AFO), WALKING BOOT TYPE, VARUS/VALGUS CORRECTION, ROCKER BOTTOM, ANTERIOR TIBIAL SHELL, SOFT INTERFACE, CUSTOM ARCH SUPPORT, PLASTIC OR OTHER MATERIAL, INCLUDES STRAPS AND CLOSURES, CUSTOM FABRICATED	
L8000	BREAST PROsthESIS, MASTECTOMY BRA	
L8010	BREAST PROsthESIS, MASTECTOMY SLEEVE	
L8015	EXTERNAL BREAST PROsthESIS GARMENT, WITH MASTECTOMY FORM, POST MASTECTOMY	
L8020	BREAST PROsthESIS, MASTECTOMY FORM	
L8030	BREAST PROsthESIS, SILICONE OR EQUAL	
L8039	BREAST PROsthESIS, NOT OTHERWISE SPECIFIED	
L8300	TRUSS, SINGLE WITH STANDARD PAD	
L8310	TRUSS, DOUBLE WITH STANDARD PADS	
L8320	TRUSS, ADDITION TO STANDARD PAD, WATER PAD	
L8330	TRUSS, ADDITION TO STANDARD PAD, SCROTAL PAD	

### Directing and monitoring emergency care

The plan covers emergency care worldwide. Members with an emergency medical condition should go to the nearest emergency room for care or call the local emergency communications system (e.g., police, fire department or 911) to request ambulance transportation.

Please note: For all Behavioral Health (mental health and substance abuse) emergency care, please refer to the Behavioral Health (mental health and substance abuse) section.

An emergency health condition is a condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- serious jeopardy to the health of the individual (or unborn child);
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Examples of covered emergencies are stroke, unconsciousness, heart attack symptoms or severe bleeding.

Emergency services do not require preauthorization. The PCP should be notified so that arrangements can be made to coordinate any needed follow-up care. The plan will work with the PCP to assure that any follow-up continuing care that is medically necessary will be arranged for the member. Follow-up care in an emergency room often will not meet a prudent layperson definition and most emergency room follow-up care can be provided in a setting other than an emergency room.

In out-of-area emergencies the member is instructed to call the local communication system (e.g., police, fire department or 911) or go to the nearest medical facility for care. Within 48 hours after receiving emergency care the member or someone on their behalf should notify the plan and contact their PCP for follow-up assistance. It is preferred that once stabilized a member returns to the service area for follow-up care.

### **Urgent care**

The member is instructed to call the PCP before seeking urgently needed services. Urgently needed services are those services needed immediately as a result of an unforeseen illness, injury or condition. The PCP should ensure that the member is seen in the PCP's office or hospital courtesy room whenever appropriate. The hospital emergency department should be recommended only when the PCP determines that the office is an inappropriate place for treatment. If out-of-area and a member requires urgent care, they are instructed to call their PCP first, if possible, before going to the nearest medical facility.

Note: Some IPA/PHO provider network agreements differ from the procedure described below. When applicable, please defer to the IPA/PHO procedures.

### **Procedure:**

#### *In-area care*

If the member calls the physician prior to treatment, the physician:

- Recommends the most appropriate plan of treatment.
- Advises the member where to go for treatment.
- Calls the hospital emergency department to advise of referral, if appropriate.

If the member does not call the physician until after receiving emergency department treatment, the physician obtains information on the service and arranges follow-up care.

The physician follows the member to ensure that emergency department care and any subsequent admission is appropriate and managed properly.

#### *Follow-up for out-of-area care*

The member calls the PCP to arrange for any follow-up care. The PCP follows referral procedures in order to authorize follow-up care with any other provider. Follow-up care should be provided in the PCP's office when appropriate.

### **Emergency Room List**

Below is a listing by town of Massachusetts hospitals that offer emergency room services, twenty four (24) hours a day, seven (7) days a week. If a member needs to access emergency care, these hospitals are available for use. Member can go to any hospital listed below for emergency care without a referral. FCHP's network hospitals are included in this section and are indicated as bold type.

---

---

**EMERGENCY CARE AND URGENT CARE**

---

---

**Athol**

Athol Memorial Hospital  
2033 Main St.  
Athol, MA 01331  
1-978-249-3511

**Attleboro**

Sturdy Memorial Hospital  
211 Park St.  
Attleboro, MA 02703  
1-508-222-5200

**Ayer**

Nashoba Valley Medical Center  
200 Groton Rd.  
Ayer, MA 01432  
1-978-784-9000

**Barnstable**

Cape Cod Hospital  
27 Park St.  
Hyannis, MA 02601  
1-508-771-1800

**Beverly**

Beverly Hospital  
85 Herrick St.  
Beverly, MA 01915  
1-978-922-3000

**Boston**

Beth Israel-Deaconess Medical  
Center  
330 Brookline Ave.  
Boston, MA 02215  
1-617-667-7000

Boston Medical Center  
One Boston Medical Center  
Place  
Boston, MA 02218  
1-617-638-8000

Brigham & Women's Hospital  
75 Francis St.  
Boston, MA 02210  
1-617-732-5500

Caritas Carney Hospital  
2100 Dorchester Ave.  
Dorchester, MA 02124  
1-617-296-4000

Children's Hospital Boston  
300 Longwood Ave.  
Boston, MA 02115  
1-617-355-6000

Faulkner Hospital  
1153 Centre St.  
Boston, MA 02130  
1-617-983-7000

Massachusetts General  
Hospital  
55 Fruit St.  
Boston, MA 02114  
1-614-726-2000

Tufts Medical Center  
750 Washington St.  
Boston, MA 02111  
1-617-636-5000

Caritas St. Elizabeth's Medical  
Center  
736 Cambridge St.  
Boston, MA 02135  
1-617-789-3000

**Brockton**

Brockton Hospital  
680 Centre St.  
Brockton, MA 02302  
1-508-941-7000

Caritas Good Samaritan  
Medical Center  
235 N. Pearl St.  
Brockton, MA 02301  
1-508-427-3000

**Burlington**

Lahey Clinic  
41 Mall Rd.  
Burlington, MA 01805  
1-781-744-5100

**Cambridge**

Cambridge Hospital  
1493 Cambridge St.  
Cambridge, MA 02139  
1-617-665-1000

Mount Auburn Hospital  
330 Mount Auburn St.  
Cambridge, MA 02138  
1-671-492-3500

**Clinton**

Clinton Hospital  
201 Highland St.  
Clinton, MA 01510  
1-978-368-3000

**Concord**

Emerson Hospital  
133 Old Rd. to Nine Acre  
Corner  
Concord, MA 01742  
1-978-369-1400

**Everett**

Whidden Memorial Hospital  
103 Garland St.  
Everett, MA 02149  
1-617-389-6270

**Fall River**

Charlton Memorial Hospital  
363 Highland Ave.  
Fall River, MA 02720  
1-508-679-3131

Saint Anne's Hospital  
795 Middle St.  
Fall River, MA 02721  
1-508-674-5741

---

---

**EMERGENCY CARE AND URGENT CARE**

---

---

**Falmouth**

Falmouth Hospital  
100 Ter Heun Dr.  
Falmouth, MA 02540  
1-508-548-5300

**Fitchburg**

HealthAlliance Hospital –  
Burbank Campus  
275 Nichols Rd.  
Fitchburg, MA 01420  
1-978-343-5000

**Framingham**

MetroWest Medical Center  
115 Lincoln St.  
Framingham, MA 01702  
1-508-383-1000

**Gardner**

Heywood Hospital  
242 Green St.  
Gardner, MA 01440  
1-978-632-3420

**Gloucester**

Addison Gilbert Hospital  
298 Washington St.  
Gloucester, MA 01930  
1-978-283-4000

**Great Barrington**

Fairview Hospital  
29 Lewis Ave.  
Great Barrington, MA 01230  
1-413-528-8600

**Greenfield**

Franklin Medical Center  
164 High St.  
Greenfield, MA 01301  
1-413-773-0211

**Haverhill**

Merrimack Valley Hospital  
140 Lincoln Ave.  
Haverhill, MA 01830  
1-978-374-2000

**Holyoke**

Holyoke Medical Center  
575 Beech St.  
Holyoke, MA 01041  
1-413-534-2500

**Hyannis**

Cape Cod Hospital  
27 Park St.  
Hyannis, MA  
1-508-771-1800

**Jamaica Plain**

Faulkner Hospital  
1153 Centre St.  
Jamaica Plain, MA 02130  
1-617-983-7000

**Lawrence**

Lawrence General Hospital  
1 General St.  
Lawrence, MA 01842  
1-978-683-4000

**Leominster**

HealthAlliance Hospital –  
Leominster Campus  
60 Hospital Rd.  
Leominster, MA 01453  
1-978-466-2000

**Lowell**

Lowell General Hospital  
295 Varnum Ave.  
Lowell, MA 01854  
1-978-937-6000

Saints Medical Center  
1 Hospital Dr.  
Lowell, MA 01852  
1-978-458-1411

**Lynn**

North Shore Medical Center  
500 Lynnfield St.  
Lynn, MA 01904  
1-781-581-9200

**Marlborough**

Marlborough Hospital  
157 Union St.  
Marlborough, MA 01752  
1-508-481-5000

**Medford**

Lawrence Memorial Hospital  
170 Governors Ave.  
Medford, MA 02155  
1-781-306-6000

**Melrose**

Melrose-Wakefield Hospital  
585 Lebanon St.  
Melrose, MA 02176  
1-781-979-3000

**Methuen**

Caritas Holy Family Hospital  
70 East St.  
Methuen, MA 01844  
1-978-687-0156

**Milford**

Milford Regional Medical  
Center  
14 Prospect St.  
Milford, MA 01757  
1-508-473-1190

**Milton**

Milton Hospital  
92 Highland St.  
Milton, MA 02186  
1-617-696-4600

**Nantucket**

Nantucket Cottage Hospital  
57 Prospect St.  
Nantucket, MA 02554  
1-508-825-8255

---

---

**EMERGENCY CARE AND URGENT CARE**

---

---

**Needham**

Beth Israel Deaconess Hospital  
– Needham  
148 Chestnut St.  
Needham, MA 02492  
1-781-453-3002

**New Bedford**

St. Luke's Hospital  
101 Page St.  
New Bedford, MA 02740  
1-508-997-1515

**Newburyport**

Anna Jaques Hospital  
25 Highland Ave.  
Newburyport, MA 01950  
1-978-463-1000

**Newton**

Newton-Wellesley Hospital  
2014 Washington St.  
Newton, MA 02456  
1-617-243-6000

**North Adams**

North Adams Regional Hospital  
71 Hospital Ave.  
North Adams, MA 01247  
1-413-663-3701

**Northampton**

Cooley Dickinson Hospital  
30 Locust St.  
Northampton, MA 01062  
1-413-582-2000

**Norwood**

Caritas Norwood Hospital  
800 Washington St.  
Norwood, MA 02062  
1-781-769-2950

**Palmer**

Wing Memorial Hospital  
40 Wright St.  
Palmer, MA 01069  
1-413-283-7651

**Oak Bluffs**

Martha's Vineyard Hospital  
1 Hospital Rd.  
Oak Bluffs, MA 02557  
1-508-693-0410

**Pittsfield**

Berkshire Medical Center  
725 North St.  
Pittsfield, MA 01202  
1-413-447-2000

Hillcrest Hospital, a campus of  
Berkshire Medical Center  
165 Tor Court  
Pittsfield, MA 01202  
1-413-443-4761

**Plymouth**

Jordan Hospital  
275 Sandwich St.  
Plymouth, MA 02364  
1-508-746-2000

**Quincy**

Quincy Medical Center  
114 Whitwell St.  
Quincy, MA 02169  
1-617-376-5500

**Salem**

North Shore Children's Hospital  
57 Highland Ave.  
Salem, MA 01970  
1-978-745-2100

**Somerville**

Somerville Hospital, a campus  
of Cambridge Health Alliance  
230 Highland Ave.  
Somerville, MA 02145  
1-617-591-4500

**South Weymouth**

South Shore Hospital  
55 Fogg Rd.  
South Weymouth, MA 02190  
1-781-340-8000

**Southbridge**

Harrington Memorial Hospital  
100 South St.  
Southbridge, MA 01550  
1-508-765-9771

**Springfield**

Baystate Medical Center  
759 Chestnut St.  
Springfield, MA 01151  
1-413-794-0000

Mercy Medical Center  
271 Carew St.  
Springfield, MA 01151  
1-413-748-9000

**Taunton**

Morton Hospital and Medical  
Center  
88 Washington St.  
Taunton, MA 02780  
1-508-828-7300

**Ware**

Mary Lane Hospital  
85 South St.  
Ware, MA 01082  
1-413-967-6211

**Wareham**

Tobey Hospital, a campus of  
Southcoast Hospitals Group  
43 High St.  
Wareham, MA 02571  
1-508-295-0880

**Webster**

Harrington Healthcare at  
Hubbard  
340 Thompson Rd.  
Webster, MA 01570  
1-508-943-2600

---

---

## EMERGENCY CARE AND URGENT CARE

---

---

### **Westfield**

Noble Hospital  
115 W. Silver St.  
Westfield, MA 01086  
1-413-568-2811

### **Winchester**

Winchester Hospital  
41 Highland Ave.  
Winchester, MA 01890  
1-781-729-9000

### **Worcester**

Saint Vincent Hospital  
20 Worcester Center Blvd.  
Worcester, MA 01608  
1-508-363-5000

UMass Memorial Medical  
Center—University Campus  
365 Plantation St.  
Worcester, MA 01601  
1-508-334-1000

UMass Memorial Medical  
Center—Memorial Campus  
119 Belmont St.  
Worcester, MA 01605  
1-508-334-100

---

---

## FCHP PROVIDER – DEFINITION AND RESPONSIBILITIES

---

---

We want to make it easy for you to serve and provide the highest quality care possible to your FCHP patients. With this goal in mind, we will keep you informed of FCHP policies and procedures as well as your responsibilities as a participating FCHP provider. We will send you our bimonthly *CONNECTION* newsletter as well as routinely update our Web site: [www.fchp.org](http://www.fchp.org)

### AS A FCHP PROVIDER YOU MUST:

- Accept and treat your FCHP patients in an identical manner to all other patients in your practice.
- Participate in discharge planning and follow-up.
- Adhere to all FCHP policies and procedures as outlined in the *Provider Manual* or other appropriate channels.
- Respond to your FCHP patients' linguistic, cultural and any other unique needs.
- Accept and treat all members regardless of race/ethnicity, age, English proficiency, sexual orientation, health status or disability.
- Help your non-English speaking members get interpreter services if necessary.
  - FCHP offers free translation services for non-English speaking members. If you need assistance translating any written FCHP materials, contact FCHP's Customer Service Department at 1-800-868-5200. All written materials are available in Spanish. FCHP will translate written materials into other languages over the phone.
- Allow members to exercise their rights without worrying about adversely affecting their treatment.
- Provide Advance Directive information according to health plan requirements.
  - For more information see [Advance Directives](#)
- Provide or coordinate all age-specific Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services according to health plan requirements.
- Meet regulatory requirements.
  - Adhere to the Standard for Privacy of Individually Identifiable Health Information.
  - Use Health Insurance Portability and Accountability Act (HIPAA) compliant practices.
  - Report mandatory findings to local health departments and notify us as appropriate.
- Comply with medical record standards as outlined in [Medical Record Standards](#) section of this manual.

---

---

## FCHP PROVIDER – DEFINITION AND RESPONSIBILITIES

---

---

- Provide treatment consistent with professional standards and have in place systems for accurately documenting:
  - Member information
  - Clinical information
  - Clinical assessments
  - Treatment Plans, services provided and outcomes
  - Contacts with a patient’s family, guardian, or partner
- Notify a patient’s primary care provider (PCP) about any services and/or treatment you provide if you are not the patient’s PCP.
- Make covered health services available to all members.
- Discuss all treatment options with your patients, regardless of cost or benefit coverage.
- Cooperate with our quality improvement activities as outlined in the [Quality Management](#) section of this manual.
- Keep your information current with us.
- You cannot charge a FCHP member for any service that is not medically necessary or not a covered service if you did not explain this, or explain that other services may meet the member’s needs. You also need to explain to the member that he/she would have to pay for such services. You will need to document that you have notified the member.

Each Fallon Community Health Plan (FCHP) member selects a primary care provider (internal medicine, family practice, pediatrics or adolescent medicine) from the list of FCHP providers. A MassHealth member may choose an Ob/Gyn for her primary care provider. The personal or primary care provider has the primary responsibility for managing and monitoring overall care and for providing the continuity of care for each member in his/her panel. The primary care provider’s role includes the following responsibilities:

- Provide primary care, including preventive care, diagnosis and treatment of illness and injury, and office laboratory and diagnostic services, as available.
- Provide medical care in the hospital or skilled nursing facility as appropriate, following procedures for “Admitting for Inpatient Stay or Same-Day Surgery.”
- Refer member for specialty care when appropriate, following procedures for “PCP Referral and Plan Preauthorization Processes.”

---

---

## FCHP PROVIDER – DEFINITION AND RESPONSIBILITIES

---

---

- Assist with case management by referring members and by participating in multidisciplinary case management teams.
- Provide coverage on 24-hour basis, direct member to appropriate place of treatment and monitor initial and follow-up treatment for member emergent/urgent conditions. Advise emergency room care as appropriate according to procedures.
- For the FCHP MassHealth product, Obstetricians/Gynecologists may choose to practice as a primary care provider for female members. The provider must complete an [Attestation for OB/GYN Provider Status for FCHP MassHealth](#).

### Permissible Marketing Activities for MassHealth and Commonwealth Care

As a state contracted managed care organization (MCO), FCHP and FCHP providers must meet MassHealth and Commonwealth Care requirements related to member marketing activities. Please see the definitions of marketing below:

Marketing - any communication from FCHP, its employees, providers, agents or material subcontractors to a member who is not enrolled in the FCHP MassHealth or Commonwealth Care plan that EOHHS can reasonably interpret as influencing the eligible individual to enroll in FCHP's MassHealth plan or Commonwealth Care plan, or either to not enroll in, or to disenroll from, another MassHealth MCO or the PCC Plan, or a Commonwealth Care Plan. This includes the production and dissemination by or on behalf of FCHP of any Marketing Materials. Marketing shall not include any personal contact between a provider and an eligible individual who is a prospective, current or former patient of that provider regarding the provisions, terms or requirements of MassHealth or Commonwealth Care as they relate to the treatment needs of that particular eligible individual.

Provider Site Marketing - any activities occurring at or originating from a provider site, whereby FCHP staff or designees, including physicians and office staff, personally present FCHP marketing materials or other marketing materials produced by the provider site to eligible individuals that EOHHS can reasonably determine influence the eligible individual to enroll in FCHP's MassHealth or Commonwealth Care plan or to disenroll from FCHP's MassHealth or Commonwealth Care plan into another MassHealth or Commonwealth Care plan. This shall include direct mail campaigns sent by the provider site to its patients who are eligible individuals.

FCHP and FCHP providers may:

- Participate in or sponsor a health fair if the Executive Office of Health and Human Services (EOHHS) or the Commonwealth Health Insurance Connector Authority (the

---

---

## FCHP PROVIDER – DEFINITION AND RESPONSIBILITIES

---

---

Connector) pre-approves marketing materials. These marketing materials must be submitted for approval 90 days in advance of use.

- Distribute free samples or gifts( of a nominal value) to all event attendees, regardless of their intent to enroll in our plan
- Participate in EOHHS or Connector sponsored health benefit fairs
- Implement EOHHS or Connector approved target marketing campaigns and distribute or publish EOHHS or Connector approved marketing materials in our service area by:
  - Posting written marketing materials at provider sites and other locations
  - Initiating mailing campaigns
  - Advertising on television, radio, newspaper, web sites, and other audio and visual advertising

FCHP and FCHP providers may not:

- Distribute any marketing materials EOHHS or the Connector does not approve
- Distribute any inaccurate, false, misleading, confusing, or fraudulent marketing materials, including but not limited to, making any assertion or statement, whether written or oral, that:
  - The recipient of the material must enroll in our plan to obtain benefits or to not lose benefits
  - The Centers for Medicare and Medicaid Services (CMS), the federal or state government, or a similar entity endorses FCHP
- Seek to influence an eligible individual’s FCHP enrollment in conjunction with the sale of or offering of any non-health insurance products (e.g., life insurance, which FCHP does not offer)
- Seek to influence an eligible individual’s FCHP enrollment in conjunction with the sale of or offering of cash, cash equivalents, or in-kind gifts
- Directly or indirectly engage in door-to-door, telephonic, or any other cold-call marketing activities
- Engage in any misleading, confusing, fraudulent marketing activities that misrepresent MassHealth, EOHHS, Commonwealth Care, the Connector, CMS or FCHP

---

---

## FCHP PROVIDER – DEFINITION AND RESPONSIBILITIES

---

---

- Conduct any provider-site marketing, except as previously discussed
- Engage in marketing activities that target eligible individuals on the basis of health status or future need for health care services, or which otherwise may discriminate against individuals eligible for health care services

### Hearing aids and assistive listening devices

#### MassHealth Hearing Aid Benefit

Coverage includes: Standard/CommonHealth, Basic and Family Assistance enrollees.

This does not include Essential enrollees.

The Contractor is responsible for providing and dispensing hearing aids, ear molds; ear impressions, batteries, accessories, aid and instruction in the use, care and maintenance of the hearing aid, and loan of a hearing aid to the Enrollee, when necessary. FCHP prior authorization is required for this benefit.

#### Commercial and Fallon Senior Plan<sup>™</sup> Members Hearing Aid Benefit

Commercial and Fallon Senior Plan<sup>™</sup> members with a standard benefit do not have coverage for hearing aids and assistive listening devices. All members are entitled to a 20% member-funded discount off the retail price of hearing and assistive listening devices when purchased from an FCHP contracted provider. Several employer groups offer a nonstandard hearing benefit. Nonstandard benefits vary among employer groups. For a complete description of hearing benefits, please refer to the "Benefit Summaries" section and/or the [Member Handbook/Evidence of Coverage](#).

#### Procedure for members whose employer group has purchased hearing aid benefits:

1. The member needs to be evaluated and referred by a plan-affiliated audiologist.
2. The referring primary or specialty provider calls the FCHP Care Review Department at 866-ASK-FCHP (866-275-3247), press 3 at the prompt to request authorization.
3. The hearing aid vendor is ultimately responsible for ensuring that the appropriate authorization is in place prior to supplying any type of device. Hearing aid vendors may confirm that an authorization is in place by contacting the FCHP Care Review Department at 866-ASK-FCHP (866-275-3247), press 3 at the prompt.

#### Procedure for the discount program:

1. The member needs to be evaluated and referred by a plan-affiliated audiologist.
2. The member contacts the FCHP Customer Service Department at 800-868-5200 (TDD/TTY: 877-608-7677) for a list of current affiliated providers in the area.

---

---

## HOME HEALTH CARE PROVIDERS

---

---

### Home Care Services

A Fallon Community Health Plan Nurse Care Specialist will perform concurrent review on all home health care (skilled home health care and home infusion) admissions. Once a member is admitted, the nurse care specialist will perform concurrent review on each case, facilitating discharge planning, assisting with disqualification of continued stay and identifying members for outpatient case management. FCHP uses nationally recognized criteria for review.

### Procedure

1. All in-home services must be ordered by a plan physician.
2. Skilled home health care is defined as nursing, physical therapy, occupational therapy, speech therapy, home health aide, and/or medical social work provided by a Medicare Certified Home Health Care Agency.
3. Home infusion services, such as home intravenous therapy, hydration, enteral and parental nutrition are provided by vendors licensed for such services.
4. The following applies to SKILLED HOME HEALTH CARE SERVICES:
  - a) Medicare skilled home health care requirements must be met (i.e. members must be homebound and skilled needs must be present based upon Medicare criteria).
  - b) If the request is approved, FCHP will provide a 30-day authorization beginning on the "start of care" date. An Agency doesn't need to send a request for an evaluation first, and then a subsequent request when the plan of care is known. All requests must be submitted on the Universal Health Plan/Home Health Authorization Form – March 1, 2006 version.
  - c) If a member needs additional skilled home health care services following the initial 30-day period, FCHP will consider authorizing subsequent services for up to a 21-day period.
  - d) If the member needs ongoing home health care services, the Agency would submit the request for consideration. Based upon the member's clinical needs, FCHP may authorize services for up to a 21-day period. Monthly vitamin B12 injections and Foley catheter changes for homebound members may be approved for up to a 60-day period.
  - e) Upon completion of all home health care services, the Agency must notify FCHP in writing of the discharge utilizing the appropriate discharge section of the Universal Health Plan/Home Health Authorization Form.

---

---

## HOME HEALTH CARE PROVIDERS

---

---

FCHP must be notified of the Agency discharge prior to, or on the day of, the last skilled discipline visit.

- f) In addition, for **all Fallon Community Health Plan Medicare Advantage members**, a copy of the Notice of Medicare Non-Coverage letter must be faxed to FCHP at the time of discharge.
5. FCHP will not authorize any requests for visits which have already been provided and not previously authorized.
  6. The following applies to HOME INFUSION SERVICES:  
FCHP may authorize home infusion services meeting criteria for up to a 93-day time period. Requests must be submitted on the Universal Home Infusion/Enteral Authorization Form dated June 28, 2006.
  7. FCHP notification to members of pre-authorization, concurrent authorization, reduction of services, termination of services and the appeals/grievance process will meet the requirements of Medicare, the Managed Care Act and the Plan.
  8. For prompt payment, the Agency must indicate the correct "start of care date" on the request form.

---

---

## HOSPITALIZATIONS AND SKILLED NURSING FACILITY ADMISSIONS

---

---

### Hospital admissions

When a Fallon Community Health Plan (FCHP) member is admitted to an acute care hospital, the hospital must notify the FCHP Inpatient Care Services Department by calling 866-ASK-FCHP (275-3247) within 24 business hours of admission. Once the notification is received, the FCHP inpatient nurse care specialist will conduct an admission review to determine the medical necessity of the admission. On-site concurrent review will be performed for contracted facilities that have an assigned inpatient nurse care specialist. All other reviews (in-area and out-of-area) will be conducted telephonically or may be submitted to FCHP Inpatient Care Services by fax. Written documentation from the medical record will be requested when verbal and faxed information is inadequate. Reviews must include the following information:

- The date and time of admission
- Type of admission (emergent or elective)
- Service the member was admitted to
- Admitting diagnosis
- Co-morbid diagnoses
- Clinical status
- Functional status
- Prescribed medical treatment
- Residence of the member (their own home, long-term care facility, assistive living, etc.)
- Name, address and phone number of the responsible party or legal guardian
- Estimated length of stay

Admission and length of stay are based on medical necessity and the appropriateness of the level of care. FCHP physician medical review is available to consult with the inpatient nurse care specialist and physician regarding medical necessity and level of care issues as they arise. The inpatient nurse care specialist works collaboratively with the physician and hospital staff to assist with and promote a timely discharge.

---



---

**HOSPITALIZATIONS AND SKILLED NURSING FACILITY ADMISSIONS**

---



---

**FCHP Standard Response Times**

<b>Product</b>	<b>Type of Request</b>	<b>Response Time</b>
<i>Commercial, MassHealth &amp; Senior Plans</i>	<b>Concurrent (Inpatient &amp; Intensive Outpatient) Approval</b>	<p>Decision is made in 1 business day of obtaining all necessary information</p> <p>Oral notification of decision is given to provider in 1 business day of decision being made</p> <p>Written/electronic notification given to member, authorized representative, if any, and provider within 1 day after oral notice</p> <p>Notice to include number of days, services, etc. extended</p>
<i>Commercial, MassHealth &amp; Senior Plans</i>	<b>Concurrent (Inpatient &amp; Intensive Outpatient) Denial</b>	<p>Decision is made in 1 business day of obtaining all necessary information</p> <p>Oral notification given to provider in 1 business day of decision</p> <p>Written / electronic notification given to member and provider in 1 day after oral notice</p> <p>Advised of expedited appeal process if request is denied</p> <p>Continue service until member notified of termination or reduction in coverage</p> <p>Notice is sent to member in sufficient time for member to appeal and get decision on appeal before the benefit is reduced or terminated.</p>
<i>Commercial, MassHealth &amp; Senior Plans</i>	Reconsideration	<p>Provider can request reconsideration at notification of denial with decision made within 1 business day.</p> <p>Oral notification given within 1 business day.</p>
<i>Commercial, MassHealth &amp; Senior Plans</i>	Post-Service Review Process	<p>Decision is made in 30 calendar days from receipt of request.</p> <p>Electronic or written notification of the decision given to member/practitioner in 30 calendar days from receipt of request.</p>

**Notification of Birth Form Submission**

The Notification of Birth (NOB-1) form must be completed by hospitals and other providers to facilitate eligibility determinations and health-plan enrollment for newborns of Fallon Community Health Plan MassHealth and Commonwealth Care-eligible women. The completed forms must include the information as specified on the form and mailed to the

---

---

## HOSPITALIZATIONS AND SKILLED NURSING FACILITY ADMISSIONS

---

---

MassHealth Enrollment Center in Revere (information is on the form), within 30 days of the newborn's date of birth. For more details and a sample of the form, see [All Provider Bulletin 136](#). You may also contact the FCHP Provider Relations Department at 866-ASK-FCHP (866-275-3247), prompt 4 or MassHealth Customer Service at 1-800-841-2900 or e-mail your inquiry to [providersupport@mahealth.net](mailto:providersupport@mahealth.net).

The NOB-1 form is a two-part carbonless form and is not available electronically. Requests for supplies of this form must be submitted in writing, and can be mailed or faxed to:

MassHealth  
ATTN: Forms Distribution  
P.O. Box 9118  
Hingham, MA 02043  
Fax: 1-617-988-8973■

### High risk screening

At the time of discharge the inpatient nurse care specialist conducts a high risk screening for all members. If indicators are present that suggest the member may be at risk for complications, discharge planning may be facilitated with the member's needs. A nurse care specialist contacts the member by telephone within 48 hours of discharge from the hospital. A telephonic assessment is conducted to determine if the member is receiving prescribed home care.

### Retrospective reviews for hospital and skilled nursing facility admissions

Admissions and discharges that occur over holidays and weekends will require a retrospective review until a concurrent review can be conducted. The hospital or skilled nursing facility is asked to have the medical record available on the medical unit or in the medical records department for the inpatient nurse care specialist to conduct retrospective reviews on site (for those contracted facilities with an assigned nurse care specialist). If the inpatient nurse care specialist is unable to conduct the review within one day because the hospital or skilled nursing facility is unable to provide the clinical information for whatever reason, it will be the responsibility of the hospital or skilled nursing facility to locate the record and contact the nurse care specialist for the review. The inpatient nurse care specialist may conduct a telephonic review, however, if information is not provided by the hospital or skilled nursing facility, it shall be the responsibility of the hospital or skilled nursing facility to obtain consent from the member and mail the medical record to FCHP Inpatient Care Services to the attention of the inpatient nurse care specialist. The hospital or skilled nursing facility shall absorb all costs associated with conducting a review by mail. A review that needs to be mailed may take

---

---

## HOSPITALIZATIONS AND SKILLED NURSING FACILITY ADMISSIONS

---

---

up to 30 days for a determination. The case manager or designated staff representative will notify the billing department of the hospital or skilled nursing facility of the determination.

### **Admission to a skilled nursing facility**

All admissions to a skilled nursing facility (SNF) must be approved by the FCHP inpatient nurse care specialist prior to admission.

For FCHP HMO/MCO members, the level of service and number of covered days that the member is admitted to the facility of admission will be based upon the medical necessity of the condition as determined by your plan physician and the plan.

FCHP MassHealth Standard/CommonHealth members - Skilled Nursing Facility, Chronic or Rehabilitation Hospital Services – services, for all levels of care, provided at a nursing facility, chronic or rehabilitation hospital, or any combination thereof, 100 days per Contract Year per Enrollee. The 2011 contract year will begin on July 1, 2010 and continue until September 30, 2011. The contract year will then run every year following from October 1, xxxx, until September 30, xxxx. The 100-day limitation shall not apply to Enrollees receiving Hospice services and the Contractor-FCHP may not request disenrollment of Enrollees receiving Hospice services based on the length of time in a skilled nursing facility. The Contractor-FCHP shall use the following MassHealth admission/coverage criteria for admission into a chronic hospital, rehabilitation hospital and nursing facility, and may not request disenrollment of any Enrollee who meets such coverage criteria until the Enrollee exhausts the 100-day limitation at either a nursing facility, chronic or rehabilitation hospital for that Contract Year. For the applicable criteria, see 130 CMR 456.408, 456.409, 456.410 and 435.408, 435.409 and 435.410 (rehabilitation hospitals). The Contractor-FCHP must ensure that its contracted nursing facilities establish and follow a written policy regarding its bed-hold period, consistent with the MassHealth bed-hold policy. For applicable criteria, see 130 CMR 456.425.

For FCHP MassHealth Family Assistance Members, only the Chronic or Rehabilitation Hospital Services apply.

FCHP MassHealth Basic and Essential enrollees do not have this benefit.

For Fallon Senior Plan<sup>™</sup> members, FCHP follows Centers for Medicaid & Medicare Services (CMS) Criteria for Skilled Nursing Facility Coverage of Services (CMS Program Manuals—Skilled Nursing Facility Chapter II). Care in an SNF will be covered if all of the following three factors are met:

---

---

## HOSPITALIZATIONS AND SKILLED NURSING FACILITY ADMISSIONS

---

---

1. The member requires skilled nursing or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel.
2. The member requires these skilled services on a daily basis.
3. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in an SNF. Services must be furnished pursuant to a physician's orders and be reasonable and necessary for the treatment of the member's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, his/her particular medical needs and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

If the member does not meet skilled care criteria or care can be provided in a less restrictive setting (including the home), the request for admission will be reviewed with the medical director and the member will be notified of the decision. If admission is denied, the member will be issued a notice of non-coverage letter. If a member requests admission to a non-contracted facility, the request will be reviewed and the member will be notified of the decision. (It is at the sole discretion of the plan to authorize a non-contracted SNF admission for FCHP HMO members). In addition, FCHP Medicare beneficiaries are entitled to a home SNF benefit as described in Title VI, Section 621 of BIPA. Under this SNF home benefit, a member may elect to receive post-hospital services through the following facilities:

- The SNF in which the enrollee resided at the time of admission.
- The SNF that provided services through a continuing care retirement community that provided residence to the enrollee at the time of admission to a hospital.
- The SNF in which the spouse of the enrollee is residing at the time an enrollee is discharged from the hospital.

A Medicare enrollee may elect to receive services through one of these facilities only if the facility has agreed to be treated in a substantially similar manner as an FCHP contracted SNF.

Prior to admission to a SNF, the physician or transferring hospital must notify the assigned inpatient nurse care specialist or contact the FCHP Inpatient Care Services Department—Skilled Nursing Facility Team at 866-ASK-FCHP (275-3247); on weekends, call weekends on-call admission at 508-368-9911 for authorization.

Upon admission to a skilled nursing facility, it is the responsibility of the designated staff at the facility to contact the FCHP inpatient nurse care specialist of the admission as soon as possible on the day of admission, and no later than within 24 hours of admission.

---

---

## HOSPITALIZATIONS AND SKILLED NURSING FACILITY ADMISSIONS

---

---

Once a member is admitted to a skilled nursing facility, the inpatient nurse care specialist conducts a concurrent review and collaborates with the treatment team and FCHP outpatient case manager for discharge planning if the member returns to a non-institutional setting.

Length of stay in a skilled nursing facility will be based on the member meeting skilled care criteria. The skilled nursing facility shall designate a case management contact that will be responsible for providing the FCHP inpatient nurse care specialist with weekly updates on the member's clinical and functional status. The SNF must contact the assigned FCHP inpatient nurse care specialist within two business days after admission. Information must include the member's functional status, skilled qualifiers, types and frequency of the therapies, discharge planning, information regarding the discharge site, family involvement and education required, discharge dates, and changes in the member's level of care.

At a minimum, the FCHP inpatient nurse care specialist will conduct weekly updates telephonically or attend weekly team meetings at the facility. The inpatient nurse care specialist may request medical records to review clinical information in addition to the information requested by fax. The skilled nursing facility is responsible for providing medical records upon request by the FCHP inpatient nurse care specialist.

When the member's status changes from skilled to custodial, the facility case manager must notify the FCHP inpatient nurse care specialist as soon as this level of care change is anticipated. The member's medical record must be sent via fax to the inpatient nurse care specialist for review by the medical director. If the decision is made to deny further skilled services, the member will be provided with a notice of non-coverage letter. We require that all contracted SNFs provide the notice of non-coverage letter to the member upon request. Length of stay in the skilled nursing facility will be based on the existence of skilled criteria, the ability of the member to achieve realistic goals and the progress of the member. Skilled nursing facilities are responsible for proactive discharge planning, following through on discharge plans, education of the patient/family and facilitating application for financial assistance based upon member needs and future plans.

The skilled nursing facility shall be responsible for notifying the FCHP inpatient nurse care specialist within one week prior to a planned discharge to prevent fragmentation of health care delivery and to ensure follow through on the discharge plan. The skilled nursing facility is responsible for notifying the FCHP inpatient nurse care specialist when the member's condition requires a change in the level of care, within 24 hours of the change.

---

---

## HOSPITALIZATIONS AND SKILLED NURSING FACILITY ADMISSIONS

---

---

Lack of notification by the skilled nursing facility to the FCHP inpatient nurse care specialist when the member's level of care changes or the member no longer requires skilled services will become the facility's financial responsibility until the FCHP inpatient nurse care specialist is notified.

If the member requires long-term care after they no longer qualify for a skilled level of care, the member may select the nursing home of choice.

---

---

## INTERPRETER SERVICES

---

---

### INTERPRETER SERVICES

FCHP offers free translation services for non-English speaking members. If you need assistance translating any written FCHP materials, contact FCHP's Customer Service Department at 1-800-868-5200 and for FCHP MassHealth members call FCHP's MassHealth Customer Service Line at 1-800-341-4848.

All written materials are available in Spanish, large print and other alternate formats like Braille. FCHP will translate written materials into other languages over the phone.

If you need an interpreter to be present during your healthcare visit, let your healthcare provider's office know at the time you schedule your healthcare appointment.

Please call FCHP's Customer Service Department at 1-800-868-5200 and for FCHP MassHealth members call the FCHP MassHealth Customer Service Line at 1-800-341-4848.(TDD/TTY: 1-877-608-7677), Monday through Friday, 8 a.m. to 6 p.m.

### **Medical records documentation standards and record keeping practices**

Fallon Community Health Plan requires medical records to be maintained in a manner that is current, detailed, and organized and permits effective and confidential patient care and quality reviews.

Practitioners contracted with Fallon Community Health Plan are responsible for maintaining medical records for FCHP members in an organized medical record keeping system. Contracted practitioners must release in a timely manner copies of medical records requested by members, or other clinicians to ensure continuity and coordination of care, including but not limited to behavioral health treatment of enrollees who express suicidal or homicidal ideation or intent, consistent with Massachusetts state law.

Practitioners contracted with FCHP must comply with FCHP's confidentiality policies related to release of medical information. Physicians are responsible for providing access of medical records for review by the health plan clinical staff for quality monitoring activities. Reviews of physician's medical records are routinely conducted with feedback to the contracted physicians.

#### *Guidelines for Medical Records*

1. Each page in the record contains the patient's name or Medical Record Number.
2. Personal biographical data include the address, employer, home and telephone numbers and marital status.
3. Entries in the medical record contain the author's identification by handwritten or electronic signature and date of service.
4. Primary care providers document all services provided directly and all ancillary and diagnostic tests that are ordered by the practitioner.
5. Referrals to diagnostic and therapeutic services for which a member was referred, such as home health nursing, specialty physician, hospital discharge and physical therapy reports should be included in the record.
6. The record is legible to someone other than the writer.
7. Significant illnesses and medical conditions are indicated on the problem list.
8. Medication allergies and adverse reactions are prominently noted in the record. If the member or patient has known allergies or history of adverse reactions, it is

---

---

## MEDICAL RECORD STANDARDS

---

---

- appropriately noted in the record.
9. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger) past medical history relates to prenatal care, birth, operations and childhood illnesses.
  10. For patients 14 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances.
  11. The history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
  12. Laboratory and other studies are ordered, as appropriate.
  13. Working diagnoses are consistent with findings.
  14. Treatment plans are consistent with diagnoses.
  15. Encounter forms or notes have a notation, when indicated, regarding follow up care, calls or visits. The specific time of return is noted in weeks, months or as needed.
  16. Unresolved problems from previous office visits are addressed in subsequent visits.
  17. The ordering practitioner signs consultation, lab and imaging reports filed in the chart to validate review of information.
  18. Members are not placed at inappropriate risk by a diagnostic or therapeutic procedure.
  19. Immunization records for children are current and complete according to the Pediatric preventive guidelines.
  20. Evidence that preventive screening and services are offered to all members in accordance with the organization's practice guidelines.
  21. Documentation of advance directives should be included in a prominent part of the medical record, including whether or not a member has executed an advance directive.
  22. Presence of current medication list.

Results of medical record review audits are shared with practitioners at the Site director's meetings, provider newsletters or direct mailings. FCHP's performance goal for Medical Record keeping compliance to the standards is 100%. Chart availability of the medical records also has a performance goal of 100%.

---

---

## MEDICAL RECORD STANDARDS

---

---

The Quality and Health Services Department is responsible for monitoring medical record keeping regarding documentation standards, and reviewing the data analysis of aggregate findings to identify key processes to improve as requested. The medical record audit tool is used to review clinical records to determine compliance with critical elements of the medical record. Findings of the record reviews are presented to the Clinical Quality Improvement Committee for the assessment of the quality of the clinical records and if needed, corrective action and targeted interventions for improved record-keeping practices.

---

---

## NETWORK PROVIDERS

---

---

### LOCATING A NETWORK PROVIDER

At FCHP we make finding a network provider easy.

FCHP members will need to pick a primary care provider (PCP) who is affiliated with FCHP and is within their network. If they do not pick a PCP, FCHP will choose one for them. Members can contact FCHP customer service at any time to assist with this process.

Whenever possible, a PCP should refer to a specialist who is in the member's network. In some cases, such as when the type of specialty that a condition requires is not available from an FCHP network provider, the PCP will need to request an authorization from FCHP for the member to see a provider outside of their FCHP network. See [PCP referrals and plan preauthorization process](#) to learn more about services that require a referral or preauthorization.

To assist members with choosing a network provider, please refer to the online provider look up tool found at: <http://www.fchp.org/FindPhysician/search.aspx>. You will be able to search by product network, provider name, location, specialty or language. You do not need a username or password to use this online tool.

You may also call FCHP's Customer Service Department at 1-800-868-5200 and for FCHP MassHealth members call FCHP's MassHealth Customer Service line at 1-800-341-4848. (TDD/TTY: 1-877-608-7677), Monday through Friday, 8 a.m. to 6 p.m. to assist with this process.

---

---

## NURSE CONNECT

---

---

### NURSE CONNECT

FCHP offers all FCHP members access to registered nurses and other health care professionals who serve as health coaches 24 hours a day, seven days a week, 365 days a year. A health coach can provide:

- Personal education and support
- Information to help your patients make health decisions
- Educational materials relevant to a diagnosis or condition (mailed right to their home)
- Assistance with finding additional health information online

Your patients can reach a Nurse Connect health coach at 1-800-609-6175 (TDD/TTY: 1-800-848-0160)

---

---

## OBSERVATION POLICY

---

---

### Observation policy

**Please note: Not all facilities are authorized to utilize the observation status.**

An observation stay is an alternative to an inpatient admission where short-term, intensive outpatient care is believed to be medically appropriate to manage and improve a member's condition and expedite the return home. Examples of diagnoses amenable to outpatient observation status are: dehydration requiring fluid administration, R/O appendicitis and renal calculi. Candidates for observation status should be identified as early as possible and orders should be written that indicate assessment or observation days.

Any member admitted up to 24 hours may be considered on observation status and considered outpatient. Members who require hospitalization more than 24 hours will be considered inpatient admissions, or per the contractual provision.

Members admitted for same-day surgery and discharged within 24 hours will be considered observation status under the same-day surgery umbrella, if applicable to the provider's contract.

The FCHP inpatient nurse care specialist reviews all admissions. If the member meets the observation status criteria, the inpatient nurse care specialist will document the hospital stay as outpatient status and inform the hospital of the determination.

### Observation policy defined

Observation is an alternative to an inpatient admission that will allow a reasonable and necessary time to evaluate and render medical services to:

- Those members with unstable conditions whose diagnosis and treatment is not expected to exceed 24 hours.
- Those members whose need for an inpatient admission can be determined within that specified time.
- Those members with conditions that may be responsive to aggressive, timely and expeditious outpatient treatment extending up to 24 hours.
- Those members undergoing post ambulatory surgical procedures requiring additional observation beyond midnight (e.g., pain control, hydration, etc.).

---

---

## OBSERVATION POLICY

---

---

- Those members with post-diagnostic procedures with an untoward complication requiring additional observation and/or treatment (e.g., allergic reaction - IVP, etc.) beyond normal recovery period for that procedure.

The 24-hour time frame should remain a benchmark. Cases that need to remain in observation more than 24 hours should be evaluated on an individual basis and should be the exception rather than the rule. Observation may not exceed 24 hours.

Observation is **not** to be used:

- As a convenience for the member or the physician.
- As a routine preparation or routine recovery from diagnostic or surgical procedures.
- For the administration of blood, chemotherapy or sleep studies.
- For socioeconomic issues or custodial care.
- In place of recovery room or an extension to surgical day care if discharge is appropriate before midnight the day of the procedure.
- For cases routinely and appropriately cared for in the emergency or outpatient department.

### Physician and hospital responsibilities:

The physician assumes the following responsibilities for an observation stay:

- The physician order should clearly indicate an admission to observation status including time and date.
- The physician may assign a member to observation directly from the office, through the emergency department, and following same-day surgery and diagnostic procedures.
- The physician is encouraged to inform a member of their observation status.
- The attending physician is responsible for evaluating the member at least once in the 24-hour time period, and more often as dictated by the clinical circumstances.
- The decision to discharge from observation, admit as an inpatient or continue in observation must be made by the 23<sup>rd</sup> hour or earlier.

The hospital assumes the following responsibilities for an Observation Stay:

- Care for Observation Status may be received on an observation unit, entirely within the emergency department (up to 24 hours) or in an inpatient bed.

---

---

## OBSERVATION POLICY

---

---

- The member treated in observation must receive appropriate inpatient care, including reasonable and necessary periodic monitoring by the nursing staff.
- The hospital must obtain an authorization for all members placed in observation status.
- The hospital must provide a census to Fallon Community Health Plan for those members placed in and/or discharged from observation during the previous 24 hours.
- Plan nurse care specialist may concurrently or retrospectively reclassify inpatient admissions to observation status, or vice-versa, if deemed medically necessary upon review.

### Fallon Community Health Plan observation diagnoses

Observation diagnoses may include, but are not limited to:

- Abdominal pain
- Angina, R/O MI
- Asthma
- Back Pain (musculoskeletal)
- Biliary colic
- Bronchiolitis/bronchitis
- Cellulitis and other skin infections
- Change in mental status
- Chest pain
- Chronic obstructive pulmonary disease
- Closed fractures
- Concussion
- Congestive heart failure
- Croup
- False/premature labor
- Fever of unknown origin (FUO)
- Gastroenteritis
- Grand mal status and other epileptic convulsions
- Headache or migraine
- Hyperemesis gravidarum
- Hypoglycemia
- Immunization-related reactions
- Kidney and urinary infections
- Lumbar puncture reaction
- Parenteral pain management
- Pelvic inflammatory disease
- Preeclampsia
- R/O CVA transient ischemic attack (TIA)

---

---

## OBSERVATION POLICY

---

---

- Dehydration
- R/O ectopic pregnancy
- Diabetes (without ketoacidosis)
- Epistaxis
- Renal colic
- Sinusitis/pharyngitis
- Smoke inhalation
- Syncope

## Oral surgery

### Policy

Fallon Community Health Plan (FCHP) covers the following oral surgery services. All services must be provided by a plan-contracted oral surgeon or physician. This does not include plan dentists.

Note: FCHP MassHealth members: FCHP provides for emergency related dental care and oral surgery performed in an outpatient hospital or ambulatory surgery setting which is medically necessary to treat an underlying medical condition, all other dental procedures are covered by MassHealth. The MassHealth member should be referred to the MassHealth Dental Customer Service Center at 1-800-207-5019.

### Please note:

All members may self-refer to an FCHP plan contracted oral surgeon for the removal or exposure of impacted teeth and emergency medical care. For any other oral surgery procedure, plan authorization is required. The provider should verify eligibility prior to performing the procedure at 866-ASK-FCHP (866-275-3247), press 2.

### Oral surgery service

1. Oral examination and subsequent extraction of teeth for the following:
  - a. Suspected infection in those at risk for developing bacterial endocarditis
  - b. Preparation for radiation treatment of the head or neck
2. Removal or exposure of impacted teeth, including both hard and soft tissue impactions
3. Surgical removal of benign or malignant lesions (includes cysts) affecting the intraoral cavity.
  - a. Reconstruction of a ridge is covered when performed as a result of and at the same time as the surgical removal of a tumor.
4. Surgery related to the jaw or any structure connected to the jaw, including structures of the facial area below the eyes. This includes:
  - a. Reduction of any fracture of the jaw or any facial bone, including dental splints or other appliances if used for this purpose.

---

---

## ORAL SURGERY

---

---

- b. Wiring of teeth when performed in connection with the reduction of a jaw fracture.
  - c. Removal of a torus palatinus (a bony protuberance of the hard palate) if the procedure is not performed to prepare the mouth for dentures.
  - d. Lingual frenectomy
  - e. Insertion of metallic implants if the implants are used to assist in or enhance the retention of a dental prosthetic as a result of a covered procedure.
5. Emergency medical care such as to relieve pain and stop bleeding as a result of accidental injury to sound natural teeth or tissues when provided as soon as medically possible after the injury. This does not include restorative or other dental services.
6. Oral examination to detect infection prior to kidney transplantation.

### Procedure for referring to oral surgeons:

The primary care provider (PCP) should contact the oral surgeon by telephone, fax or mail and provide the PCP's name, NPI number, and the reason for the initial consultation. There is no referral required for extraction of impacted teeth by a plan-contracted provider.

All subsequent visits for these services require preauthorization by the servicing provider.

The oral surgeon must submit a *Request for Preauthorization Form* for all subsequent oral surgery services and treatment to the FCHP Care Review Department at 508-368-9700.

The form must have the following sections completed:

Form section #	Complete:
I.	Member information
II.	Referring physician
III.	Preauthorization request
IV.	Fallon Senior Plan pre-service denial (if applicable)
V.	Signature

All services are subject to coverage, benefit, network and contract policies and exclusions.

---

---

## OUT-OF-AREA CARE

---

---

### Out of area care

Members are covered for emergency services, post-stabilization services and urgent care services, such as injuries and sudden illnesses, wherever they travel, even when outside of FCHP's service area. If a member becomes seriously sick or hurt while out of area, they should be instructed to go to the nearest doctor or emergency room or call 911. Members are instructed to call their PCP within 48 hours of receiving health care while traveling.

**Routine health care is not covered outside of FCHP's service area.** The following are examples of care that is NOT covered while a member is traveling:

- Tests or treatment that a PCP requested before the member traveled
- Routine care or care that can wait until the member returns home (for example, physical exams or immunizations)
- Routine care that can be anticipated as a need before traveling (for example, routine prenatal care)

As a provider you may ask a member (excluding MassHealth members) to pay for care received outside of FCHP's service area at the time of emergency or urgent care service. The Commonwealth of Massachusetts Executive Office of Health and Human Services precludes billing MassHealth members. It is preferred that FCHP be contacted directly for payment by calling FCHP's Customer Service Department at 1-800-868-5200 and for FCHP MassHealth members call FCHP's MassHealth Customer Service line at 1-800-341-4848 (TDD/TTY: 1-877-608-7677), Monday through Friday, 8 a.m. to 6 p.m.

---

---

## PCP REFERRAL AND PLAN PRIOR AUTHORIZATION PROCESS

---

---

Fallon Community Health Plan's (FCHP) referral and prior authorization process is outlined in the following pages. A grid is provided to describe the PCP referral and prior authorization, and notification policies and procedures. The type of service, services included and referral process are outlined within the grid. FCHP's PCP referral and prior authorization process applies to all FCHP HMO/MCO products and Fallon Senior Plan™.

The following are important reminders about FCHP's referral and prior authorization process:

- PCP coordination of care is the foundation for care delivery.
- All specialty visits, initial and follow up, must be coordinated by the PCP. Specialists cannot refer to other specialists.
- Specialty visits that occur without PCP coordination will not be reimbursed. Any exceptions to this rule, e.g., member self-referrals, are specifically noted below.
- Office-based procedures: FCHP has a [designated list of procedure codes that require plan prior authorization](#) by the performing physician.
- PCPs are allowed to direct for specific types of specialty services for eligible health plan members who are being referred within the members' network option.
  - If the PCP refers a member for **non-covered benefits, or to non-contracted providers**, the **PCP's referral becomes void**, as these situations require plan prior authorization.
  - Please note that if these non-covered or out-of-network services are not specifically preauthorized by the plan, reimbursement to these providers will not occur, and either the member or referring physician will be financially liable for the services.
- To comply with the Centers for Medicare & Medicaid Services (CMS) regulation, a pre-service denial box has been added to the Request for Prior Authorization form. CMS requires that if a Fallon Senior Plan member disagrees with his/her physician or clinician regarding a request for service, the member has the right to appeal this decision. FCHP must then issue a written determination notice to the member and include the member's right to appeal. Our physician reviewers must have the clinical rationale in order to exercise an independent clinical judgment. Should FCHP agree with the decision to decline or deny a referral for medical services or supplies, a formal

---

---

## PCP REFERRAL AND PLAN PRIOR AUTHORIZATION PROCESS

---

---

denial will be issued to the Fallon Senior Plan member, which, per CMS regulatory requirements, may be subsequently appealed by the member.

**Note:** Some provider network agreements require referrals be submitted directly to the network IPA or PHO. When applicable, please defer to your IPA or PHO procedures.

### PCP referrals

Referrals for specialty care are required for commercial HMO, MassHealth and Fallon Senior Plan™ members.

1. The PCP refers the member to a specialist within the member's product for medically necessary care.
2. PCP contacts the specialist by telephone, fax, mail, or script and provides the PCP's name, their NPI number, the reason for the referral and number of visits approved.
3. Referral should be documented in member's medical records for both PCP & specialist. FCHP reserves the right to audit medical records to ensure specialty referral was obtained. Lack of proof of referral may result in claims retractions.
4. The specialist verifies member's eligibility through the FCHP online eligibility tool, POS device or by contacting FCHP at 866-ASK-FCHP, option 1, Monday through Friday from 8:00 a.m. to 5:00 p.m.
5. The specialist treats the member according to the PCP's request and exchanges clinical information with the member's PCP.

All services are subject to network, coverage, benefit and contract policies and exclusions.

**Please refer to the** Explanation of Benefits for the FCHP product in question and for FCHP MassHealth members, please refer to the [FCHP MassHealth Covered Services lists](#).

---



---

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

---



---

**PCP referral and preauthorization grid**

Applies to all Fallon Community Health Plan  
HMO products, MassHealth and Fallon Senior Plan <sup>™</sup>

Type of service	Services	Referral process/Preauthorization
Primary care	Family practice Internal medicine Pediatrics A MassHealth Member may choose an OB/Gyn as her Primary Care Provider.	Member self-referral
	Specialty visits—all FCHP contracted providers within member's product (excluding tertiary providers)	PCP referral (Note: All FCHP Direct Care members and only those FCHP Select Care members with a Fallon Clinic PCP may self-refer to any Fallon Clinic specialist without a PCP referral. POS members have the option of receiving care out-of-network without a referral. PPO members do not need a referral for specialty services.)
Specialty services	Specialty visits—all noncontracted, tertiary and <i>Peace of Mind Program</i> <sup>™</sup> providers	Plan preauthorization requested by PCP. For additional information on the <i>Peace of Mind Program</i> <sup>™</sup> please visit the <a href="#">Peace of Mind Program</a> <sup>™</sup> section of this grid. Please note: the Peace of Mind Program is not available to MassHealth members.
Specialty services	Annual GYN (one visit)	Member self-referral within product option
	Other GYN	Member self-referral within product option (Pursuant to Chapter 141)
	Chiropractors	For a referral to a participating chiropractor, the PCP must provide the member and/or the chiropractor with a written prescription each calendar year. The chiropractor needs to submit a copy of the prescription to American Specialty Health Network when submitting the initial claim. NOTE: Chiropractic services are not covered for FCHP

---



---

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

---



---

**PCP referral and preauthorization grid**

Applies to all Fallon Community Health Plan  
HMO products, MassHealth and Fallon Senior Plan <sup>TM</sup>

Type of service	Services	Referral process/Preauthorization
		MassHealth Essential members.
	Infertility/Assisted Reproductive Technology (ART)	Plan prior authorization requested by PCP or specialist NOTE: These services are not covered for FCHP MassHealth members.
	Obstetrics (prenatal and maternity)	Member self-referral within product option
	Oral surgery (impacted teeth)	Member self-referral within product option NOTE: FCHP MassHealth members-FCHP provides for emergency related dental care and oral surgery performed in an outpatient hospital or ambulatory surgery setting which is medically necessary to treat an underlying medical condition, all other dental procedures are covered by MassHealth. The MassHealth member should be referred to the MassHealth Dental Customer Service Center 1-800-207-5019
	Oral surgeon consultation * See benefit coverage for FCHP MassHealth members above	PCP referral within product option. For additional information, please <a href="#">refer to the oral surgery section</a> in this document.
	Oral surgery services and treatment * See benefit coverage for FCHP MassHealth members above	Plan preauthorization requested by specialty (for office or facility-based services) for procedures specified on the <a href="#">Procedure Codes list</a> .
	Plastic reconstructive surgeon consultation	PCP referral

All services are subject to network, coverage, benefit and contract policies and exclusions.

---



---

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

---



---

**PCP referral and preauthorization grid**

Applies to all Fallon Community Health Plan

HMO products, MassHealth and Fallon Senior Plan <sup>TM</sup>

Type of service	Services	Referral process/Preauthorization
	Plastic reconstructive surgery and treatment	Plan preauthorization requested by specialist (for office or facility-based services) for procedures specified on the <a href="#">Procedure Codes list</a> .
	Podiatry services	Plan prior authorization is no longer required for most services; although some procedures may still require a plan prior authorization. For additional information, please <a href="#">refer to the podiatry section</a> in this manual.
Specialty services	Transplant evaluation	Plan prior authorization requested by PCP or specialist.
Office-based procedures	For all office-based procedures identified on the <a href="#">List of Procedure Codes Requiring Prior Authorization</a> , the PCP or specialist must obtain plan prior authorization.	
Other professional services	Abortion	Member self-referral (Coverage based on member's benefit)
	Neuropsychological testing	Plan preauthorization requested by PCP or specialist (CPT codes 96115 and 96117).
	Nutrition	PCP referral
	Pain clinic	PCP referral
	Preventive dental	Member self-referral
	For FCHP MassHealth members (age 21 and under) fluoride varnish treatments can be provided by a primary care provider. Refer to the MassHealth Dental Benefit section for full description.	NOTE: FCHP MassHealth members dental benefits are provided by MassHealth. Dental screenings and cleanings are available for children, adolescents and young adults under the age of 21. The enrollee should be referred to MassHealth Dental Customer Service Center 1-800-207-5019.
	Routine eye exam	Member self-referral

All services are subject to network, coverage, benefit and contract policies and exclusions.

---



---

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

---



---

**PCP referral and preauthorization grid**

Applies to all Fallon Community Health Plan

HMO products, MassHealth and Fallon Senior Plan <sup>™</sup>

Type of service	Services	Referral process/Preauthorization
	Physical, occupational or speech therapy	Covered physical therapy and occupational therapy do not require a PCP referral or prior authorization by the plan. A physician prescription is required and therapists must be contracted by FCHP. Members will be covered up to their benefit maximum. Speech therapy requires plan prior authorization by the plan.
	All unlisted CPT-4 codes and all unspecified HCPCS	Plan prior authorization requested by PCP or specialist.
	Genetic testing	PCP referral to specialist required for initial consultation. Plan preauthorization requested by PCP or specialist needed for subsequent testing.
Outpatient diagnostic tests	PET scans	Plan preauthorization requested by PCP or specialist for the following products that are not participating in the MedSolutions program: MassHealth, Summit ElderCare, Major Medical, UltraBenefits, Fallon Senior Plan Preferred (Senior PPO), Fallon Preferred Care (Commercial PPO) and Fallon Companion Care.
	All noncontracted, tertiary and <i>Peace of Mind Program</i> <sup>™</sup> facilities	Plan preauthorization requested by PCP or specialist. Peace of Mind Program is <b>not available</b> for members enrolled in FCHP MassHealth, FCHP Independent Care, FCHP Flex Care, Fallon Preferred Care or Fallon Senior Plan <sup>™</sup> .

All services are subject to network, coverage, benefit and contract policies and exclusions.

---



---

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

---



---

**PCP referral and preauthorization grid**

Applies to all Fallon Community Health Plan

HMO products, MassHealth and Fallon Senior Plan <sup>TM</sup>

Type of service	Services	Referral process/Preauthorization
Hospital/facility	Elective hospital/facility same-day surgery and ambulatory procedures	For all facility-based services identified on the <a href="#">list of procedure codes requiring prior authorization</a> , the PCP or specialist must obtain plan prior authorization and the facility must provide notification to FCHP.
	All elective inpatient admissions	Plan prior authorization requested by PCP or specialist
DME	DME	Plan prior authorization is required for certain DME services. For additional information, <a href="#">see the DME section</a> in this document.
Nutritional supplements	Nutritional supplements for which coverage is mandated by law are supplied through contracted pharmacies	Plan prior authorization is required. Provider writes a prescription for the nutritional supplement; member fills the prescription at a contracted retail pharmacy. NOTE: For FCHP MassHealth members refer to the Special formula (enteral-nutrition products) process located in the FCHP Products section. A specific form for special formulas must be completed and submitted for review.
Hospice	Hospice	Plan prior authorization is required.
Oxygen	Oxygen	Plan prior authorization is required.
Prosthetics and orthotics	Prosthetics and orthotics	Plan prior authorization is required.
Nonemergency ambulance	Nonemergency ambulance	Plan prior authorization is required for the following HCPCS codes: A0420, A0426, A0428, A0999, A0130, S0209, S0215

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

**PCP referral and preauthorization grid**

Applies to all Fallon Community Health Plan  
HMO products, MassHealth and Fallon Senior Plan <sup>TM</sup>

Type of service	Services	Referral process/Preauthorization
<p>FCHP MassHealth Standard/Comm onHealth members only:</p> <p>Transportation non-emergent <i>out-of-state location</i></p> <p>Not covered by either FCHP or MassHealth for MassHealth Basic, Essential, or Family Assistance enrollees.</p>	<p>FCHP covers non-emergency transportation by ambulance and other common carriers that generally are pre-arranged to transport a member to a service that is located outside a 50 mile radius of the MA border.</p>	<p>Plan prior authorization is required.</p>
<p>MassHealth Standard/Comm onHealth enrollees only:</p> <p>Transportation non-emergent, to in-state location or location within 50 miles of the Massachusetts border</p> <p>Note: No longer covered by MassHealth for Family</p>	<p>FCHP can coordinate this service, but generally the MassHealth member contacts his/her physician who will complete and send the PT-1 form requesting the non-emergent transportation to MassHealth. MassHealth provides coverage for ambulance (land), chair car, taxi, and common carriers that generally are pre-arranged to transport an Enrollee to a covered service that is located in-state or within a 50-mile</p>	<p>PT-1 Form Required.</p>

All services are subject to network, coverage, benefit and contract policies and exclusions.

---



---

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

---



---

**PCP referral and preauthorization grid**

Applies to all Fallon Community Health Plan

HMO products, MassHealth and Fallon Senior Plan <sup>TM</sup>

Type of service	Services	Referral process/Preauthorization
Assistance and Basic Enrollees with the FY11 Contract.	radius of the Massachusetts border.	
<b>Behavioral health</b>	Outpatient mental health and outpatient substance abuse	Member self-referral by calling Beacon Health Strategies at 888-421-8861.
<p>Please note this is not a comprehensive list of all FCHP Covered Services. Please refer to the Explanation of Benefits for the FCHP product in question and for FCHP MassHealth members, please refer to the FCHP MassHealth Covered Services lists.</p>		

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

**FCHP Standard Response Times**

Product	Type of Request	FCHP will respond within:
<i>Commercial &amp; MassHealth Plans</i>	<ul style="list-style-type: none"> <li>• <b>Pre-Service Non-urgent (Routine) Approval</b></li> </ul>	<ul style="list-style-type: none"> <li>• Decision is made in 2 business days of obtaining all necessary information FCHP may extend the 14 calendar day time frame by up to 14 additional calendar days if the member, authorized appeal representative, if any, or provider requests the extension, or if FCHP can justify a need for additional information, there is a reasonable likelihood that such information would lead to approval of the request, if received, and such information is reasonably expected to be received within 14 calendar days. If FCHP takes an extension, the member and authorized appeal representative, if any, must be given written notice of the reason for the extension and inform the member and authorized appeal representative, if any, of the right to file a grievance if the member or authorized appeal representative, if any, disagrees with the extension.</li> <li>• Oral notice is given to the provider in 24 hours of decision</li> <li>• Written / electronic notice is given to the member, authorized appeal representative, if any, and provider in 2 business days after oral notice</li> </ul>
<i>Senior Plan</i>	<ul style="list-style-type: none"> <li>• <b>Pre-Service Non-urgent (Routine) Approval</b></li> </ul>	<ul style="list-style-type: none"> <li>• Decision is made within 14 calendar days of receiving request for service</li> <li>• Oral notice is given to the provider in 24 hours of decision</li> <li>• Written / electronic notice is given to the member and provider in 2</li> </ul>

\* All unlisted/unspecified CPT/HCPCS codes require preauthorization.

\*\* Please refer to the FCHP Provider Manual for a comprehensive list of services which require pre-auth

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

		business days after oral notice
<i>Commercial &amp; MassHealth Plans</i>	<ul style="list-style-type: none"> <li>• <b>Pre-Service Non-urgent (Routine) Denial</b></li> </ul>	<p>Decision is made in 2 business days of obtaining all necessary information. All preauthorization requests expedited by the requesting physician (FCHP determines whether to expedite a request if taking the time for a standard authorization decision would seriously jeopardize the member's health) are processed (and written determination notice to the member, authorized appeal representative, if any, and provider is made) as expeditiously as the member's health requires, but not to exceed 48 hours after the receipt of the expedited request for service. FCHP will address any extensions for expedited authorizations as well as grievance rights if the member disagrees with the Plan requested extension.</p> <p>Oral notice is given to the provider in 24 hours of decision</p> <p>Written / electronic notice is given to the member, authorized appeal representative, if any, and provider in one (1) business day after oral notice</p>
<i>Senior Plans</i>	<ul style="list-style-type: none"> <li>• <b>Pre-Service Non-urgent (Routine) Denial</b></li> </ul>	<p>Decision is made within 14 business days of receiving request for service</p> <p>Oral notice is given to the provider in 24 hours of decision</p> <p>Written / electronic notice is given to the member and provider in 1 business day after oral notice</p>
<i>Commercial, MassHealth &amp; Senior Plans</i>	<ul style="list-style-type: none"> <li>• <b>Pre-Service Urgent/Expedited Approval</b></li> </ul>	<p>Decision is made in 72 hours from receipt of request</p> <p>Oral and written notice given to member, authorized appeal representative, if any, or practitioner in 72 hours of request.</p>

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

<p><i>Commercial, MassHealth &amp; Senior Plans</i></p>	<ul style="list-style-type: none"> <li>• <b>Pre-Service Urgent/Expedited Denial</b></li> </ul>	<p>Decision is made in 72 hours from receipt of request</p> <p>Oral and written notice given to member, authorized appeal representative, if any or practitioner in 72 hours of request</p>
<p><i>Commercial, MassHealth &amp; Senior Plans</i></p>	<ul style="list-style-type: none"> <li>• <b>Pre-Service Urgent/Expedited Extension</b></li> </ul>	<p>Decision time frame is extended once up to 48 hours if unable to make decision due to lack of necessary information</p> <p>FCHP may extend the 14 calendar day time frame by up to 14 additional calendar days if the member or provider requests the extension, or if FCHP can justify a need for additional information, there is a reasonable likelihood that such information would lead to approval of the request, if received, and such information is reasonably expected to be received within 14 days. If FCHP takes an extension, the member must be given written notice of the reason for the extension and inform the member of the right to file a grievance if the member disagrees with the extension.</p> <p>Decision must be made within 48 hours of receiving the information, or by the end of 48-hour period given the member to supply the information, whichever is earlier</p> <p>Decision must be made even if information is incomplete or was not received within this period</p> <p>Notification must be sent to member within 24 hours of the request to extend the decision time frame regarding specific information to make the decision</p> <p>Member has 48 hours to provide the specified information</p>

All services are subject to network, coverage, benefit and contract policies and exclusions.

---



---

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

---



---

<i>Commercial, MassHealth &amp; Senior Plans</i>	Reconsideration	<p>Provider can request reconsideration at notification of denial with decision made within 1 business day.</p> <p>Oral notification given within 1 business day.</p>
<i>Commercial, MassHealth &amp; Senior Plans</i>	Post-Service Review Process	<p>Decision is made in 30 calendar days from receipt of request.</p> <p>Electronic or written notification of the decision given to member/practitioner in 30 calendar days from receipt of request.</p>

All services are subject to network, coverage, benefit and contract policies and exclusions.

---



---

## PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS

---



---

### Fallon Community Health Plan

List of Procedures Requiring Plan Prior Authorization and Facility Notification  
Effective March 1, 2012

Applies to all Fallon Community Health Plan HMO products and Fallon Senior Plan

For all office and facility-based services identified, the PCP or specialist must obtain plan prior authorization and the facility must provide notification to FCHP.

**Please note: This is not a complete list. For a complete list of procedure codes requiring plan prior authorization, please refer to the Procedure code look-up tool located in the provider section of the web site at [www.fchp.org](http://www.fchp.org).**

Code	Description
0024T	NON-SURGICAL SEPTAL REDUCTION THERAPY, WITH OR WITHOUT TEMP PACEMAKER
00740	ANESTHESIA FOR UPPER GASTROINTESTINAL ENDOSCOPIC PROCEDURES, ENDOSCOPE INTRODUCED PROXIMAL TO DUODENUM
0075T	TRANSCATHETER PLACEMENT OF EXTRACRANIAL VERTEBRAL OR INTRATHORACIC CAROTID ARTERY STENT(S), INCLUDING RADIOLOGIC SUPERVISION AND INTERPRETATION, PERCUTANEOUS; INITIAL VESS
0076T	TRANSCATHETER PLACEMENT OF EXTRACRANIAL VERTEBRAL OR INTRATHORACIC CAROTID ARTERY STENT(S), INCLUDING RADIOLOGIC SUPERVISION AND INTERPRETATION, PERCUTANEOUS; EACH ADDITIONAL VESSEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0078T	ENDOVASCULAR REPAIR OF ABDOMINAL AORTIC ANEURYSM, PSEUDOANEURYSM OR DISSECTION, ABDOMINAL AORTA INVOLVING VISCERAL VESSELS (SUPERIOR MESENTERIC, CELIAC OR RENAL); USING FENESTRATED MODULAR BIFURCATED PROSTHESIS (TWO DOCKING LIMBS)
0079T	PLACEMENT OF VISCERAL EXTENSION PROSTHESIS FOR ENDOVASCULAR REPAIR OF ABDOMINAL AORTIC ANEURYSM INVOLVING VISCERAL VESSELS, EACH VISCERAL BRANCH
0080T	ENDOVASCULAR REPAIR OF ABDOMINAL AORTIC ANEURYSM, PSEUDOANEURYSM OR DISSECTION, ABDOMINAL AORTA INVOLVING VISCERAL VESSELS (SUPERIOR MESENTERIC, CELIAC OR RENAL); USING FENESTRATED MODULAR BIFURCATED PROSTHESIS (TWO DOCKING LIMBS), RADIOLOGICAL SUPERVISION AND INTERPRETATION
00810	ANESTHESIA FOR LOWER INTESTINAL ENDOSCOPIC PROCEDURES, ENDOSCOPE INTRODUCED DISTAL TO DUODENUM
0081T	PLACEMENT OF VISCERAL EXTENSION PROSTHESIS FOR ENDOVASCULAR REPAIR OF ABDOMINAL AORTIC ANEURYSM INVOLVING VISCERAL VESSELS, EACH VISCERAL BRANCH, RADIOLOGICAL SUPERVISION AND INTERPRETATION
0085T	BREATH TEST FOR HEART TRANSPLANT REJECTION
0092T	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISCS), ANTERIOR APPROACH, INCLUDING DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), EACH ADDITIONAL INTERSPACE
0098T	REVISION OF TOTAL DISC ARTHROPLASTY, ANTERIOR APPROACH; EACH ADDITIONAL INTERSPACE
0184T	EXCISION OF RECTAL TUMOR, TRANSANAL ENDOSCOPIC MICROSURGICAL APPROACH (IE. TEMS), INCLUDING MUSCULARIS PROPRIA (IE. FULL THICKNESS)
0193T	TRANSURETHRAL, RADIOFREQUENCY MICRO-REMODELING OF THE FEMALE BLADDER NECK AND PROXIMAL URETHRA FOR STRESS URINARY INCONTINENCE
0195T	ARTHRODESIS, PRE-SACRAL INTERBODY TECHNIQUE, INCLUDING INSTRUMENTATION, IMAGING (WHEN PERFORMED), AND DISCECTOMY TO PREPARE INTERSPACE, LUMBAR; SINGLE INTERSPACE
0196T	ARTHRODESIS, PRE-SACRAL INTERBODY TECHNIQUE, INCLUDING INSTRUMENTATION, IMAGING (WHEN PERFORMED), AND DISCECTOMY TO PREPARE INTERSPACE, LUMBAR; EACH ADDITIONAL INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0197T	INTRA-FRACTION LOCALIZATION AND TRACKING OF TARGET OR PATIENT MOTION DURING DELIVERY OF

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
	RADIATION THERAPY (EG, 3D POSITIONAL TRACKING, GATING, 3D SURFACE TRACKING), EACH FRACTION OF TREATMENT
0198T	MEASUREMENT OF OCULAR BLOOD FLOW BY REPETITIVE INTRAOCULAR PRESSURE SAMPLING, WITH INTERPRETATION AND REPORT
0203T	SLEEP STUDY, UNATTENDED, SIMULTANEOUS RECORDING; HEART RATE, OXYGEN SATURATION, RESPIRATORY ANALYSIS (EG, BY AIRFLOW OR PERIPHERAL ARTERIAL TONE) AND SLEEP TIME
0204T	SLEEP STUDY, UNATTENDED, SIMULTANEOUS RECORDING; MINIMUM OF HEART RATE, OXYGEN SATURATION, AND RESPIRATORY ANALYSIS (EG, BY AIRFLOW OR PERIPHERAL ARTERIAL TONE)
0205T	INTRAVASCULAR CATHETER-BASED CORONARY VESSEL OR GRAFT SPECTROSCOPY (EG, INFRARED) DURING DIAGNOSTIC EVALUATION AND/OR THERAPEUTIC INTERVENTION INCLUDING IMAGING SUPERVISION, INTERPRETATION, AND REPORT, EACH VESSEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0206T	ALGORITHMIC ANALYSIS, REMOTE, OF ELECTROCARDIOGRAPHIC-DERIVED DATA WITH COMPUTER PROBABILITY ASSESSMENT, INCLUDING REPORT
0207T	EVACUATION OF MEIBOMIAN GLANDS, AUTOMATED, USING HEAT AND INTERMITTENT PRESSURE, UNILATERAL
0208T	PURE TONE AUDIOMETRY (THRESHOLD), AUTOMATED (INCLUDES USE OF COMPUTER-ASSISTED DEVICE); AIR ONLY
0209T	PURE TONE AUDIOMETRY (THRESHOLD), AUTOMATED (INCLUDES USE OF COMPUTER-ASSISTED DEVICE); AIR AND BONE
0210T	SPEECH AUDIOMETRY THRESHOLD, AUTOMATED (INCLUDES USE OF COMPUTER-ASSISTED DEVICE);
0211T	SPEECH AUDIOMETRY THRESHOLD, AUTOMATED (INCLUDES USE OF COMPUTER-ASSISTED DEVICE); WITH SPEECH RECOGNITION
0212T	COMPREHENSIVE AUDIOMETRY THRESHOLD EVALUATION AND SPEECH RECOGNITION (0209T, 0211T COMBINED), AUTOMATED (INCLUDES USE OF COMPUTER-ASSISTED DEVICE)
0213T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, CERVICAL OR THORACIC; SINGLE LEVEL
0214T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, CERVICAL OR THORACIC; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0215T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, CERVICAL OR THORACIC; THIRD AND ANY ADDITIONAL LEVEL(S) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0216T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, LUMBAR OR SACRAL; SINGLE LEVEL
0217T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, LUMBAR OR SACRAL; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0218T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, LUMBAR OR SACRAL; THIRD AND ANY ADDITIONAL LEVEL(S). (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0219T	PLACEMENT OF POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; CERVICAL
0220T	PLACEMENT OF POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; THORACIC
0221T	PLACEMENT OF POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; LUMBAR
0222T	PLACEMENT OF POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; EACH ADDITIONAL VERTEBRAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
0223T	ACOUSTIC CARDIOGRAPHY, INCLUDING AUTOMATED ANALYSIS OF COMBINED ACOUSTIC AND ELECTRICAL INTERVALS; SINGLE, WITH INTERPRETATION AND REPORT
0224T	ACOUSTIC CARDIOGRAPHY, INCLUDING AUTOMATED ANALYSIS OF COMBINED ACOUSTIC AND ELECTRICAL INTERVALS; MULTIPLE, INCLUDING SERIAL TRENDED ANALYSIS AND LIMITED REPROGRAMMING OF DEVICE PARAMETER - AV OR VV DELAYS ONLY, WITH INTERPRETATION AND REPORT
0225T	ACSTIC/ELEC CARDGRPHY AV+VV
0545F	PLAN FOR FOLLOW-UP CARE FOR MAJOR DEPRESSIVE DISORDER, DOCUMENTED (MDD ADOL)
11760	REPAIR OF NAIL BED
11762	RECONSTRUCTION OF NAIL BED WITH GRAFT
11920	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN; 6.0 SQ CM OR LESS
11921	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN; 6.1 - 20.0 SQ CM
11922	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN; EACH ADDITIONAL 20.0 SQ CM
11950	SUBCUTANEOUS INJECTION OF "FILLING" MATERIAL (EG COLLAGEN), 1CC OR LESS
11951	SUBCUTANEOUS INJECTION OF "FILLING" MATERIAL (EG COLLAGEN), 1.1 - 5.0 CC
11952	SUBCUTANEOUS INJECTION OF "FILLING" MATERIAL (EG COLLAGEN), 5.1 - 10.0 CC
11954	SUBCUTANEOUS INJECTION OF "FILLING" MATERIAL (EG COLLAGEN), OVER 10.0 CC
11960	INSERTION OF TISSUE EXPANDER(S) FOR OTHER THAN BREAST
11970	REPLACE TISSUE EXPANDER WITH PERMANENT PROSTHESIS
11971	REMOVAL TISSUE EXPANDER W/O INSERTION PROSTHESIS
1200F	SEIZURE TYPE(S) AND CURRENT SEIZURE FREQUENCY(IES) DOCUMENTED (EPI)
1205F	ETIOLOGY OF EPILEPSY OR EPILEPSY SYNDROME(S) REVIEWED AND DOCUMENTED (EPI)
15170	ACELLULAR DERMAL REPLACEMENT, TRUNK, ARMS, LEGS; FIRST 100 SQ CM OR LESS, OR ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN
15171	ACELLULAR DERMAL REPLACEMENT, TRUNK, ARMS, LEGS; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
15175	ACELLULAR DERMAL REPLACEMENT, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; FIRST 100 SQ CM OR LESS, OR ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN
15176	ACELLULAR DERMAL REPLACEMENT, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
15271	APPLICATION OF SKIN SUBSTITUTE GRAFT TO TRUNK, ARMS, LEGS, TOTAL WOUND SURFACE AREA UP TO 100 SQ CM; FIRST 25 SQ CM OR LESS WOUND SURFACE AREA
15272	APPLICATION OF SKIN SUBSTITUTE GRAFT TO TRUNK, ARMS, LEGS, TOTAL WOUND SURFACE AREA UP TO 100 SQ CM; EACH ADDITIONAL 25 SQ CM WOUND SURFACE AREA, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
15273	APPLICATION OF SKIN SUBSTITUTE GRAFT TO TRUNK, ARMS, LEGS, TOTAL WOUND SURFACE AREA GREATER THAN OR EQUAL TO 100 SQ CM; FIRST 100 SQ CM WOUND SURFACE AREA, OR 1% OF BODY AREA OF INFANTS AND CHILDREN
15274	APPLICATION OF SKIN SUBSTITUTE GRAFT TO TRUNK, ARMS, LEGS, TOTAL WOUND SURFACE AREA GREATER THAN OR EQUAL TO 100 SQ CM; EACH ADDITIONAL 100 SQ CM WOUND SURFACE AREA, OR PART THEREOF, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
15275	APPLICATION OF SKIN SUBSTITUTE GRAFT TO FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS, TOTAL WOUND SURFACE AREA UP TO 100 SQ CM; FIRST 25 SQ CM OR LESS WOUND SURFACE AREA
15276	APPLICATION OF SKIN SUBSTITUTE GRAFT TO FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS, TOTAL WOUND SURFACE AREA UP TO 100 SQ CM; EACH ADDITIONAL 25 SQ CM WOUND SURFACE AREA, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
15277	APPLICATION OF SKIN SUBSTITUTE GRAFT TO FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS, TOTAL WOUND SURFACE AREA GREATER THAN OR EQUAL TO 100 SQ CM; FIRST 100 SQ CM WOUND SURFACE AREA, OR 1% OF BODY AREA OF INFANTS AND CHILDREN
15278	APPLICATION OF SKIN SUBSTITUTE GRAFT TO FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS, TOTAL WOUND SURFACE AREA GREATER THAN OR EQUAL TO 100 SQ CM; EACH ADDITIONAL 100 SQ CM WOUND SURFACE AREA, OR PART THEREOF, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
15331	ACELLULAR DERMAL ALLOGRAFT, TRUNK, ARMS, LEGS; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
15335	ACELLULAR DERMAL ALLOGRAFT, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; FIRST 100 SQ CM OR LESS, OR ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN
15336	ACELLULAR DERMAL ALLOGRAFT, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
15340	TISSUE CULTURED ALLOGENEIC SKIN SUBSTITUTE; FIRST 25 SQ CM OR LESS
15341	TISSUE CULTURED ALLOGENEIC SKIN SUBSTITUTE; EACH ADDITIONAL 25 SQ CM
15360	TISSUE CULTURED ALLOGENEIC DERMAL SUBSTITUTE; TRUNK, ARMS, LEGS; FIRST 100 SQ CM OR LESS, OR ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN
15361	TISSUE CULTURED ALLOGENEIC DERMAL SUBSTITUTE; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
15365	TISSUE CULTURED ALLOGENEIC DERMAL SUBSTITUTE, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; FIRST 100 SQ CM OR LESS, OR ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN
15366	TISSUE CULTURED ALLOGENEIC DERMAL SUBSTITUTE, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
15431	ACELLULAR XENOGRAFT IMPLANT; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
15775	PUNCH GRAFT FOR HAIR TRANSPLANT, 1 TO 15 PUNCH GRAFTS
15776	PUNCH GRAFT FOR HAIR TRANSPLANT, MORE THAN 15 PUNCH GRAFTS
15777	IMPLANTATION OF BIOLOGIC IMPLANT (EG, ACELLULAR DERMAL MATRIX) FOR SOFT TISSUE REINFORCEMENT (EG, BREAST, TRUNK) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
15780	DERMABRASION, TOTAL FACE

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

<b>Code</b>	<b>Description</b>
15781	DERMABRASION, SEGMENTAL, FACE
15782	DERMABRASION, REGIONAL, OTHER THAN FACE
15783	DERMABRASION, SUPERFICIAL, ANY SITE
15786	ABRASION, SINGLE LESION
15787	ABRASION, EACH ADDITION FOUR LESIONS OR LESS
15788	CHEMICAL PEEL, FACIAL, EPIDERMAL
15789	CHEMICAL PEEL, FACIAL, DERMAL
15792	CHEMICAL PEEL, NONFACIAL, EPIDERMAL
15793	CHEMICAL PEEL, NONFACIAL, DERMAL
15819	CERVICOPLASTY
15820	BLEPHAROPLASTY, EYELID, LOWER
15821	BLEPHAROPLASTY, EYELID, LOWER, WITH EXTENSIVE HERNIATED FAT PAD
15822	BLEPHAROPLASTY, EYELID, UPPER
15823	BLEPHAROPLASTY UPPER EYELID WITH EXCESSIVE SKIN WEIGHTING LID
15824	RHYTIDECTOMY FOREHEAD (FOREHEAD LIFT/BROW LIFT)
15825	RHYTIDECTOMY, NECK WITH PLATYSMAL TIGHTENING
15826	RHYTIDECTOMY, GLABELLAR FROWN LINES
15828	RHYTIDECTOMY, CHEEK, CHIN, AND NECK
15829	RHYTIDECTOMY, SUPERFICIAL MUSCULOAPONEUROTIC SYSTEM
15830	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); ABDOMEN, INFRAUMBILICAL PANNICULECTOMY
15832	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE, THIGH
15833	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE, LEG
15834	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE, HIP
15835	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE, BUTTOCK
15836	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE, ARM
15837	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE, FOREARM OR HAND
15838	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE, SUBMENTAL FAT PAD
15839	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE, OTHER AREA
15847	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY), ABDOMEN (EG, ABDOMINOPLASTY) (INCLUDES UMBILICAL TRANSPOSITION AND FASCIAL PPLICATION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
15876	SUCTION-ASSISTED LIPECTOMY; HEAD AND NECK
15877	SUCTION-ASSISTED LIPECTOMY; TRUNK
15878	SUCTION-ASSISTED LIPECTOMY; UPPER EXTREMITY
15879	SUCTION-ASSISTED LIPECTOMY; LOWER EXTREMITY
17106	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS; LESS THAN 10.0 SQ CM
17107	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS; 10.0 - 50.0 SQ CM
17108	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS; OVER 50.0 SQ CM
17360	CHEMICAL EXFOLIATION FOR ACNE
17380	ELECTROLYSIS EPILATION, EACH 1/2 HOUR
19105	ABLATION, CRYOSURGICAL, OF FIBROADENOMA, INCLUDING ULTRASOUND GUIDANCE, EACH FIBROADENOMA
19300	MASTECTOMY FOR GYNECOMASTIA
19316	MASTOPEXY
19318	REDUCTION MAMMPLASTY
19324	MAMMPLASTY, AUGMENTATION, WITHOUT PROSTHETIC IMPLANT

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
19325	MAMMPLASTY, AUGMENTATION, WITH PROSTHETIC IMPLANT
19328	REMOVAL OF INTACT MAMMARY IMPLANT
19330	REMOVAL OF MAMMARY IMPLANT MATERIAL
19340	IMMEDIATE INSERTION OF BREAST PROTHESIS FOLLOWING MASTOPEXY, MASTECTOMY OR IN RECONSTRUCTION
19342	DELAYED INSERTION OF BREAST PROSTHESIS FOLLOWING MASTOPEXY, MASTECTOMY, OR IN RECONSTRUCTION
19350	NIPPLE/AREOLA RECONSTRUCTION
19355	CORRECTION OF INVERTED NIPPLE(S)
19370	OPEN PERIPROSTHETIC CAPSULOTOMY, BREAST
19371	PERIPROSTHETIC CAPSULECTOMY, BREAST
19380	REVISION OF RECONSTRUCTED BREAST
20240	BIOPSY, BONE, EXCISIONAL; SUPERFICIAL
20245	BIOPSY, BONE, EXCISIONAL; DEEP
20520	REMOVAL OF FOREIGN BODY IN MUSCLE OR TENDON SHEATH, SIMPLE
20527	INJECTION, ENZYME (EG, COLLAGENASE), PALMAR FASCIAL CORD (IE, DUPUYTREN'S CONTRACTURE)
20555	PLACEMENT OF NEEDLES OR CATHETERS INTO MUSCLE AND/OR SOFT TISSUE FOR SUBSEQUENT INTERSTITIAL RADIOELEMENT APPLICATION (AT THE TIME OF OR SUBSEQUENT TO THE PROCEDURE)
2060F	PATIENT INTERVIEWED DIRECTLY BY EVALUATING CLINICIAN ON OR BEFORE DATE OF DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER (MDD ADOL)
20930	ALLOGRAFT FOR SPINE SURGERY ONLY; MORSELIZED (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
20931	ALLOGRAFT FOR SPINE SURGERY ONLY; STRUCTURAL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
20936	AUTOGRAFT FOR SPINE SURGERY ONLY (INCLUDES HARVESTING THE GRAFT); LOCAL (EG, RIBS, SPINOUS PROCESS, OR LAMINAR FRAGMENTS) OBTAINED FROM SAME INCISION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
20937	AUTOGRAFT FOR SPINE SURGERY ONLY (INCLUDES HARVESTING THE GRAFT); MORSELIZED (THROUGH SEPARATE SKIN OR FASCIAL INCISION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
20938	AUTOGRAFT FOR SPINE SURGERY ONLY (INCLUDES HARVESTING THE GRAFT); STRUCTURAL, BICORTICAL OR TRICORTICAL (THROUGH SEPARATE SKIN OR FASCIAL INCISION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
20974	ELECTRICAL STIMULATION TO AID BONE HEALING; NONINVASIVE
20975	ELECTRICAL STIMULATION TO AID BONE HEALING; INVASIVE
20979	LOW INTENSITY ULTRASOUND STIMULATION TO AID BONE HEALING; NON-INVASIVE
20982	ABLATION, BONE TUMOR(S) (EG, OSTEOID OSTEOOMA, METASTASIS) RADIOFREQUENCY, PERCUTANEOUS, INCLUDING COMPUTED TOMOGRAPHIC GUIDANCE
21025	EXCISION OF BONE; MANDIBLE
21029	REMOVAL BY CONTOURING OF BENIGN TUMOR OF FACIAL BONE
21031	EXCISION OF TORUS MANDIBULARIS
21032	EXCISION OF MAXILLARY TORUS PALATINUS
21045	EXCISION OF MALIGNANT TUMOR OF MANDIBLE; RADICAL RESECTION
21046	EXCISION OF BENIGN TUMOR OR CYST OF MANDIBLE; REQUIRING INTRA-ORAL OSTEOTOMY (EG, LOCALLY AGGRESSIVE OR DESTRUCTIVE LESION(S))
21047	EXCISION OF BENIGN TUMOR OR CYST OF MANDIBLE; REQUIRING EXTRA-ORAL OSTEOTOMY AND PARTIAL MANDIBULECTOMY (EG, LOCALLY AGGRESSIVE OR DESTRUCTIVE LESION(S))
21048	EXCISION OF BENIGN TUMOR OR CYST OF MAXILLA; REQUIRING INTRA-ORAL OSTEOTOMY (EG, LOCALLY AGGRESSIVE OR DESTRUCTIVE LESION(S))

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
21049	EXCISION OF BENIGN TUMOR OR CYST OF MAXILLA; REQUIRING EXTRA-ORAL OSTEOTOMY AND PARTIAL MAXILLECTOMY (EG, LOCALLY AGGRESSIVE OR DESTRUCTIVE LESION(S))
21050	CONDYLECTOMY, TEMPOROMANDIBULAR JOINT
21060	MENISCECTOMY, PARTIAL OR COMPLETE, TEMPOROMANDIBULAR JOINT
21070	CORONOIDECTOMY
21073	MANIPULATION OF TEMPOROMANDIBULAR JOINT(S) (TMJ), THERAPEUTIC, REQUIRING AN ANESTHESIA SERVICE (IE, GENERAL OR MONITORED ANESTHESIA CARE)
21084	IMPRESSION AND CUSTOM PREPARATION; SPEECH AID PROSTHESIS
21116	INJECTION PROCEDURE FOR TEMPOROMANDIBULAR JOINT ARTHROGRAPHY
21120	GENIOPLASTY, AUGMENTATION
21123	GENIOPLASTY, SLIDING, AUGMENTATION WITH INTERPOSITIONAL BONE GRAFTS
21141	RECONSTRUCTION MID FACE, LE FORT I; SINGLE PIECE, SEGMENT MOVEMENT IN ANY DIRECTION, WITHOUT BONE GRAFT
21145	RECONSTRUCTION MID FACE, LE FORT I; SINGLE PIECE, SEGMENT MOVEMENT IN ANY DIRECTION, REQUIRING BONE GRAFTS
21146	RECONSTRUCTION MID FACE, LE FORT I; TWO PIECES, SEGMENT MOVEMENT IN ANY DIRECTION, REQUIRING BONE GRAFTS
21147	RECONSTRUCTION MID FACE, LE FORT I; THREE OR MORE PIECES, SEGMENT MOVEMENT IN ANY DIRECTION, REQUIRING BONE GRAFTS
21150	RECONSTRUCTION MID FACE, LE FORT II; ANTERIOR INTRUSION
21181	RECONSTRUCTION BY CONTOURING OF BENIGN TUMOR OF CRANIAL BONES, EXTRACRANIAL
21193	RECONSTRUCTION OF MADIBULAR RAMI, HORIZONTAL, VERTICAL, C, OR L OSTEOTOMY; WITHOUT BONE GRAFT
21194	RECONSTRUCTION OF MADIBULAR RAMI, HORIZONTAL, VERTICAL, C, OR L OSTEOTOMY; WITH BONE GRAFT
21195	RECONSTRUCTION OF MANDIBULAR RAMI AND/OR BODY, SAGITTAL SPLIT; WITHOUT INTERNAL RIGID FIXATION
21196	RECONSTRUCTION OF MANDIBULAR RAMI AND/OR BODY, SAGITTAL SPLIT; WITH INTERNAL RIGID FIXATION
21198	OSTEOTOMY, MANDIBLE, SEGMENTAL
21206	OSTEOTOMY, MAXILLA, SEGMENTAL
21208	OSTEOPLASTY, FACIAL BONES; AUGMENTATION (AUTOGRAFT,ALLOGRFT OR PROSTHETIC IMPLANT)
21209	OSTEOPLASTY, FACIAL BONES; REDUCTION
21210	GRAFT, BONE; NASAL, MAXILLARY OR MALAR AREAS
21215	GRAFT, BONE; MANDIBLE
21230	GRAFT; RIB CARTILAGE, AUTOGENOUS TO FACE, CHIN, NOSE, OR EAR
21240	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, W OR W/O AUTOGRAFT
21242	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, W ALLOGRAFT
21243	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, W PROS JOINT REPLACEMENT
21244	RECONSTRUCTION OF MANDIBLE, EXTRAORAL, WITH TRANSOSTEAL BONE PLATE
21245	RECONSTRUCTION MANDIBLE/MAXILLA,SUBPERIOSTEAL IMPLANT; PARTIAL
21246	RECONSTRUCTION MANDIBLE/MAXILLA,SUBPERIOSTEAL IMPLANT; COMPLETE
21247	RECONSTRUCTION OF MANDIBULAR CONDYLE WITH BONE AND CARTILAGE AUTOGRAFTS
21248	RECONSTRUCTION OF MANDIBLE OR MAXILLA, ENDOSTEAL IMPLANT, PARTIAL
21249	RECONSTRUCTION OF MANDIBLE OR MAXILLA, ENDOSTEAL IMPLANT, COMPLETE
21267	ORBITAL REPOSITIONING, PERIORBITAL OSTEOTOMIES, UNILATERAL, WITH BONE GRAFTS, EXTRA CRANIAL APPROACH
21270	MALAR AUGMENTATION, PROSTHETIC MATERIAL

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
21275	SECONDARY REVISION OF ORBITOCRANIOFACIAL RECONSTRUCTION
21280	MEDIAL CANTHOPEXY (SEPARATE PROCEDURE)
21282	LATERAL CANTHOPEXY
21296	REDUCTION OF MASSETER MUSCLE AND BONE, INTRAORAL APPROACH
21345	CLOSED TREATMENT OF NASOMAXILLARY COMPLEX FRACTURE (LE FORT II TYPE) WITH INTERDENTAL WIRE FIXATION OR FIXATION OF DENTURE OR SPLINT
21346	OPEN TREATMENT OF NASOMAXILLARY COMPLEX FRACTURE (LE FORT II TYPE); WITH WIRING AND / OR LOCAL FIXATION
21355	PERCUTANEOUS TREATMENT OF FRACTURE OF MALAR AREA, INCLUDING ZYGOMATIC ARCH AND MALAR TRIPOD, WITH MANIPULATION
21360	OPEN TREATMENT OF DEPRESSED MALAR FRACTURE, INCLUDING ZYGOMATIC ARCH AND MALAR TRIPOD
21365	OPEN TREATMENT OF COMPLICATED FRACTURE(S) OF MALAR AREA, INCLUDING ZYGOMATIC ARCH AND MALAR TRIPOD; WITH INTERNAL FIXATION AND MULTIPLE SURGICAL APPROACHES
21422	OPEN TREATMENT OF PALATAL OR MAXILLARY FRACTURE (LE FORT I TYPE)
21435	OPEN TREATMENT OF CRANIOFACIAL SEPARATION (LE FORT III TYPE); COMPLICATED, UTILIZING INTERNAL AND / OR EXTERNAL FIXATION TECHNIQUES
21436	OPEN TREATMENT OF CRANIOFACIAL SEPARATION (LE FORT III TYPE); COMPLICATED, MULTIPLE SURGICAL APPROACHES, INTERNAL FIXATION, WITH BONE GRAFTING
21461	OPEN TREATMENT OF MANDIBULAR FRACTURE; WITHOUT INTERDENTAL FIXATION
21462	OPEN TREATMENT OF MANDIBULAR FRACTURE; WITH INTERDENTAL FIXATION
21480	CLOSED TREATMENT OF TEMPOROMANDIBULAR DISLOCATION; INITIAL OR SUBSEQUENT
21490	OPEN TREATMENT OF TEMPOROMANDIBULAR DISLOCATION
21497	INTERDENTAL WIRING, FOR CONDITION OTHER THAN FRACTURE
21555	EXCISION TUMOR, SOFT TISSUE NECK OR THORAX; SUBCUTANEOUS
21557	RADICAL RESECTION OF TUMOR, SOFT TISSUE OF NECK OR THORAX
21685	HYOID MYOTOMY AND SUSPENSION
21742	RECONSTRUCTIVE REPAIR OF PECTUS EXCAVATUM OR CARINATUM; MINIMALLY INVASIVE APPROACH (NUSS PROCEDURE) WITHOUT THORACOSCOPY
21743	RECONSTRUCTIVE REPAIR OF PECTUS EXCAVATUM OR CARINATUM; MINIMALLY INVASIVE APPROACH (NUSS PROCEDURE) WITH THORACOSCOPY
21935	RADICAL RESECTION OF TUMOR, SOFT TISSUE OF BACK OR FLANK
22220	OSTEOTOMY OF SPINE, INCLUDING DISCECTOMY, ANTERIOR APPROACH, SINGLE VERTEBRAL SEGMENT; CERVICAL
22224	OSTEOTOMY OF SPINE, INCLUDING DISCECTOMY, ANTERIOR APPROACH, SINGLE VERTEBRAL SEGMENT; LUMBAR
22318	OPEN TREATMENT AND/OR REDUCTION OF ODONTOID FRACTURE(S) AND OR DISLOCATION(S) (INCLUDING OS ODONTOIDEUM), ANTERIOR APPROACH, INCLUDING PLACEMENT OF INTERNAL FIXATION; WITHOUT GRAFTING
22319	OPEN TREATMENT AND/OR REDUCTION OF ODONTOID FRACTURE(S) AND OR DISLOCATION(S) (INCLUDING OS ODONTOIDEUM), ANTERIOR APPROACH, INCLUDING PLACEMENT OF INTERNAL FIXATION; WITH GRAFTING
22505	MANIPULATION OF SPINE REQUIRING ANESTHESIA, ANY REGION
22520	PERCUTANEOUS VERTEBROPLASTY, ONE VERTEBRAL BODY, UNILATERAL OR BILATERAL INJECTION; THORACIC
22521	PERCUTANEOUS VERTEBROPLASTY, ONE VERTEBRAL BODY, UNILATERAL OR BILATERAL INJECTION; LUMBAR
22522	PERCUTANEOUS VERTEBROPLASTY, EACH ADDITIONAL THORACIC OR LUMBAR VERTEBRAL BODY
22523	PERCUTANEOUS VERTEBRAL AUGMENTATION, INCLUDING CAVITY CREATION (FRACTURE REDUCTION

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
	AND BONE BIOPSY INCLUDED WHEN PERFORMED) USING MECHANICAL DEVICE, ONE VERTEBRAL BODY, UNILATERAL OR BILATERAL CANNULATION (E.G., KYPHOPLASTY); THORACIC
22524	PERCUTANEOUS VERTEBRAL AUGMENTATION, INCLUDING CAVITY CREATION (FRACTURE REDUCTION AND BONE BIOPSY INCLUDED WHEN PERFORMED) USING MECHANICAL DEVICE, ONE VERTEBRAL BODY, UNILATERAL OR BILATERAL CANNULATION (EG, KYPHOPLASTY); LUMBAR (COVERED FOR SENIOR PLAN ONLY)
22525	PERCUTANEOUS VERTEBRAL AUGMENTATION, INCLUDING CAVITY CREATION (FRACTURE REDUCTION AND BONE BIOPSY INCLUDED WHEN PERFORMED) USING MECHANICAL DEVICE, ONE VERTEBRAL BODY, UNILATERAL OR BILATERAL CANNULATION (E.G., KYPHOPLASTY); EACH ADDITIONAL THORACIC OR LUMBAR VERTEBRAL BODY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
22533	ARTHRODESIS, LATERAL EXTRACAVITARY TECHNIQUE, INCLUDING MINIMAL DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); LUMBAR
22548	ARTHRODESIS, ANTERIOR TRANSORAL OR EXTRAORAL TECHNIQUE, CLIVUS-C1-C2 (ATLAS-AXIS), WITH OR WITHOUT EXCISION OF ODONTOID PROCESS
22551	ARTHRODESIS, ANTERIOR INTERBODY, INCLUDING DISC SPACE PREPARATION, DISCECTOMY, OSTEOPHYTECTOMY AND DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOTS; CERVICAL BELOW C2
22552	ARTHRODESIS, ANTERIOR INTERBODY, INCLUDING DISC SPACE PREPARATION, DISCECTOMY, OSTEOPHYTECTOMY AND DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOTS; CERVICAL BELOW C2, EACH ADDITIONAL INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR SEPARATE PROCEDURE)
22554	ARTHRODESIS, ANTERIOR INTERBODY TECHNIQUE, INCLUDING MINIMAL DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); CERVICAL BELOW C2
22558	ARTHRODESIS, ANTERIOR INTERBODY TECHNIQUE, INCLUDING MINIMAL DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); LUMBAR
22585	ARTHRODESIS, ANTERIOR INTERBODY TECHNIQUE, INCLUDING MINIMAL DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); EACH ADDITIONAL INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
22590	ARTHRODESIS, POSTERIOR TECHNIQUE, CRANIOCERVICAL (OCCIPUT-C2)
22595	ARTHRODESIS, POSTERIOR TECHNIQUE, ATLAS-AXIS (C1-C2)
22600	ARTHRODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE, SINGLE LEVEL; CERVICAL BELOW C2 SEGMENT
22612	ARTHRODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE, SINGLE LEVEL; LUMBAR (WITH OR WITHOUT LATERAL TRANSVERSE TECHNIQUE)
22630	ARTHRODESIS, POSTERIOR INTERBODY TECHNIQUE, INCLUDING LAMINECTOMY AND/OR DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE; LUMBAR
22633	ARTHRODESIS, COMBINED POSTERIOR OR POSTEROLATERAL TECHNIQUE WITH POSTERIOR INTERBODY TECHNIQUE INCLUDING LAMINECTOMY AND/OR DISCECTOMY SUFFICIENT TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE AND SEGMENT; LUMBAR
22634	ARTHRODESIS, COMBINED POSTERIOR OR POSTEROLATERAL TECHNIQUE WITH POSTERIOR INTERBODY TECHNIQUE INCLUDING LAMINECTOMY AND/OR DISCECTOMY SUFFICIENT TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE AND SEGMENT; EACH ADDITIONAL INTERSPACE AND SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
22840	POSTERIOR NON-SEGMENTAL INSTRUMENTATION (E.G., HARRINGTON ROD TECHNIQUE, PEDICLE FIXATION ACROSS 1 INTERSPACE, ATLANTOAXIAL TRANSARTICULAR SCREW FIXATION, SUBLAMINAR WIRING AT C1, FACET SCREW FIXATION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
22841	INTERNAL SPINAL FIXATION BY WIRING OF SPINOUS PROCESSES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
22842	POSTERIOR SEGMENTAL INSTRUMENTATION (E.G., PEDICLE FIXATION, DUAL RODS WITH MULTIPLE HOOKS AND SUBLAMINAR WIRES); 3 TO 6 VERTEBRAL SEGMENTS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
22843	POSTERIOR SEGMENTAL INSTRUMENTATION (E.G., PEDICLE FIXATION, DUAL RODS WITH MULTIPLE HOOKS AND SUBLAMINAR WIRES); 7 TO 12 VERTEBRAL SEGMENTS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
22844	POSTERIOR SEGMENTAL INSTRUMENTATION (E.G., PEDICLE FIXATION, DUAL RODS WITH MULTIPLE HOOKS AND SUBLAMINAR WIRES); 13 OR MORE VERTEBRAL SEGMENTS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
22845	ANTERIOR INSTRUMENTATION; 2 TO 3 VERTEBRAL SEGMENTS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
22846	ANTERIOR INSTRUMENTATION; 4 TO 7 VERTEBRAL SEGMENTS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
22847	ANTERIOR INSTRUMENTATION; 8 OR MORE VERTEBRAL SEGMENTS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
22848	PELVIC FIXATION (ATTACHMENT OF CAUDAL END OF INSTRUMENTATION TO PELVIC BONY STRUCTURES) OTHER THAN SACRUM (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
22849	REINSERTION OF SPINAL FIXATION DEVICE
22850	REMOVAL OF POSTERIOR NONSEGMENTAL INSTRUMENTATION (E.G., HARRINGTON ROD)
22851	APPLICATION OF INTERVERTEBRAL BIOMECHANICAL DEVICE(S) (E.G., SYNTHETIC CAGE(S), METHYLMETHACRYLATE) TO VERTEBRAL DEFECT OR INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
22856	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY WITH END PLATE PREPARATION (INCLUDES OSTEOPHYECTOMY FOR NERVE ROOT OR SPINAL CORD DECOMPRESSION AND MICRODISSECTION), SINGLE INTERSPACE, CERVICAL
22861	REVISION INCLUDING REPLACEMENT OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, SINGLE INTERSPACE; CERVICAL
22862	REVISION INCLUDING REPLACEMENT OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC) ANTERIOR APPROACH, LUMBAR, SINGLE INTERSPACE
22864	REMOVAL OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, SINGLE INTERSPACE; CERVICAL
22865	REMOVAL OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC) ANTERIOR APPROACH, LUMBAR, SINGLE INTERSPACE
22900	EXCISION, ABDOMINAL WALL TUMOR, SUBFASCIAL
24075	EXCISION, TUMOR, SOFT TISSUE OF UPPER ARM OR ELBOW AREA; SUBCUTANEOUS
25075	EXCISION, TUMOR, SOFT TISSUE OF FOREARM AND / OR WRIST AREA; SUBCUTANEOUS
26113	EXCISION, TUMOR, SOFT TISSUE, OR VASCULAR MALFORMATION, OF HAND OR FINGER, SUBFASCIAL (EG, INTRAMUSCULAR); 1.5 CM OR GREATER
27130	ARTHROPLASTY, ACETABULAR AND PROXIMAL FEMORAL PROSTHETIC REPLACEMENT (TOTAL HIP ARTHROPLASTY), WITH OR WITHOUT AUTOGRAFT OR ALLOGRAFT
27327	EXCISION, TUMOR, THIGH OR KNEE AREA; SUBCUTANEOUS
27412	AUTOLOGOUS CHONDROCYTE IMPLANTATION, KNEE
27415	OSTEOCHONDRAL ALLOGRAFT, KNEE, OPEN
27416	OSTEOCHONDRAL AUTOGRAFT(S), KNEE, OPEN (EG, MOSAICPLASTY) (INCLUDES HARVESTING OF AUTOGRAFT[S])
27447	ARTHROPLASTY, KNEE, CONDYLE AND PLATEAU; MEDIAL AND LATERAL COMPONENTS WITH OR WITHOUT PATELLA RESURFACING (TOTAL KNEE ARTHROPLASTY)
27618	EXCISION, TUMOR, LEG OR ANKLE; SUBCUTANEOUS TISSUE
28446	OPEN OSTEOCHONDRAL AUTOGRAFT, TALUS (INCLUDES OBTAINING GRAFT[S])
29581	APPLICATION OF MULTI-LAYER VENOUS WOUND COMPRESSION SYSTEM, BELOW KNEE
29800	ARTHROSCOPY, TEMPOROMANDIBULAR JOINT, DIAGNOSTIC, WITH OR WITHOUT SYNOVIAL BIOPSY (SEPARATE PROCEDURE)

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
29804	ARTHROSCOPY, TEMPOROMANDIBULAR JOINT, SURGICAL
29866	ARTHROSCOPY, KNEE, SURGICAL; OSTEOCHONDRAL AUTOGRAFT(S) (EG, MOSAICPLASTY) (INCLUDES HARVESTING OF THE AUTOGRAFT)
29867	ARTHROSCOPY, KNEE, SURGICAL; OSTEOCHONDRAL ALLOGRAFT (EG, MOSAICPLASTY)
3008F	BODY MASS INDEX (BMI), DOCUMENTED (PV)
30120	EXCISION OR SURGICAL PLANING OF SKIN OF NOSE FOR RHINOPHYMA
30150	RHINECTOMY PARTIAL
3015F	CERVICAL CANCER SCREENING RESULTS DOCUMENTED AND REVIEWED (PV)
30210	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR CELLS; SPECIFIC CELL DEPLETION WITHIN HARVEST, T-CELL DEPLETION
3038F	PULMONARY FUNCTION TEST PERFORMED WITHIN 12 MONTHS PRIOR TO SURGERY (LUNG/ESOP CX)
30400	RHINOPLASTY, PRIMARY; LATERAL AND ALAR CARTILAGES AND / OR ELEVATION OF NASAL TIP
30410	RHINOPLASTY, PRIMARY; COMPLETE, EXTERNAL PARTS INCLUDING BONY PYRAMID, LATERAL AND ALAR CARTILAGES, AND / OR ELEVATION OF NASAL TIP
30420	RHINOPLASTY, PRIMARY; INCLUDING MAJOR SEPTAL REPAIR
30430	RHINOPLASTY, SECONDARY; MINOR REVISION
30435	RHINOPLASTY, SECONDARY; INTERMEDIATE REVISION
30450	RHINOPLASTY, SECONDARY; MAJOR REVISION
30460	RHINOPLASTY FOR NASAL DEFORMITY SECONDARY TO CONGENITAL CLEFT LIP AND / OR PALATE, INCLUDING COLUMELLAR LENGTHENING; TIP ONLY
30462	RHINOPLASTY FOR NASAL DEFORMITY SECONDARY TO CONGENITAL CLEFT LIP AND / OR PALATE, INCLUDING COLUMELLAR LENGTHENING; TIP, SEPTUM, OSTEOTOMIES
30465	REPAIR OF NASAL VESTIBULAR STENOSIS
32491	REMOVAL OF LUNG, OTHER THAN TOTAL PNEUMONECTOMY; EXCISION-PLICATION OF EMPHYSEMATOUS LUNG(S) FOR LUNG VOLUME REDUCTION, STERNAL SPLIT, OR TRANSTHORACIC APPROACH WITH OR WITHOUT ANY PLEURAL PROCEDURE
32552	REMOVAL OF INDWELLING TUNNELED PLEURAL CATHETER WITH CUFF
32553	PLACEMENT OF INTERSTITIAL DEVICE(S) FOR RADIATION THERAPY GUIDANCE (EG, FIDUCIAL MARKERS, DOSIMETER), PERCUTANEOUS, INTRA-THORACIC, SINGLE OR MULTIPLE
32561	INSTILLATION(S), VIA CHEST TUBE/CATHETER, AGENT FOR FIBRINOLYSIS (EG, FIBRINOLYTIC AGENT FOR BREAK UP OF MULTILOCULATED EFFUSION); INITIAL DAY
32562	INSTILLATION(S), VIA CHEST TUBE/CATHETER, AGENT FOR FIBRINOLYSIS (EG, FIBRINOLYTIC AGENT FOR BREAK UP OF MULTILOCULATED EFFUSION); SUBSEQUENT DAY
32850	DONOR PNEUMONECTOMY(S) (INCLUDING COLD PRESERVATION), FROM CADAVER DONOR
32851	LUNG TRANSPLANT, SINGLE; WITHOUT CARDIOPULMONARY BYPASS
32852	LUNG TRANSPLANT, SINGLE; WITH CARDIOPULMONARY BYPASS
32853	LUNG TRANSPLANT, DOUBLE (BILATERAL SEQUENTIAL OR EN BLOC); WITHOUT CARDIOPULMONARY BYPASS
32854	LUNG TRANSPLANT, DOUBLE (BILATERAL SEQUENTIAL OR EN BLOC); WITH CARDIOPULMONARY BYPASS
3293F	ABO AND RH BLOOD TYPING DOCUMENTED AS PERFORMED (PRE-CR)
3294F	GROUP B STREPTOCOCCUS (GBS) SCREENING DOCUMENTED AS PERFORMED DURING WEEK 35-37 GESTATION (PRE-CR)
32998	ABLATION THERAPY FOR REDUCTION OR ERADICATION OF ONE OR MORE PULMONARY TUMOR(S) INCLUDING PLEURA OR CHEST WALL WHEN INVOLVED BY TUMOR EXTENSION, PERCUTANEOUS, RADIOFREQUENCY, UNILATERAL
33140	TRANSMYOCARDIAL LASER REVASCULARIZATION, BY THORACOTOMY (SEPARATE PROCEDURE)
33141	TRANSMYOCARDIAL LASER REVASCULARIZATION, BY THORACOTOMY; PERFORMED AT THE TIME OF OTHER OPEN CARDIAC PROCEDURE

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
3323F	CLINICAL TUMOR, NODE AND METASTASES (TNM) STAGING DOCUMENTED AND REVIEWED PRIOR TO SURGERY (LUNG/ESOP CX)
3324F	MRI OR CT SCAN ORDERED, REVIEWED OR REQUESTED (EPI)
3328F	PERFORMANCE STATUS DOCUMENTED AND REVIEWED WITHIN 2 WEEKS PRIOR TO SURGERY(LUNG/ESOP CX)
33782	AORTIC ROOT TRANSLOCATION WITH VENTRICULAR SEPTAL DEFECT AND PULMONARY STENOSIS REPAIR (IE, NIKAI DOH PROCEDURE); WITHOUT CORONARY OSTIUM REIMPLANTATION
33783	AORTIC ROOT TRANSLOCATION WITH VENTRICULAR SEPTAL DEFECT AND PULMONARY STENOSIS REPAIR (IE, NIKAI DOH PROCEDURE); WITH REIMPLANTATION OF 1 OR BOTH CORONARY OSTIA
33864	ASCENDING AORTA GRAFT, WITH CARDIOPULMONARY BYPASS WITH VALVE SUSPENSION, WITH CORONARY RECONSTRUCTION AND VALVE-SPARING AORTIC ANNULUS REMODELING (EG, DAVID PROCEDURE, YACOUB PROCEDURE)
33925	REPAIR OF PULMONARY ARTERY ARBORIZATION ANOMALIES BY UNIFOCALIZATION; WITHOUT CARDIOPULMONARY BYPASS
33926	REPAIR OF PULMONARY ARTERY ARBORIZATION ANOMALIES BY UNIFOCALIZATION; WITH CARDIOPULMONARY BYPASS
33930	DONOR CARDIECTOMY-PNEUMONECTOMY (INCLUDING COLD PRESERVATION)
33935	HEART-LUNG TRANSPLANT WITH RECIPIENT CARDIECTOMY-PNEUMONECTOMY
33945	HEART TRANSPLANT, WITH OR WITHOUT RECIPIENT CARDIECTOMY
33981	REPLACEMENT OF EXTRACORPOREAL VENTRICULAR ASSIST DEVICE, SINGLE OR BIVENTRICULAR, PUMP(S), SINGLE OR EACH PUMP
33982	REPLACEMENT OF VENTRICULAR ASSIST DEVICE PUMP(S); IMPLANTABLE INTRACORPOREAL, SINGLE VENTRICLE, WITHOUT CARDIOPULMONARY BYPASS
33983	REPLACEMENT OF VENTRICULAR ASSIST DEVICE PUMP(S); IMPLANTABLE INTRACORPOREAL, SINGLE VENTRICLE, WITH CARDIOPULMONARY BYPASS
34800	ENDOVASCULAR REPAIR OF INFRARENAL ABDOMINAL AORTIC ANEURYSM OR DISSECTION; USING AORTO-AORTIC TUBE PROSTHESIS
34802	ENDOVASCULAR REPAIR OF INFRARENAL ABDOMINAL AORTIC ANEURYSM OR DISSECTION; USING MODULAR BIFURCATED PROSTHESIS (ONE DOCKING LIMB)
34803	ENDOVASCULAR REPAIR OF INFRARENAL ABDOMINAL AORTIC ANEURYSM OR DISSECTION; USING MODULAR BIFURCATED PROSTHESIS (TWO DOCKING LIMBS)
34804	ENDOVASCULAR REPAIR OF INFRARENAL ABDOMINAL AORTIC ANEURYSM OR DISSECTION; USING UNIBODY BIFURCATED PROSTHESIS
34805	ENDOVASCULAR REPAIR OF INFRARENAL ABDOMINAL AORTIC ANEURYSM OR DISSECTION; USING AORTO-UNILIAC OR AORTO-UNIFEMORAL PROSTHESIS
34806	TRANSCATHETER PLACEMENT OF WIRELESS PHYSIOLOGIC SENSOR IN ANEURYSMAL SAC DURING ENDOVASCULAR REPAIR, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION, INSTRUMENT CALIBRATION, AND COLLECTION OF PRESSURE DATA (LIST SEPARATELY IN ADDITION TO CODE FOR PR
34808	ENDOVASCULAR PLACEMENT OF ILIAC ARTERY OCCLUSION DEVICE
34833	OPEN ILIAC ARTERY EXPOSURE WITH CREATION OF CONDUIT FOR DELIVERY OF INFRARENAL AORTIC OR ILIAC ENDOVASCULAR PROSTHESIS, BY ABDOMINAL OR RETROPERITONEAL INCISION, UNILATERAL
34834	OPEN BRACHIAL ARTERY EXPOSURE WITH CREATION OF CONDUIT FOR DELIVERY OF INFRARENAL AORTIC OR ILIAC ENDOVASCULAR PROSTHESIS BY ARM INCISION, UNILATERAL
34900	ENDOVASCULAR GRAFT REPLACEMENT FOR REPAIR OF ILIAC ARTERY (EG, ANEURYSM, PSEUDOANEURYSM, ARTERIOVENOUS MALFORMATION, TRAUMA)
35632	BYPASS GRAFT, WITH OTHER THAN VEIN;ILIO-CELIAC
36147	INTRODUCTION OF NEEDLE AND/OR CATHETER, ARTERIOVENOUS SHUNT CREATED FOR DIALYSIS (GRAFT/FISTULA); INITIAL ACCESS WITH COMPLETE RADIOLOGICAL EVALUATION OF DIALYSIS ACCESS, INCLUDING FLUOROSCOPY, IMAGE DOCUMENTATION AND REPORT (INCLUDES ACCESS OF SHUNT, INJECTION[S] OF CONTRAST, AND ALL NECESSARY IMAGING FROM THE ARTERIAL ANASTOMOSIS AND

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
	ADJACENT ARTERY THROUGH ENTIRE VENOUS OUTFLOW INCLUDING THE INFERIOR OR SUPERIOR VENA CAVA)
36148	INTRODUCTION OF NEEDLE AND/OR CATHETER, ARTERIOVENOUS SHUNT CREATED FOR DIALYSIS (GRAFT/FISTULA); ADDITIONAL ACCESS FOR THERAPEUTIC INTERVENTION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
36468	SINGLE OR MULTIPLE INJECTIONS OF SCLEROSING SOLUTIONS, SPIDER VEINS; LIMB OR TRUNK
36469	SINGLE OR MULTIPLE INJECTIONS OF SCLEROSING SOLUTIONS, SPIDER VEINS; FACE
36470	INJECTION OF SCLEROSING SOLUTION; SINGLE VEIN
36471	INJECTION OF SCLEROSING SOLUTION; MULTIPLE VEINS, SAME LEG
36475	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, RADIOFREQUENCY; FIRST VEIN TREATED
36476	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, RADIOFREQUENCY; SECOND AND SUBSEQUENT VEINS TREATED IN A SINGLE EXTREMITY, EACH THROUGH SEPARATE ACCESS SITES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
36478	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, LASER; FIRST VEIN TREATED
36479	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, LASER; SECOND AND SUBSEQUENT VEIN TREATED IN A SINGLE EXTREMITY, EACH THROUGH SEPARATE ACCESS SIGHTS
3650F	ELECTROENCEPHALOGRAM (EEG) ORDERED, REVIEWED OR REQUESTED (EPI)
36563	INSERTION OF TUNNELED CENTRALLY INSERTED CENTRAL VENOUS ACCESS DEVICE WITH SUBCUTANEOUS PUMP
36583	REPLACEMENT, COMPLETE, OF A TUNNELED CENTRALLY INSERTED CENTRAL VENOUS ACCESS DEVICE, WITH SUBCUTANEOUS PUMP, THROUGH SAME VENOUS ACCESS
37188	PERCUTANEOUS TRANSLUMINAL MECHANICAL THROMBECTOMY, VEIN(S), INCLUDING INTRAPROCEDURAL PHARMACOLOGICAL THROMBOLYTIC INJECTIONS AND FLUOROSCOPIC GUIDANCE, REPEAT TREATMENT ON SUBSEQUENT DAY DURING COURSE OF THROMBOLYTIC THERAPY
37215	TRANSCATHETER PLACEMENT OF INTRAVASCULAR STENT(S), CERVICAL CAROTID ARTERY, PERCUTANEOUS; WITH DISTAL EMBOLIC PROTECTION
37216	TRANSCATHETER PLACEMENT OF INTRAVASCULAR STENT(S), CERVICAL CAROTID ARTERY, PERCUTANEOUS; WITHOUT EMBOLIC PROTECTION
37501	UNLISTED VASCULAR ENDOSCOPY PROCEDURE
37660	LIGATION OF COMMON ILIAC VEIN
37700	LIGATION AND DIVISION OF LONG SAPHENOUS VEIN AT SAPHENOFEMORAL JUNCTION, OR DISTAL INTERRUPTIONS
37718	LIGATION, DIVISION, AND STRIPPING, SHORT SAPHENOUS VEIN
37722	LIGATION, DIVISION, AND STRIPPING, LONG (GREATER) SAPHENOUS VEINS FROM SAPHENOFEMORAL JUNCTION TO KNEE OR BELOW
37735	LIGATION AND DIVISION AND COMPLETE STRIPPING OF LONG OR SHORT SAPHENOUS VEINS WITH RADICAL EXCISION OF ULCER AND SKIN GRAFT AND / OR INTERRUPTION OF COMMUNICATING VEINS OF LOWER LEG, WITH EXCISION OF DEEP FASCIA
37765	STAB PHLEBECTOMY OF VARICOSE VEINS, ONE EXTREMITY; 10-20 STAB INCISIONS
37766	STAB PHLEBECTOMY OF VARICOSE VEINS, ONE EXTREMITY; MORE THAN 20 INCISIONS
37780	LIGATION AND DIVISION OF SHORT SAPHENOUS VEIN AT SAPHENOPOPLITEAL JUNCTION
37785	LIGATION, DIVISION, AND / OR EXCISION OF RECURRENT OF SECONDARY VARICOSE VEINS (CLUSTERS), ONE LEG

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
38205	BLOOD-DERIVED HEMATOPOIETIC PROGENITOR CELL HARVESTING FOR TRANSPLANTATION, PER COLLECTION; ALLOGENIC
38206	BLOOD-DERIVED HEMATOPOIETIC PROGENITOR CELL HARVESTING FOR TRANSPLANTATION, PER COLLECTION; AUTOLOGOUS
38210	TRANSPLANT PREPARATION OF HEMATOPOIETIC PROGENITOR CELLS; SPECIFIC CELL DEPLETION WITHIN HARVEST, T-CELL DEPLETION
38230	BONE MARROW HARVESTING FOR TRANSPLANTATION
38232	BONE MARROW HARVESTING FOR TRANSPLANTATION; AUTOLOGOUS
38240	BONE MARROW OR BLOOD-DERIVED PERIPHERAL STEM CELL TRANSPLANTATION; ALLOGENIC
38241	BONE MARROW OR BLOOD-DERIVED PERIPHERAL STEM CELL TRANSPLANTATION; AUTOLOGOUS
38242	BONE MARROW OR BLOOD-DERIVED PERIPHERAL STEM CELL TRANSPLANTATION; ALLOGENEIC DONOR LYMPHOCYTE INFUSIONS
4004F	PATIENT SCREENED FOR TOBACCO USE AND RECEIVED TOBACCO CESSATION COUNSELING, IF IDENTIFIED AS A TOBACCO USER (PV)
4063F	ANTIDEPRESSANT PHARMACOTHERAPY CONSIDERED AND NOT PRESCRIBED (MDD ADOL)
40700	PLASTIC REPAIR OF CLEFT LIP / NASAL DEFORMITY; PRIMARY, PARTIAL OR COMPLETE, UNILATERAL
40701	PLASTIC REPAIR OF CLEFT LIP / NASAL DEFORMITY; PRIMARY BILATERAL, ONE STAGE PROCEDURE
40720	PLASTIC REPAIR OF CLEFT LIP / NASAL DEFORMITY; SECONDARY, BY RECREATION OF DEFECT AND RECLOSURE
40800	DRAINAGE OF ABSCESS, CYST, HEMATOMA, VESTIBULE OF MOUTH; SIMPLE
40805	REMOVAL OF EMBEDDED FOREIGN BODY, VESTIBULE OF MOUTH; COMPLICATED
40806	INCISION OF LABIAL FRENUM (FRENOTOMY)
40819	EXCISION OF FRENUM, LABIAL, OR BUCCAS (FRENUECTOMY, FRENUECTOMY, FRENUECTOMY)
40840	VESTIBULOPLASTY; ANTERIOR
40842	VESTIBULOPLASTY; POSTERIOR, UNILATERAL
40843	VESTIBULOPLASTY; POSTERIOR, BILATERAL
40844	VESTIBULOPLASTY; ENTIRE ARCH
40845	VESTIBULOPLASTY; COMPLEX (INCLUDING RIDGE EXTENSION, MUSCLE REPOSITIONING)
41010	INCISION OF LINGUAL FRENUM (FRENOTOMY)
41019	PLACEMENT OF NEEDLES, CATHETERS, OR OTHER DEVICE(S) INTO THE HEAD AND/OR NECK REGION (PERCUTANEOUS, TRANSORAL, OR TRANSNASAL) FOR SUBSEQUENT INTERSTITIAL RADIOELEMENT APPLICATION
41115	EXCISION OF LINGUAL FRENUM (FRENUECTOMY)
41520	FRENOPLASTY (SURGICAL REVISION OF FRENUM, E.G. WITH Z-PLASTY)
41800	DRAINAGE OF ABSCESS, CYST, HEMATOMA FROM DENTOALVEOLAR STRUCTURES
41805	REMOVAL OF EMBEDDED FOREIGN BODY FROM DENTOALVEOLAR STRUCTURES, SOFT TISSUE
41806	REMOVAL OF EMBEDDED FOREIGN BODY FROM DENTOALVEOLAR STRUCTURES, BONE
41820	GINGIVECTOMY, EXCISION GINGIVA, EACH QUADRANT
41821	OPERCULECTOMY, EXCISION PERICORONAL TISSUES
41828	EXCISION OF HYPERPLASTIC ALVEOLAR MUCOSA, EACH QUADRANT
41850	DESTRUCTION OF LESION (EXCEPT EXCISIONS), DENTOALVEOLAR STRUCTURES
41872	GINGIVOPLASTY, EACH QUADRANT
41874	ALVEOLOPLASTY, EACH QUADRANT
42140	UVULECTOMY, EXCISION OF UVULA
42145	PALATOPHARYNGOPLASTY (E.G. UVULOPALATOPHARYNGOPLASTY, UVULOPHARYNGOPLASTY)
42408	EXCISION OF SUBLINGUAL SALIVARY CYST (RANULA)
42500	PLASTIC REPAIR OF SALIVARY DUCT, SIALODOCHOPLASTY; PRIMARY OR SIMPLE

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
4255F	DURATION OF GENERAL OR NEURAXIAL ANESTHESIA 60 MINUTES OR LONGER, AS DOCUMENTED IN THE ANESTHESIA RECORD (CRIT)
4256F	DURATION OF GENERAL OR NEURAXIAL ANESTHESIA LESS THAN 60 MINUTES, AS DOCUMENTED IN THE ANESTHESIA RECORD (CRIT)
42600	CLOSURE SALIVARY FISTULA
43201	ESOPHAGOSCOPY, RIGID OR FLEXIBLE; WITH DIRECTED SUBMUCOSAL INJECTION(S), ANY SUBSTANCE
43236	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS, STOMACH, AND EITHER DUODENUM AND / OR JEJUNUM AS APPROPRIATE; WITH DIRECTED SUBMUCOSAL INJECTION(S), ANY SUBSTANCE
43281	LAPAROSCOPY, SURGICAL, REPAIR OF PARAESOPHAGEAL HERNIA, INCLUDES FUNDOPLASTY, WHEN PERFORMED; WITHOUT IMPLANTATION OF MESH
43282	LAPAROSCOPY, SURGICAL, REPAIR OF PARAESOPHAGEAL HERNIA, INCLUDES FUNDOPLASTY, WHEN PERFORMED; WITH IMPLANTATION OF MESH
4330F	COUNSELING ABOUT EPILEPSY SPECIFIC SAFETY ISSUES PROVIDED TO PATIENT (OR CAREGIVER (S)) (EPI)
4340F	COUNSELING FOR WOMEN OF CHILDBEARING POTENTIAL WITH EPILEPSY (EPI)
43644	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; WITH GASTRIC BYPASS AND ROUX-EN-Y GASTROENTEROSTOMY (ROUX LIMB 150 CM OR LESS)
43647	LAPAROSCOPY, SURGICAL; IMPLANTATION OR REPLACEMENT OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM
43648	LAPAROSCOPY, SURGICAL; REVISION OR REMOVAL OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM
43770	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; PLACEMENT OF ADJUSTABLE GASTRIC BAND (GASTRIC BAND AND SUBCUTANEOUS PORT COMPONENTS)
43771	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REVISION OF ADJUSTABLE GASTRIC BAND COMPONENT ONLY
43772	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REMOVAL OF ADJUSTABLE GASTRIC BAND COMPONENT ONLY
43773	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REMOVAL AND REPLACEMENT OF ADJUSTABLE GASTRIC BAND COMPONENT ONLY
43774	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REMOVAL OF ADJUSTABLE GASTRIC BAND AND SUBCUTANEOUS PORT COMPONENTS
43775	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; LONGITUDINAL GASTRECTOMY (IE, SLEEVE GASTRECTOMY)
43842	GASTRIC RESTRICTIVE PROCEDURE WITHOUT GASTRIC BYPASS, FOR MORBID OBESITY; VERTICAL BANDED GASTROPLASTY
43843	GASTRIC RESTRICTIVE PROCEDURE WITHOUT GASTRIC BYPASS, FOR MORBID OBESITY; OTHER THAN VERTICAL BANDED GASTROPLASTY
43846	GASTRIC RESTRICTIVE PROCEDURE, WITH GASTRIC BYPASS FOR MORBID OBESITY; WITH SHORT LIMB (LESS THAN 100 CM) ROUX-EN-Y GASTROENTEROSTOMY
43847	GASTRIC RESTRICTIVE PROCEDURE, WITH GASTRIC BYPASS FOR MORBID OBESITY; WITH SMALL INTESTINE RECONSTRUCTION TO LIMIT ABSORPTION
43881	IMPLANTATION OR REPLACEMENT OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM, OPEN
43882	REVISION OR REMOVAL OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM, OPEN
43886	GASTRIC RESTRICTIVE PROCEDURE, OPEN; REVISION OF SUBCUTANEOUS PORT COMPONENT ONLY
43887	GASTRIC RESTRICTIVE PROCEDURE, OPEN; REMOVAL OF SUBCUTANEOUS PORT COMPONENT ONLY
43888	GASTRIC RESTRICTIVE PROCEDURE, OPEN; REMOVAL AND REPLACEMENT OF SUBCUTANEOUS PORT COMPONENT ONLY
46505	CHEMODENERVATION OF INTERNAL ANAL SPHINCTER
47133	DONOR HEPATECTOMY (INCLUDING COLD PRESERVATION), FROM CADAVER DONOR

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
47135	LIVER ALLOTRANSPLANTATION; ORTHOTOPIC, PARTIAL OR WHOLE, FROM CADAVER OR LIVING DONOR, ANY AGE
47136	LIVER ALLOTRANSPLANTATION; HETEROTOPIC, PARTIAL OR WHOLE, FROM CADAVER OR LIVING DONOR, ANY AGE
47140	DONOR HEPATECTOMY, WITH PREPARATION AND MAINTENANCE OF ALLOGRAFT, FROM LIVING DONOR; LEFT LATERAL SEGMENT ONLY (SEGMENTS II AND III)
47141	TOTAL LEFT LOBECTOMY (SEGMENTS II, III AND IV)
47142	TOTAL RIGHT LOBECTOMY (SEGMENTS V, VI, VII AND VIII)
47370	LAPAROSCOPY, SURGICAL, ABLATION OF ONE OR MORE LIVER TUMOR(S); RADIOFREQUENCY
47371	LAPAROSCOPY, SURGICAL, ABLATION OF ONE OR MORE LIVER TUMOR(S); CRYOSURGICAL
47380	ABLATION, OPEN, OF ONE OR MORE LIVER TUMOR(S); RADIOFREQUENCY
47381	ABLATION, OPEN, OF ONE OR MORE LIVER TUMOR(S); CRYOSURGICAL
47382	ABLATION, ONE OR MORE LIVER TUMOR(S); PERCUTANEOUS, RADIOFREQUENCY
48550	DONOR PANCREATECTOMY (INCLUDING COLD PRESERVATION), WITH OR WITHOUT DUODENAL SEGMENT FOR TRANSPLANTATION
48554	TRANSPLANTATION OF PANCREATIC ALLOGRAFT
49411	PLACEMENT OF INTERSTITIAL DEVICE(S) FOR RADIATION THERAPY GUIDANCE (EG, FIDUCIAL MARKERS, DOSIMETER), PERCUTANEOUS, INTRA-ABDOMINAL, INTRA-PELVIC (EXCEPT PROSTATE), AND/OR RETROPERITONEUM, SINGLE OR MULTIPLE
49419	INSERTION OF INTRAPERITONEAL CANNULA OR CATHETER, WITH SUBCUTANEOUS RESERVOIR, PERMANENT (EG, TOTALLY IMPLANTABLE)
50250	ABLATION, OPEN, ONE OR MORE RENAL MASS LESION(S), CRYOSURGICAL, INCLUDING INTRAOPERATIVE ULTRASOUND, IF PERFORMED
50300	DONOR NEPHRECTOMY (INCLUDING COLD PRESERVATION); FROM CADAVER DONOR, UNILATERAL OR BILATERAL
50320	DONOR NEPHRECTOMY (INCLUDING COLD PRESERVATION); OPEN, FROM LIVING DONOR
50340	RECIPIENT NEPHRECTOMY (SEPARATE PROCEDURE)
50360	RENAL ALLOTRANSPLANTATION, IMPLANTATION OF GRAFT; WITHOUT RECIPIENT NEPHRECTOMY
50365	RENAL ALLOTRANSPLANTATION, IMPLANTATION OF GRAFT; WITH RECIPIENT NEPHRECTOMY
50380	RENAL AUTOTRANSPLANTATION, REIMPLANTATION OF KIDNEY
50547	LAPAROSCOPY, SURGICAL, DONOR NEPHRECTOMY FROM LIVING DONOR
50592	ABLATION, ONE OR MORE RENAL TUMOR(S), PERCUTANEOUS, UNILATERAL, RADIOFREQUENCY
50593	ABLATION, RENAL TUMOR(S), UNILATERAL, PERCUTANEOUS, CRYOTHERAPY
50800	URETEROSIGMOIDOSTOMY, WITH CREATION OF SIGMOID BLADDER AND ESTABLISHMENT OF ABDOMINAL OR PERINEAL COLOSTOMY, INCLUDING INTESTINE ANASTOMOSIS
51727	COMPLEX CYSTOMETROGRAM (IE, CALIBRATED ELECTRONIC EQUIPMENT); WITH URETHRAL PRESSURE PROFILE STUDIES (IE, URETHRAL CLOSURE PRESSURE PROFILE), ANY TECHNIQUE
51728	COMPLEX CYSTOMETROGRAM (IE, CALIBRATED ELECTRONIC EQUIPMENT); WITH VOIDING PRESSURE STUDIES (IE, BLADDER VOIDING PRESSURE), ANY TECHNIQUE
51729	COMPLEX CYSTOMETROGRAM (IE, CALIBRATED ELECTRONIC EQUIPMENT); WITH VOIDING PRESSURE STUDIES (IE, BLADDER VOIDING PRESSURE) AND URETHRAL PRESSURE PROFILE STUDIES (IE, URETHRAL CLOSURE PRESSURE PROFILE), ANY TECHNIQUE
5200F	CONSIDERATION OF REFERRAL FOR A NEUROLOGICAL EVALUATION OF APPROPRIATENESS FOR SURGICAL THERAPY FOR INTRACTABLE EPILEPSY WITHIN THE PAST 3 YEARS (EPI)
52250	CYSTOURETHROSCOPY WITH INSERTION OF RADIOACTIVE SUBSTANCE, WITH OR WITHOUT BIOPSY OR FULGURATION
52649	LASER ENUCLEATION OF THE PROSTATE WITH MORCELLATION, INCLUDING CONTROL OF POSTOPERATIVE BLEEDING, COMPLETE (VASECTOMY, MEATOTOMY, CYSTOURETHROSCOPY, URETHRAL CALIBRATION AND/OR DILATION, INTERNAL URETHROTOMY AND TRANSURETHRAL RESECTION OF

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
	PROSTATE ARE INC
53855	INSERTION OF A TEMPORARY PROSTATIC URETHRAL STENT, INCLUDING URETHRAL MEASUREMENT
53860	TRANSURETHRAL RADIOFREQUENCY MICRO-REMODELING OF THE FEMALE BLADDER NECK AND PROXIMAL URETHRA FOR STRESS URINARY INCONTINENCE
54164	FRENULOTOMY OF PENIS
55875	TRANSPERINEAL PLACEMENT OF NEEDLES OR CATHETERS INTO PROSTATE FOR INTERSTITIAL RADIOELEMENT APPLICATION, WITH OR WITHOUT CYSTOSCOPY
55876	PLACEMENT OF INTERSTITIAL DEVICE(S) FOR RADIATION THERAPY GUIDANCE (EG, FIDUCIAL MARKERS, DOSIMETER), PROSTATE (VIA NEEDLE, ANY APPROACH), SINGLE OR MULTIPLE
55876	PLACEMENT OF INTERSTITIAL DEVICE(S) FOR RADIATION THERAPY GUIDANCE (EG, FIDUCIAL MARKERS, DOSIMETER), PROSTATE (VIA NEEDLE, ANY APPROACH), SINGLE OR MULTIPLE
56800	PLASTIC REPAIR OF INTROITUS
57285	PARAVAGINAL DEFECT REPAIR (INCLUDING REPAIR OF CYSTOCELE, IF PERFORMED); VAGINAL APPROACH
57415	REMOVAL OF IMPACTED VAGINAL FOREIGN BODY (SEPARATE PROCEDURE) UNDER ANESTHESIA
57423	PARAVAGINAL DEFECT REPAIR (INCLUDING REPAIR OF CYSTOCELE, IF PERFORMED), LAPAROSCOPIC APPROACH
58150	TOTAL ABDOMINAL HYSTERECTOMY (CORPUS AND CERVIX), WITH OR WITHOUT REMOVAL OF TUBE(S), WITH OR WITHOUT REMOVAL OF OVARY(S)
58180	SUPRACERVICAL ABDOMINAL HYSTERECTOMY (SUBTOTAL HYSTERECTOMY), WITH OR WITHOUT REMOVAL OF TUBE(S), WITH OR WITHOUT REMOVAL OF OVARY(S)
58200	TOTAL ABDOMINAL HYSTERECTOMY, INCLUDING PARTIAL VAGINECTOMY, WITH PARA-AORTIC AND PELVIC LYMPH NODE SAMPLING, WITH OR WITHOUT REMOVAL OF TUBE(S), WITH OR WITHOUT REMOVAL OF OVARY(S)
58260	VAGINAL HYSTERECTOMY, FOR UTERUS 250 GRAMS OR LESS
58262	VAGINAL HYSTERECTOMY, FOR UTERUS 250 GRAMS OR LESS; WITH REMOVAL OF TUBE(S), AND/OR OVARY(S)
58263	VAGINAL HYSTERECTOMY, FOR UTERUS 250 GRAMS OR LESS; WITH REMOVAL OF TUBE(S), AND/OR OVARY(S), WITH REPAIR OF ENTEROCELE
58270	VAGINAL HYSTERECTOMY, FOR UTERUS 250 GRAMS OR LESS; WITH REPAIR OF ENTEROCELE
58290	VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 GRAMS
58291	VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 GRAMS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
58294	VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 GRAMS; WITH REPAIR OF ENTEROCELE
58321	ARTIFICIAL INSEMINATION; INTRA-CERVICAL
58322	ARTIFICIAL INSEMINATION; INTRA-UTERINE
58323	SPERM WASHING FOR ARTIFICIAL INSEMINATION
58541	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS
58542	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
58543	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G
58544	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 GRAMS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
58550	LAPAROSCOPY SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS 250 GRAMS OR LESS
58552	LAPAROSCOPY SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS 250 GRAMS OR LESS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
58553	LAPAROSCOPY, SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 GRAMS
58554	LAPAROSCOPY, SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 GRAMS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
59072	FETAL UMBILICAL CORD OCCLUSION, INCLUDING ULTRASOUND GUIDANCE
59076	FETAL SHUNT PLACEMENT, INCLUDING ULTRASOUND GUIDANCE
6070F	PATIENT QUERIED AND COUNSELED ABOUT ANTI-EPILEPTIC DRUG (AED) SIDE EFFECTS (EPI)
61796	STEREOTACTIC RADIOSURGERY (PARTIAL BEAM, GAMMA RAY, OR LINEAR ACCELERATOR); 1 SIMPLE CRANIAL LESION
61797	STEREOTACTIC RADIOSURGERY (PARTIAL BEAM, GAMMA RAY, OR LINEAR ACCELERATOR); EACH ADDITIONAL CRANIAL LESION, SIMPLE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
61798	STEREOTACTIC RADIOSURGERY (PARTIAL BEAM, GAMMA RAY, OR LINEAR ACCELERATOR); 1 COMPLEX CRANIAL LESION
61799	STEREOTACTIC RADIOSURGERY (PARTIAL BEAM, GAMMA RAY, OR LINEAR ACCELERATOR); EACH ADDITIONAL CRANIAL LESION, COMPLEX (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
61800	APPLICATION OF STEREOTACTIC HEADFRAME FOR STEREOTACTIC RADIOSURGERY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
61863	TWIST DRILL, BURR HOLE, CRANIOTOMY, OR CRANIECTOMY WITH STEREOTACTIC IMPLANATION OF NEUROSTIMULATOR EDLECTRODE ARRAY IN SUBCORTICAL SITE (EG, THALAMUS, GLOBUS, PALLIDUS, SUBTHALAMIC NUCLEUS, PERIVENTRICULAR, PERIAQUEDUCTAL GRAY), WITHOUT USE OF INTRAOPERATIVE MICROELECTRODE RECORDING; FIRST ARRAY
61864	TWIST DRILL, BURR HOLE, CRANIOTOMY, OR CRANIECTOMY WITH STEREOTACTIC IMPLANATION OF NEUROSTIMULATOR EDLECTRODE ARRAY IN SUBCORTICAL SITE (EG, THALAMUS, GLOBUS, PALLIDUS, SUBTHALAMIC NUCLEUS, PERIVENTRICULAR, PERIAQUEDUCTAL GRAY), WITHOUT USE OF INTRAOPERATIVE MICROELECTRODE RECORDING; EACH ADDITIONAL ARRAY (LIST SEPARATELY IN ADDITION TO PRIMARY PROCEDURE)
61867	TWIST DRILL, BURR HOLE, CRANIOTOMY, OR CRANIECTOMY WITH STEREOTACTIC IMPLANATION OF NEUROSTIMULATOR EDLECTRODE ARRAY IN SUBCORTICAL SITE (EG, THALAMUS, GLOBUS, PALLIDUS, SUBTHALAMIC NUCLEUS, PERIVENTRICULAR, PERIAQUEDUCTAL GRAY), WITH USE OF INTRAOPERATIVE MICROELECTRODE RECORDING; FIRST ARRAY
61868	TWIST DRILL, BURR HOLE, CRANIOTOMY, OR CRANIECTOMY WITH STEREOTACTIC IMPLANATION OF NEUROSTIMULATOR EDLECTRODE ARRAY IN SUBCORTICAL SITE (EG, THALAMUS, GLOBUS, PALLIDUS, SUBTHALAMIC NUCLEUS, PERIVENTRICULAR, PERIAQUEDUCTAL GRAY), WITH USE OF INTRAOPERATIVE MICROELECTRODE RECORDING; EACH ADDITIONAL ARRAY (LIST SEPARATELY IN ADDITION TO PRIMARY PROCEDURE)
61880	REVISION OR REMOVAL OF INTRACRANIAL NEUROSTIMULATOR ELECTRODES
61885	INCISION AND SUBCUTANEOUS PLACEMENT OF CRANIAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, DIRECT OR INDUCTIVE COUPLING; WITH CONNECTION TO A SINGLE ELECTRODE ARRAY
61886	INCISION AND SUBCUTANEOUS PLACEMENT OF CRANIAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, DIRECT OR INDUCTIVE COUPLING; WITH CONNECTION TO TWO OR MORE ELECTRODE ARRAYS
61888	REVISION OR REMOVAL OF CRANIAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER
62264	PERCUTANEOUS LYSIS OF EPIDURAL ADHESIONS USING SOLUTION INJECTION OR MECHANICAL MEANS INCLUDING RADIOLOGIC LOCALIZATION, MULTIPLE ADHESIOLYSIS SESSIONS, 1 DAY (NOT COVERED FOR COMMERCIAL PLAN MEMBERS)
62287	DECOMPRESSION PROCEDURE, PERCUTANEOUS, OF NUCLEUS PULPOSUS OF INTERVERTEBRAL DISC, ANY METHOD, SINGLE OR MULTIPLE LEVELS, LUMBAR (EG, MANUAL OR AUTOMATED PERCUTANEOUS DISCECTOMY, PERCUTANEOUS LASER DISCECTOMY)

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
62292	INJECTION PROCEDURE FOR CHEMONUCLEOLYSIS, INCLUDING DISKOGRAPHY, INTERVERTEBRAL DISK, SINGLE OR MULTIPLE LEVELS, LUMBAR
63001	LAMINECTOMY WITH EXPLORATION AND/OR DECOMPRESSION OF SPINAL CORD AND/OR CAUDA EQUINA, WITHOUT FACETECTOMY, FORAMINOTOMY OR DISCECTOMY (EG, SPINAL STENOSIS), 1 OR 2 VERTEBRAL SEGMENTS; CERVICAL
63015	LAMINECTOMY WITH EXPLORATION AND/OR DECOMPRESSION OF SPINAL CORD AND/OR CAUDA EQUINA, WITHOUT FACETECTOMY, FORAMINOTOMY OR DISCECTOMY (EG, SPINAL STENOSIS), MORE THAN 2 VERTEBRAL SEGMENTS; CERVICAL
63020	LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF NERVE ROOT(S), INCLUDING PARTIAL FACETECTOMY, FORAMINOTOMY AND/OR EXCISION OF HERNIATED INTERVERTEBRAL DISC, INCLUDING OPEN AND ENDOSCOPICALLY-ASSISTED APPROACHES; 1 INTERSPACE, CERVICAL
63030	LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF NERVE ROOT(S), INCLUDING PARTIAL FACETECTOMY, FORAMINOTOMY AND/OR EXCISION OF HERNIATED INTERVERTEBRAL DISC, INCLUDING OPEN AND ENDOSCOPICALLY-ASSISTED APPROACHES; 1 INTERSPACE, LUMBAR
63040	LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF NERVE ROOT(S), INCLUDING PARTIAL FACETECTOMY, FORAMINOTOMY AND/OR EXCISION OF HERNIATED INTERVERTEBRAL DISC, REEXPLORATION, SINGLE INTERSPACE; CERVICAL
63042	LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF NERVE ROOT(S), INCLUDING PARTIAL FACETECTOMY, FORAMINOTOMY AND/OR EXCISION OF HERNIATED INTERVERTEBRAL DISC, REEXPLORATION, SINGLE INTERSPACE; LUMBAR
63045	LAMINECTOMY, FACETECTOMY AND FORAMINOTOMY (UNILATERAL OR BILATERAL WITH DECOMPRESSION OF SPINAL CORD, CAUDA EQUINA AND/OR NERVE ROOT[S], [EG, SPINAL OR LATERAL RECESS STENOSIS]), SINGLE VERTEBRAL SEGMENT; CERVICAL
63050	LAMINOPLASTY, CERVICAL, WITH DECOMPRESSION OF THE SPINAL CORD, 2 OR MORE VERTEBRAL SEGMENTS;
63051	LAMINOPLASTY, CERVICAL, WITH DECOMPRESSION OF THE SPINAL CORD, 2 OR MORE VERTEBRAL SEGMENTS; WITH RECONSTRUCTION OF THE POSTERIOR BONY ELEMENTS (INCLUDING THE APPLICATION OF BRIDGING BONE GRAFT AND NON-SEGMENTAL FIXATION DEVICES (EG, WIRE, SUTURE, MINI-PLATES), WHEN PERFORMED)
63075	DISCECTOMY, ANTERIOR, WITH DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOT(S), INCLUDING OSTEOPHYTECTOMY; CERVICAL, SINGLE INTERSPACE
63076	DISCECTOMY, ANTERIOR, WITH DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOT(S), INCLUDING OSTEOPHYTECTOMY; CERVICAL, EACH ADDITIONAL INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
63081	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, ANTERIOR APPROACH WITH DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOT(S); CERVICAL, SINGLE SEGMENT
63082	VERTEBRAL CORPECTOMY (VERTEBRAL BODY RESECTION), PARTIAL OR COMPLETE, ANTERIOR APPROACH WITH DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOT(S); CERVICAL, EACH ADDITIONAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
63620	STEREOTACTIC RADIOSURGERY (PARTICLE BEAM, GAMMA RAY, OR LINEAR ACCELERATOR); 1 SPINAL LESION
63621	STEREOTACTIC RADIOSURGERY (PARTICLE BEAM, GAMMA RAY, OR LINEAR ACCELERATOR); EACH ADDITIONAL SPINAL LESION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
63650	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY, EPIDURAL
63655	LAMINECTOMY FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES, PLATE / PADDLE, EPIDURAL
63685	INCISION AND SUBCUTANEOUS PLACEMENT OF SPINAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, DIRECT OR INDUCTIVE COUPLING
63688	REVISION OR REMOVAL OF IMPLANTED SPINAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER
64435	INJECTION, ANESTHETIC AGENT; PARACERVICAL (UTERINE) NERVE
64455	INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, PLANTAR COMMON DIGITAL NERVE(S) (EG, MORTON'S NEUROMA)

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
64479	INJECTION, ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL; CERVICAL OR THORACIC, SINGLE LEVEL
64490	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), CERVICAL OR THORACIC; SINGLE LEVEL
64491	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), CERVICAL OR THORACIC; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
64492	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), CERVICAL OR THORACIC; THIRD AND ANY ADDITIONAL LEVEL(S) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
64493	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; SINGLE LEVEL
64494	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
64495	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; THIRD AND ANY ADDITIONAL LEVEL(S) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
64505	INJECTION, ANESTHETIC AGENT; SPHENOPALATINE GANGLION
64517	INJECTION, ANESTHETIC AGENT; SUPERIOR HYPOGASTRIC PLEXUS
64561	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES, SACRAL NERVE
64565	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES, NEUROMUSCULAR
64568	INCISION FOR IMPLANTATION OF CRANIAL NERVE (EG, VAGUS NERVE) NEUROSTIMULATOR ELECTRODE ARRAY AND PULSE GENERATOR
64569	REVISION OR REPLACEMENT OF CRANIAL NERVE (EG, VAGUS NERVE) NEUROSTIMULATOR ELECTRODE ARRAY, INCLUDING CONNECTION TO EXISTING PULSE GENERATOR
64573	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; CRANIAL NERVE
64575	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES, PERIPHERAL NERVE (EXCLUDES SACRAL NERVE)
64581	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES, SACRAL NERVE
64585	REVISION OR REMOVAL OF PERIPHERAL NEUROSTIMULATOR ELECTRODES
64590	INCISION AND SUBCUTANEOUS PLACEMENT OF PERIPHERAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, DIRECT OR INDUCTIVE COUPLING
64595	REVISION OR REMOVAL OF PERIPHERAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER
64612	CHEMODENERVATION OF MUSCLE(S); MUSCLE(S) INNERVATED BY FACIAL NERVE (EG, FOR BLEPHAROSPASM, HEMIFACIAL SPASM)
64613	CHEMODENERVATION OF MUSCLE(S); NECK MUSCLE(S) (EG, FOR SPASMODIC TORTICOLLIS, SPASMODIC DYSPHONIA)
64614	CHEMODENERVATION OF MUSCLE(S); EXTREMITY(S) AND/OR TRUNK MUSCLE(S) (EG, FOR DYSTONIA, CEREBRAL PALSY, MULTIPLE SCLEROSIS)
64650	CHEMODENERVATION OF ECCRINE GLANDS; BOTH AXILLAE
64653	CHEMODENERVATION OF ECCRINE GLANDS; OTHER AREA(S) (EG, SCALP, FACE, NECK), PER DAY
65710	KERATOPLASTY (CORNEAL TRANSPLANT); LAMELLAR
65730	KERATOPLASTY (CORNEAL TRANSPLANT); PENETRATING (EXCEPT IN APHAKIA)
65750	KERATOPLASTY (CORNEAL TRANSPLANT); PENETRATING (IN APHAKIA)
65755	KERATOPLASTY (CORNEAL TRANSPLANT); PENETRATING (IN PSEUDOPHAKIA)

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
65756	KERATOPLASTY (CORNEAL TRANSPLANT); ENDOTHELIAL
65757	BACKBENCH PREPARATION OF CORNEAL ENDOTHELIAL ALLOGRAFT PRIOR TO TRANSPLANTATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
65760	KERATOMILEUSIS
65765	KERATOPHAKIA
65767	EPIKERATOPLASTY
65770	KERATOPROSTHESIS
65771	RADIAL KERATOTOMY
65778	PLACEMENT OF AMNIOTIC MEMBRANE ON THE OCULAR SURFACE FOR WOUND HEALING; SELF-RETAINING
65779	PLACEMENT OF AMNIOTIC MEMBRANE ON THE OCULAR SURFACE FOR WOUND HEALING; SINGLE LAYER, SUTURED
65780	OCULAR SURFACE RECONSTRUCTION; AMNIOTIC MEMBRANE TRANSPLANTATION
65781	OCULAR SURFACE RECONSTRUCTION; LIMBAL STEM CELL ALLOGRAFT (EG, CADAVERIC OR LIVING DONOR)
65782	OCULAR SURFACE RECONSTRUCTION; LIMBAL CONJUNCTIVAL AUTOGRAFT (INCLUDES OBTAINING GRAFT)
67221	DESTRUCTION OF LOCALIZED LESION OF CHOROID; PHOTODYNAMIC THERAPY (INCLUDES INTRAVENOUS INFUSION)
67225	DESTRUCTION OF LOCALIZED LESION OF CHOROID; PHOTODYNAMIC THERAPY, SECOND EYE, AT SINGLE SESSION
67345	CHEMODENERVATION OF EXTRAOCULAR MUSCLE
67900	REPAIR BROW PTOSIS (SUPRACILIARY, MID-FOREHEAD, OR CORONAL APPROACH)
67901	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH SUTURE OR OTHER MATERIAL
67902	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH FASCIAL SLING (INCLUDES OBTAINING FASCIA)
67903	REPAIR OF BLEPHAROPTOSIS; (TARSO) LEVATOR RESECTION OF ADVANCEMENT, INTERNAL APPROACH
67904	REPAIR OF BLEPHAROPTOSIS; (TARSO) LEVATOR RESECTION OF ADVANCEMENT, EXTERNAL APPROACH
67906	REPAIR OF BLEPHAROPTOSIS; SUPERIOR RECTUS TECHNIQUE WITH FASCIAL SLING (INCLUDES OBTAINING FASCIA)
67908	REPAIR OF BLEPHAROPTOSIS; CONJUNCTIVO-TARSO-MULLER'S MUSCLE-LEVATOR RESECTION
67909	REDUCTION OF OVERCORRECTION OF PTOSIS
67961	EXCISION AND REPAIR OF EYELID, INVOLVING LID MARGIN, TARSUS, CONJUNCTIVA, CANTHUS, OR FULL THICKNESS, MAY INCLUDE PREPARATION FOR SKIN GRAFT OR PEDICLE FLAP WITH ADJACENT TISSUE TRANSFER OR REARRANGEMENT, UP TO ONE-FOURTH OF LID MARGIN
67966	EXCISION AND REPAIR OF EYELID, INVOLVING LID MARGIN, TARSUS, CONJUNCTIVA, CANTHUS, OR FULL THICKNESS, MAY INCLUDE PREPARATION FOR SKIN GRAFT OR PEDICLE FLAP WITH ADJACENT TISSUE TRANSFER OR REARRANGEMENT, OVER ONE-FOURTH OF LID MARGIN
67971	RECONSTRUCTION OF AN EYELID, FULL THICKNESS BY TRANSFER OF TARSOCONJUNCTIVAL FLAP FROM OPPOSING EYELID; UP TO TWO THIRDS OF EYELID, ONE STAGE OR FIRST STAGE
67973	RECONSTRUCTION OF AN EYELID, FULL THICKNESS BY TRANSFER OF TARSOCONJUNCTIVAL FLAP FROM OPPOSING EYELID; TOTAL EYELID, LOWER, ONE STAGE OR FIRST STAGE
67974	RECONSTRUCTION OF AN EYELID, FULL THICKNESS BY TRANSFER OF TARSOCONJUNCTIVAL FLAP FROM OPPOSING EYELID; TOTAL EYELID, UPPER, ONE STAGE OR FIRST STAGE
67975	RECONSTRUCTION OF AN EYELID, FULL THICKNESS BY TRANSFER OF TARSOCONJUNCTIVAL FLAP FROM OPPOSING EYELID; SECOND STAGE
68371	HARVESTING CONJUNCTIVAL ALOGRAFT, LIVING DONOR
69090	EAR PIERCING

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
69300	OTOPLASTY, PROTRUDING EAR, WITH OR WITHOUT SIZE REDUCTION
69930	COCHLEAR DEVICE IMPLANT, WITH OR WITHOUT MASTOIDECTOMY
74174	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, ABDOMEN AND PELVIS, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING
74176	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL
74177	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITH CONTRAST MATERIAL(S)
74178	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL IN ONE OR BOTH BODY REGIONS, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS IN ONE OR BOTH BODY REGIONS
74261	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, DIAGNOSTIC, INCLUDING IMAGE POSTPROCESSING; WITHOUT CONTRAST MATERIAL
74262	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, DIAGNOSTIC, INCLUDING IMAGE POSTPROCESSING; WITH CONTRAST MATERIAL(S) INCLUDING NON-CONTRAST IMAGES, IF PERFORMED
75565	CARDIAC MAGNETIC RESONANCE IMAGING FOR VELOCITY FLOW MAPPING (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
75571	COMPUTED TOMOGRAPHY, HEART, WITHOUT CONTRAST MATERIAL, WITH QUANTITATIVE EVALUATION OF CORONARY CALCIUM
75572	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL, FOR EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY (INCLUDING 3D IMAGE POSTPROCESSING, ASSESSMENT OF CARDIAC FUNCTION, AND EVALUATION OF VENOUS STRUCTURES, IF PERFORMED)
75573	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL, FOR EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY IN THE SETTING OF CONGENITAL HEART DISEASE (INCLUDING 3D IMAGE POSTPROCESSING, ASSESSMENT OF LV CARDIAC FUNCTION, RV STRUCTURE AND FUNCTION AND EVALUATION OF VENOUS STRUCTURES, IF PERFORMED)
75574	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, HEART, CORONARY ARTERIES AND BYPASS GRAFTS (WHEN PRESENT), WITH CONTRAST MATERIAL, INCLUDING 3D IMAGE POSTPROCESSING (INCLUDING EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY, ASSESSMENT OF CARDIAC FUNCTION, AND EVALUATION OF VENOUS STRUCTURES, IF PERFORMED)
75791	ANGIOGRAPHY, ARTERIOVENOUS SHUNT (EG, DIALYSIS PATIENT FISTULA/GRAFT), COMPLETE EVALUATION OF DIALYSIS ACCESS, INCLUDING FLUOROSCOPY, IMAGE DOCUMENTATION AND REPORT (INCLUDES INJECTIONS OF CONTRAST AND ALL NECESSARY IMAGING FROM THE ARTERIAL ANASTOMOSIS AND ADJACENT ARTERY THROUGH ENTIRE VENOUS OUTFLOW INCLUDING THE INFERIOR OR SUPERIOR VENA CAVA), RADIOLOGICAL SUPERVISION AND INTERPRETATION
75954	ENDOVASCULAR REPAIR OF ILIAC ARTERY ANEURYSM , PSEUDOANEURYSM, ARTERIOVENOUS MALFORMATION, OR TRAUMA, RADIOLOGICAL SUPERVISION AND INTERPRETATION
76940	ULTRASOUND GUIDANCE FOR, AND MONITORING FOR, VISCERAL TISSUE ABLATION
77338	MULTI-LEAF COLLIMATOR (MLC) DEVICE(S) FOR INTENSITY MODULATED RADIATION THERAPY (IMRT), DESIGN AND CONSTRUCTION PER IMRT PLAN
78451	MYOCARDIAL PERFUSION IMAGING, TOMOGRAPHIC (SPECT) (INCLUDING ATTENUATION CORRECTION, QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); SINGLE STUDY, AT REST OR STRESS (EXERCISE OR PHARMACOLOGIC)
78452	MYOCARDIAL PERFUSION IMAGING, TOMOGRAPHIC (SPECT) (INCLUDING ATTENUATION CORRECTION, QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); MULTIPLE STUDIES, AT REST AND/OR STRESS (EXERCISE OR PHARMACOLOGIC) AND/OR REDISTRIBUTION AND/OR REST REINJECTION
78453	MYOCARDIAL PERFUSION IMAGING, PLANAR (INCLUDING QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); SINGLE STUDY, AT REST OR STRESS (EXERCISE OR PHARMACOLOGIC)
78454	MYOCARDIAL PERFUSION IMAGING, PLANAR (INCLUDING QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); MULTIPLE STUDIES, AT REST AND/OR STRESS (EXERCISE OR PHARMACOLOGIC) AND/OR

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
	REDISTRIBUTION AND/OR REST REINJECTION
79403	RADIOPHARMACEUTICAL THERAPY, RADIOLABELED MONOCLONAL ANTIBODY BY INTRAVENOUS INFUSION
80104	DRUG SCREEN, QUALITATIVE; MULTIPLE DRUG CLASSES OTHER THAN CHROMATOGRAPHIC METHOD, EACH PROCEDURE
81200	ASPA (ASPARTOACYLASE) (EG, CANAVAN DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, E285A, Y231X)
81205	BCKDHB (BRANCHED-CHAIN KETO ACID DEHYDROGENASE E1, BETA POLYPEPTIDE) (EG, MAPLE SYRUP URINE DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, R183P, G278S, E422X)
81206	BCR/ABL1 (T(9;22)) (EG, CHRONIC MYELOGENOUS LEUKEMIA) TRANSLOCATION ANALYSIS; MAJOR BREAKPOINT, QUALITATIVE OR QUANTITATIVE
81207	BCR/ABL1 (T(9;22)) (EG, CHRONIC MYELOGENOUS LEUKEMIA) TRANSLOCATION ANALYSIS; MINOR BREAKPOINT, QUALITATIVE OR QUANTITATIVE
81208	BCR/ABL1 (T(9;22)) (EG, CHRONIC MYELOGENOUS LEUKEMIA) TRANSLOCATION ANALYSIS; OTHER BREAKPOINT, QUALITATIVE OR QUANTITATIVE
81209	BLM (BLOOM SYNDROME, RECO HELICASE-LIKE) (EG, BLOOM SYNDROME) GENE ANALYSIS, 2281DEL6INS7 VARIANT
81210	BRAF (V-RAF MURINE SARCOMA VIRAL ONCOGENE HOMOLOG B1) (EG, COLON CANCER), GENE ANALYSIS, V600E VARIANT
81211	BRCA1, BRCA2 (BREAST CANCER 1 AND 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS AND COMMON DUPLICATION/DELETION VARIANTS IN BRCA1 (IE, EXON 13 DEL 3.835KB, EXON 13 DUP 6KB, EXON 14-20 DEL 26KB, EXON 22 DEL 510BP, EXON 8-9 DEL 7.1KB)
81212	BRCA1, BRCA2 (BREAST CANCER 1 AND 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; 185DEL6, 5385INSC, 6174DEL7 VARIANTS
81213	BRCA1, BRCA2 (BREAST CANCER 1 AND 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; UNCOMMON DUPLICATION/DELETION VARIANTS
81214	BRCA1 (BREAST CANCER 1) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS AND COMMON DUPLICATION/DELETION VARIANTS (IE, EXON 13 DEL 3.835KB, EXON 13 DUP 6KB, EXON 14-20 DEL 26KB, EXON 22 DEL 510BP, EXON 8-9 DEL 7.1KB)
81215	BRCA1 (BREAST CANCER 1) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; KNOWN FAMILIAL VARIANT
81216	BRCA2 (BREAST CANCER 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS
81217	BRCA2 (BREAST CANCER 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; KNOWN FAMILIAL VARIANT
81220	CFTR (CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR) (EG, CYSTIC FIBROSIS) GENE ANALYSIS; COMMON VARIANTS (EG, ACMG/ACOG GUIDELINES)
81221	CFTR (CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR) (EG, CYSTIC FIBROSIS) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS
81222	CFTR (CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR) (EG, CYSTIC FIBROSIS) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS
81223	CFTR (CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR) (EG, CYSTIC FIBROSIS) GENE ANALYSIS; FULL GENE SEQUENCE
81224	CFTR (CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR) (EG, CYSTIC FIBROSIS) GENE ANALYSIS; INTRON 8 POLY-T ANALYSIS (EG, MALE INFERTILITY)
81225	CYP2C19 (CYTOCHROME P450, FAMILY 2, SUBFAMILY C, POLYPEPTIDE 19) (EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *2, *3, *4, *8, *17)
81226	CYP2D6 (CYTOCHROME P450, FAMILY 2, SUBFAMILY D, POLYPEPTIDE 6) (EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)
81227	CYP2C9 (CYTOCHROME P450, FAMILY 2, SUBFAMILY C, POLYPEPTIDE 9) (EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *2, *3, *5, *6)
81228	CYTOGENOMIC CONSTITUTIONAL (GENOME-WIDE) MICROARRAY ANALYSIS; INTERROGATION OF

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
	GENOMIC REGIONS FOR COPY NUMBER VARIANTS (EG, BACTERIAL ARTIFICIAL CHROMOSOME [BAC] OR OLIGO-BASED COMPARATIVE GENOMIC HYBRIDIZATION [CGH] MICROARRAY ANALYSIS)
81229	CYTOGENOMIC CONSTITUTIONAL (GENOME-WIDE) MICROARRAY ANALYSIS; INTERROGATION OF GENOMIC REGIONS FOR COPY NUMBER AND SINGLE NUCLEOTIDE POLYMORPHISM (SNP) VARIANTS FOR CHROMOSOMAL ABNORMALITIES
81240	F2 (PROTHROMBIN, COAGULATION FACTOR II) (EG, HEREDITARY HYPERCOAGULABILITY) GENE ANALYSIS, 20210G>A VARIANT
81241	F5 (COAGULATION FACTOR V) (EG, HEREDITARY HYPERCOAGULABILITY) GENE ANALYSIS, LEIDEN VARIANT
81242	FANCC (FANCONI ANEMIA, COMPLEMENTATION GROUP C) (EG, FANCONI ANEMIA, TYPE C) GENE ANALYSIS, COMMON VARIANT (EG, IVS4+4A>T)
81243	FMR1 (FRAGILE X MENTAL RETARDATION 1) (EG, FRAGILE X MENTAL RETARDATION) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES
81244	FMR1 (FRAGILE X MENTAL RETARDATION 1) (EG, FRAGILE X MENTAL RETARDATION) GENE ANALYSIS; CHARACTERIZATION OF ALLELES (EG, EXPANDED SIZE AND METHYLATION STATUS)
81245	FLT3 (FMS-RELATED TYROSINE KINASE 3) (EG, ACUTE MYELOID LEUKEMIA), GENE ANALYSIS, INTERNAL TANDEM DUPLICATION (ITD) VARIANTS (IE, EXONS 14, 15)
81250	G6PC (GLUCOSE-6-PHOSPHATASE, CATALYTIC SUBUNIT) (EG, GLYCOGEN STORAGE DISEASE, TYPE 1A, VON GIERKE DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, R83C, Q347X)
81251	GBA (GLUCOSIDASE, BETA, ACID) (EG, GAUCHER DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, N370S, 84GG, L444P, IVS2+1G>A)
81255	HEXA (HEXOSAMINIDASE A [ALPHA POLYPEPTIDE]) (EG, TAY-SACHS DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, 1278INSTATC, 1421+1G>C, G269S)
81256	HFE (HEMOCHROMATOSIS) (EG, HEREDITARY HEMOCHROMATOSIS) GENE ANALYSIS, COMMON VARIANTS (EG, C282Y, H63D)
81257	HBA1/HBA2 (ALPHA GLOBIN 1 AND ALPHA GLOBIN 2) (EG, ALPHA THALASSEMIA, HB BART HYDROPS FETALIS SYNDROME, HBH DISEASE), GENE ANALYSIS, FOR COMMON DELETIONS OR VARIANT (EG, SOUTHEAST ASIAN, THAI, FILIPINO, MEDITERRANEAN, ALPHA3.7, ALPHA4.2, ALPHA20.5, AND CONSTANT SPRING)
81260	IKBKAP (INHIBITOR OF KAPPA LIGHT POLYPEPTIDE GENE ENHANCER IN B-CELLS, KINASE COMPLEX-ASSOCIATED PROTEIN) (EG, FAMILIAL DYSAUTONOMIA) GENE ANALYSIS, COMMON VARIANTS (EG, 2507+6T>C, R696P)
81261	IGH@ (IMMUNOGLOBULIN HEAVY CHAIN LOCUS) (EG, LEUKEMIAS AND LYMPHOMAS, B-CELL), GENE REARRANGEMENT ANALYSIS TO DETECT ABNORMAL CLONAL POPULATION(S); AMPLIFIED METHODOLOGY (EG, POLYMERASE CHAIN REACTION)
81262	IGH@ (IMMUNOGLOBULIN HEAVY CHAIN LOCUS) (EG, LEUKEMIAS AND LYMPHOMAS, B-CELL), GENE REARRANGEMENT ANALYSIS TO DETECT ABNORMAL CLONAL POPULATION(S); DIRECT PROBE METHODOLOGY (EG, SOUTHERN BLOT)
81263	IGH@ (IMMUNOGLOBULIN HEAVY CHAIN LOCUS) (EG, LEUKEMIA AND LYMPHOMA, B-CELL), VARIABLE REGION SOMATIC MUTATION ANALYSIS
81264	IGK@ (IMMUNOGLOBULIN KAPPA LIGHT CHAIN LOCUS) (EG, LEUKEMIA AND LYMPHOMA, B-CELL), GENE REARRANGEMENT ANALYSIS, EVALUATION TO DETECT ABNORMAL CLONAL POPULATION(S)
81265	COMPARATIVE ANALYSIS USING SHORT TANDEM REPEAT (STR) MARKERS; PATIENT AND COMPARATIVE SPECIMEN (EG, PRE-TRANSPLANT RECIPIENT AND DONOR GERMLINE TESTING, POST-TRANSPLANT NON-HEMATOPOIETIC RECIPIENT GERMLINE [EG, BUCCAL SWAB OR OTHER GERMLINE TISSUE SAMPLE] AND DONOR TESTING, TWIN ZYGOSITY TESTING, OR MATERNAL CELL CONTAMINATION OF FETAL CELLS)
81266	COMPARATIVE ANALYSIS USING SHORT TANDEM REPEAT (STR) MARKERS; EACH ADDITIONAL SPECIMEN (EG, ADDITIONAL CORD BLOOD DONOR, ADDITIONAL FETAL SAMPLES FROM DIFFERENT CULTURES, OR ADDITIONAL ZYGOSITY IN MULTIPLE BIRTH PREGNANCIES) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
81267	CHIMERISM (ENGRAFTMENT) ANALYSIS, POST TRANSPLANTATION SPECIMEN (EG, HEMATOPOIETIC STEM CELL), INCLUDES COMPARISON TO PREVIOUSLY PERFORMED BASELINE ANALYSES; WITHOUT CELL SELECTION

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
81268	CHIMERISM (ENGRAFTMENT) ANALYSIS, POST TRANSPLANTATION SPECIMEN (EG, HEMATOPOIETIC STEM CELL), INCLUDES COMPARISON TO PREVIOUSLY PERFORMED BASELINE ANALYSES; WITH CELL SELECTION (EG, CD3, CD33), EACH CELL TYPE
81270	JAK2 (JANUS KINASE 2) (EG, MYELOPROLIFERATIVE DISORDER) GENE ANALYSIS, P.VAL617PHE (V617F) VARIANT
81275	KRAS (V-KI-RAS2 KIRSTEN RAT SARCOMA VIRAL ONCOGENE) (EG, CARCINOMA) GENE ANALYSIS, VARIANTS IN CODONS 12 AND 13
81280	LONG QT SYNDROME GENE ANALYSES (EG, KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, AND ANK2); FULL SEQUENCE ANALYSIS
81281	LONG QT SYNDROME GENE ANALYSES (EG, KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, AND ANK2); KNOWN FAMILIAL SEQUENCE VARIANT
81282	LONG QT SYNDROME GENE ANALYSES (EG, KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, AND ANK2); DUPLICATION/DELETION VARIANTS
81290	MCOLN1 (MUCOLIPIN 1) (EG, MUCOLIPIDOSIS, TYPE IV) GENE ANALYSIS, COMMON VARIANTS (EG, IVS3-2A>G, DEL6.4KB)
81291	MTHFR (5,10-METHYLENETETRAHYDROFOLATE REDUCTASE) (EG, HEREDITARY HYPERCOAGULABILITY) GENE ANALYSIS, COMMON VARIANTS (EG, 677T, 1298C)
81292	MLH1 (MUTL HOMOLOG 1, COLON CANCER, NONPOLYPOSIS TYPE 2) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS
81293	MLH1 (MUTL HOMOLOG 1, COLON CANCER, NONPOLYPOSIS TYPE 2) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS
81294	MLH1 (MUTL HOMOLOG 1, COLON CANCER, NONPOLYPOSIS TYPE 2) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS
81295	MSH2 (MUTS HOMOLOG 2, COLON CANCER, NONPOLYPOSIS TYPE 1) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS
81296	MSH2 (MUTS HOMOLOG 2, COLON CANCER, NONPOLYPOSIS TYPE 1) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS
81297	MSH2 (MUTS HOMOLOG 2, COLON CANCER, NONPOLYPOSIS TYPE 1) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS
81298	MSH6 (MUTS HOMOLOG 6 [E. COLI]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS
81299	MSH6 (MUTS HOMOLOG 6 [E. COLI]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS
81300	MSH6 (MUTS HOMOLOG 6 [E. COLI]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS
81301	MICROSATELLITE INSTABILITY ANALYSIS (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) OF MARKERS FOR MISMATCH REPAIR DEFICIENCY (EG, BAT25, BAT26), INCLUDES COMPARISON OF NEOPLASTIC AND NORMAL TISSUE, IF PERFORMED
81302	MECP2 (METHYL CPG BINDING PROTEIN 2) (EG, RETT SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS
81303	MECP2 (METHYL CPG BINDING PROTEIN 2) (EG, RETT SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANT
81304	MECP2 (METHYL CPG BINDING PROTEIN 2) (EG, RETT SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS
81310	NPM1 (NUCLEOPHOSMIN) (EG, ACUTE MYELOID LEUKEMIA) GENE ANALYSIS, EXON 12 VARIANTS
81315	PML/RARALPHA, (T(15;17)), (PROMYELOCYTIC LEUKEMIA/RETINOIC ACID RECEPTOR ALPHA) (EG, PROMYELOCYTIC LEUKEMIA) TRANSLOCATION ANALYSIS; COMMON BREAKPOINTS (EG, INTRON 3 AND INTRON 6), QUALITATIVE OR QUANTITATIVE
81316	PML/RARALPHA, (T(15;17)), (PROMYELOCYTIC LEUKEMIA/RETINOIC ACID RECEPTOR ALPHA) (EG, PROMYELOCYTIC LEUKEMIA) TRANSLOCATION ANALYSIS; SINGLE BREAKPOINT (EG, INTRON 3, INTRON 6 OR EXON 6), QUALITATIVE OR QUANTITATIVE
81317	PMS2 (POSTMEIOTIC SEGREGATION INCREASED 2 [S. CEREVISIAE]) (EG, HEREDITARY NON-POLYPOSIS

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
	COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS
81318	PMS2 (POSTMEIOTIC SEGREGATION INCREASED 2 [S. CEREVISIAE]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS
81319	PMS2 (POSTMEIOTIC SEGREGATION INCREASED 2 [S. CEREVISIAE]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS
81330	SMPD1 (SPHINGOMYELIN PHOSPHODIESTERASE 1, ACID LYSOSOMAL) (EG, NIEMANN-PICK DISEASE, TYPE A) GENE ANALYSIS, COMMON VARIANTS (EG, R496L, L302P, FSP330)
81331	SNRPN/UBE3A (SMALL NUCLEAR RIBONUCLEOPROTEIN POLYPEPTIDE N AND UBIQUITIN PROTEIN LIGASE E3A) (EG, PRADER-WILLI SYNDROME AND/OR ANGELMAN SYNDROME), METHYLATION ANALYSIS
81332	SERPINA1 (SERPIN PEPTIDASE INHIBITOR, CLADE A, ALPHA-1 ANTIPROTEINASE, ANTITRYPSIN, MEMBER 1) (EG, ALPHA-1-ANTITRYPSIN DEFICIENCY), GENE ANALYSIS, COMMON VARIANTS (EG, *S AND *Z)
81340	TRB@ (T CELL ANTIGEN RECEPTOR, BETA) (EG, LEUKEMIA AND LYMPHOMA), GENE REARRANGEMENT ANALYSIS TO DETECT ABNORMAL CLONAL POPULATION(S); USING AMPLIFICATION METHODOLOGY (EG, POLYMERASE CHAIN REACTION)
81341	TRB@ (T CELL ANTIGEN RECEPTOR, BETA) (EG, LEUKEMIA AND LYMPHOMA), GENE REARRANGEMENT ANALYSIS TO DETECT ABNORMAL CLONAL POPULATION(S); USING DIRECT PROBE METHODOLOGY (EG, SOUTHERN BLOT)
81342	TRG@ (T CELL ANTIGEN RECEPTOR, GAMMA) (EG, LEUKEMIA AND LYMPHOMA), GENE REARRANGEMENT ANALYSIS, EVALUATION TO DETECT ABNORMAL CLONAL POPULATION(S)
81350	UGT1A1 (UDP GLUCURONOSYLTRANSFERASE 1 FAMILY, POLYPEPTIDE A1) (EG, IRINOTECAN METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *28, *36, *37)
81355	VKORC1 (VITAMIN K EPOXIDE REDUCTASE COMPLEX, SUBUNIT 1) (EG, WARFARIN METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, -1639/3673)
81370	HLA CLASS I AND II TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); HLA-A, -B, -C, -DRB1/3/4/5, AND -DQB1
81371	HLA CLASS I AND II TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); HLA-A, -B, AND -DRB1/3/4/5 (EG, VERIFICATION TYPING)
81372	HLA CLASS I TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); COMPLETE (IE, HLA-A, -B, AND -C)
81373	HLA CLASS I TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); ONE LOCUS (EG, HLA-A, -B, OR -C), EACH
81374	HLA CLASS I TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); ONE ANTIGEN EQUIVALENT (EG, B*27), EACH
81375	HLA CLASS II TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); HLA-DRB1/3/4/5 AND -DQB1
81376	HLA CLASS II TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); ONE LOCUS (EG, HLA-DRB1/3/4/5, -DQB1, -DQA1, -DPB1, OR -DPA1), EACH
81377	HLA CLASS II TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); ONE ANTIGEN EQUIVALENT, EACH
81378	HLA CLASS I AND II TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS), HLA-A, -B, -C, AND -DRB1
81379	HLA CLASS I TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); COMPLETE (IE, HLA-A, -B, AND -C)
81380	HLA CLASS I TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); ONE LOCUS (EG, HLA-A, -B, OR -C), EACH
81381	HLA CLASS I TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); ONE ALLELE OR ALLELE GROUP (EG, B*57:01P), EACH
81382	HLA CLASS II TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); ONE LOCUS (EG, HLA-DRB1, -DRB3, -DRB4, -DRB5, -DQB1, -DQA1, -DPB1, OR -DPA1), EACH
81383	HLA CLASS II TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); ONE ALLELE OR ALLELE GROUP (EG, HLA-DQB1*06:02P), EACH
81400	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 1 (EG, IDENTIFICATION OF SINGLE GERMLINE VARIANT [EG, SNP] BY TECHNIQUES SUCH AS RESTRICTION ENZYME DIGESTION OR MELT CURVE ANALYSIS)ACADM (ACYL-COA DEHYDROGENASE, C-4 TO C-12 STRAIGHT CHAIN, MCAD) (EG, MEDIUM CHAIN ACYL DEHYDROGENASE DEFICIENCY), K304E VARIANT ACE (ANGIOTENSIN CONVERTING ENZYME) (EG,

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
	<p>HEREDITARY BLOOD PRESSURE REGULATION), INSERTION/DELETION VARIANT AGTR1 (ANGIOTENSIN II RECEPTOR, TYPE 1) (EG, ESSENTIAL HYPERTENSION), 1166A&gt;C VARIANT CCR5 (CHEMOKINE C-C MOTIF RECEPTOR 5) (EG, HIV RESISTANCE), 32-BP DELETION MUTATION/794 825DEL32 DELETION DPYD (DIHYDROPYRIMIDINE DEHYDROGENASE) (EG, 5-FLUOROURACIL/5-FU AND CAPECITABINE DRUG METABOLISM), IVS14+1G&gt;A VARIANT F2 (COAGULATION FACTOR 2) (EG, HEREDITARY HYPERCOAGULABILITY), 1199G&gt;A VARIANT F5 (COAGULATION FACTOR V) (EG, HEREDITARY HYPERCOAGULABILITY), HR2 VARIANT F7 (COAGULATION FACTOR VII [SERUM PROTHROMBIN CONVERSION ACCELERATOR]) (EG, HEREDITARY HYPERCOAGULABILITY), R353Q VARIANT F13B (COAGULATION FACTOR XIII, B POLYPEPTIDE) (EG, HEREDITARY HYPERCOAGULABILITY), V34L VARIANT FGB (FIBRINOGEN BETA CHAIN) (EG, HEREDITARY ISCHEMIC HEART DISEASE), -455G&gt;A VARIANT HUMAN PLATELET ANTIGEN 1 GENOTYPING (HPA-1), ITGB3 (INTEGRIN, BETA 3 [PLATELET GLYCOPROTEIN IIIA], ANTIGEN CD61 [GPIIIA]) (EG, NEONATAL ALLOIMMUNE THROMBOCYTOPENIA [NAIT], POST-TRANSFUSION PURPURA), HPA-1A/B (L33P) HUMAN PLATELET ANTIGEN 2 GENOTYPING (HPA-2), GP1BA (GLYCOPROTEIN IB [PLATELET], ALPHA POLYPEPTIDE [GPIBA]) (EG, NEONATAL ALLOIMMUNE THROMBOCYTOPENIA [NAIT], POST-TRANSFUSION PURPURA), HPA-2A/B (T145M) HUMAN PLATELET ANTIGEN 3 GENOTYPING (HPA-3), ITGA2B (INTEGRIN, ALPHA 2B [PLATELET GLYCOPROTEIN IIB OF IIB/IIIA COMPLEX], ANTIGEN CD41 [GPIIB]) (EG, NEONATAL ALLOIMMUNE THROMBOCYTOPENIA [NAIT], POST-TRANSFUSION PURPURA), HPA-3A/B (I843S) HUMAN PLATELET ANTIGEN 4 GENOTYPING (HPA-4), ITGB3 (INTEGRIN, BETA 3 [PLATELET GLYCOPROTEIN IIIA], ANTIGEN CD61 [GPIIIA]) (EG, NEONATAL ALLOIMMUNE THROMBOCYTOPENIA [NAIT], POST-TRANSFUSION PURPURA), HPA-4A/B (R143Q) HUMAN PLATELET ANTIGEN 5 GENOTYPING (HPA-5), ITGA2 (INTEGRIN, ALPHA 2 [CD49B, ALPHA 2 SUBUNIT OF VLA-2 RECEPTOR] [GPIA]) (EG, NEONATAL ALLOIMMUNE THROMBOCYTOPENIA [NAIT], POST-TRANSFUSION PURPURA), HPA-5A/B (K505E) HUMAN PLATELET ANTIGEN 6 GENOTYPING (HPA-6W), ITGB3 (INTEGRIN, BETA 3 [PLATELET GLYCOPROTEIN IIIA], ANTIGEN CD61 [GPIIIA]) (EG, NEONATAL ALLOIMMUNE THROMBOCYTOPENIA [NAIT], POST-TRANSFUSION PURPURA), HPA-6A/B (R489Q) HUMAN PLATELET ANTIGEN 9 GENOTYPING (HPA-9W), ITGA2B (INTEGRIN, ALPHA 2B [PLATELET GLYCOPROTEIN IIB OF IIB/IIIA COMPLEX], ANTIGEN CD41 [GPIIB]) (EG, NEONATAL ALLOIMMUNE THROMBOCYTOPENIA [NAIT], POST-TRANSFUSION PURPURA), HPA-9A/B (V837M) HUMAN PLATELET ANTIGEN 15 GENOTYPING (HPA-15), CD109 (CD109 MOLECULE) (EG, NEONATAL ALLOIMMUNE THROMBOCYTOPENIA [NAIT], POST-TRANSFUSION PURPURA), HPA-15A/B(S682Y) SERPINE1 (SERPINE PEPTIDASE INHIBITOR CLADE E, MEMBER 1, PLASMINOGEN ACTIVATOR INHIBITOR -1, PAI-1) (EG, THROMBOPHILIA), 4G VARIANT</p>
81401	<p>MOLECULAR PATHOLOGY PROCEDURE, LEVEL 2 (EG, 2-10 SNPS, 1 METHYLATED VARIANT, OR 1 SOMATIC VARIANT [TYPICALLY USING NONSEQUENCING TARGET VARIANT ANALYSIS], OR DETECTION OF A DYNAMIC MUTATION DISORDER/TRIPLET REPEAT) ABL (C-ABL ONCOGENE 1, RECEPTOR TYROSINE KINASE) (EG, ACQUIRED IMATINIB RESISTANCE), T315I VARIANT ACADM (ACYL-COA DEHYDROGENASE, C-4 TO C-12 STRAIGHT CHAIN, MCAD) (EG, MEDIUM CHAIN ACYL DEHYDROGENASE DEFICIENCY), COMMONS VARIANTS (EG, K304E, Y42H) ADRB2 (ADRENERGIC BETA-2 RECEPTOR SURFACE) (EG, DRUG METABOLISM), COMMON VARIANTS (EG, G16R, Q27E) APOE (APOLIPOPROTEIN E) (EG, HYPERLIPOPROTEINEMIA TYPE III, CARDIOVASCULAR DISEASE, ALZHEIMER DISEASE), COMMON VARIANTS (EG, *2, *3, *4) CBFMB/MYH11 (INV(16)) (EG, ACUTE MYELOID LEUKEMIA), QUALITATIVE, AND QUANTITATIVE, IF PERFORMED CCND1/IGH (BCL1/IGH, T(11;14)) (EG, MANTLE CELL LYMPHOMA) TRANSLOCATION ANALYSIS, MAJOR BREAKPOINT, QUALITATIVE, AND QUANTITATIVE, IF PERFORMED CFH/ARMS2 (COMPLEMENT FACTOR H/AGE-RELATED MACULOPATHY SUSCEPTIBILITY 2) (EG, MACULAR DEGENERATION), COMMON VARIANTS (EG, Y402H [CFH], A69S [ARMS2]) CYP3A4 (CYTOCHROME P450, FAMILY 3, SUBFAMILY A, POLYPEPTIDE 4) (EG, DRUG METABOLISM), COMMON VARIANTS (EG, *2, *3, *4, *5, *6) CYP3A5 (CYTOCHROME P450, FAMILY 3, SUBFAMILY A, POLYPEPTIDE 5) (EG, DRUG METABOLISM), COMMON VARIANTS (EG, *2, *3, *4, *5, *6) DMPK (DYSTROPHIA MYOTONICA-PROTEIN KINASE) (EG, MYOTONIC DYSTROPHY, TYPE 1), EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES F11 (COAGULATION FACTOR XI) (EG, COAGULATION DISORDER), COMMON VARIANTS (EG, E117X [TYPE II], F283L [TYPE III], IVS14DEL14, AND IVS14+1G&gt;A [TYPE I]) FGFR3 (FIBROBLAST GROWTH FACTOR RECEPTOR 3) (EG, ACHONDROPLASIA), COMMON VARIANTS (EG, 1138G&gt;A, 1138G&gt;C) FIP1L1/PDGFR (DEL[4Q12]) (EG, IMATINIB-SENSITIVE CHRONIC EOSINOPHILIC LEUKEMIA), QUALITATIVE, AND QUANTITATIVE, IF PERFORMED GALT (GALACTOSE-1-PHOSPHATE URIDYLTRANSFERASE) (EG, GALACTOSEMIA), COMMON VARIANTS (EG, Q188R, S135L, K285N, T138M, L195P, Y209C, IVS2-2A&gt;G, P171S, DEL5KB, N314D,</p>

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
	L218L/N314D) HBB (HEMOGLOBIN, BETA) (EG, SICKLE CELL ANEMIA, HEMOGLOBIN C, HEMOGLOBIN E), COMMON VARIANTS (EG, HBS, HBC, HBE) HTT (HUNTINGTIN) (EG, HUNTINGTON DISEASE), EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES RUNX1/RUNX1T1 (T(8;21)) (EG, ACUTE MYELOID LEUKEMIA) TRANSLOCATION ANALYSIS, QUALITATIVE, AND QUANTITATIVE, IF PERFORMED SEPT9 (SEPTIN 9) (EG, COLON CANCER), METHYLATION ANALYSIS TPMT (THIOPURINE S-METHYLTRANSFERASE) (EG, DRUG METABOLISM), COMMON VARIANTS (EG, *2, *3) VWF (VON WILLEBRAND FACTOR) (EG, VON WILLEBRAND DISEASE TYPE 2N), COMMON VARIANTS (EG, T791M, R816W, R854Q)
81402	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 3 (EG, >10 SNPS, 2-10 METHYLATED VARIANTS, OR 2-10 SOMATIC VARIANTS [TYPICALLY USING NON-SEQUENCING TARGET VARIANT ANALYSIS]), IMMUNOGLOBULIN AND T-CELL RECEPTOR GENE REARRANGEMENTS, DUPLICATION/DELETION VARIANTS 1 EXON) CYP21A2 (CYTOCHROME P450, FAMILY 21, SUBFAMILY A, POLYPEPTIDE 2) (EG, CONGENITAL ADRENAL HYPERPLASIA, 21-HYDROXYLASE DEFICIENCY), COMMON VARIANTS (EG, IVS2-13G, P30L, I172N, EXON 6 MUTATION CLUSTER [I235N, V236E, M238K], V281L, L307FFSX6, Q318X, R356W, P453S, G110VFSX21, 30-KB DELETION VARIANT) ESR1/PGR (RECEPTOR 1/PROGESTERONE RECEPTOR) RATIO (EG, BREAST CANCER) KIT (V-KIT HARDY-ZUCKERMAN 4 FELINE SARCOMA VIRAL ONCOGENE HOMOLOG) (EG, MASTOCYTOSIS), COMMON VARIANTS (EG, D816V, D816Y, D816F) MEFV (MEDITERRANEAN FEVER) (EG, FAMILIAL MEDITERRANEAN FEVER), COMMON VARIANTS (EG, E148Q, P369S, F479L, M680I, I692DEL, M694V, M694I, K695R, V726A, A744S, R761H) MPL (MYELOPROLIFERATIVE LEUKEMIA VIRUS ONCOGENE, THROMBOPOIETIN RECEPTOR, TPOR) (EG, MYELOPROLIFERATIVE DISORDER), COMMON VARIANTS (EG, W515A, W515K, W515L, W515R) TRD@ (T CELL ANTIGEN RECEPTOR, DELTA) (EG, LEUKEMIA AND LYMPHOMA), GENE REARRANGEMENT ANALYSIS, EVALUATION TO DETECT ABNORMAL CLONAL POPULATION
81403	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 4 (EG, ANALYSIS OF SINGLE EXON BY DNA SEQUENCE ANALYSIS, ANALYSIS OF >10 AMPLICONS USING MULTIPLEX PCR IN 2 OR MORE INDEPENDENT REACTIONS, MUTATION SCANNING OR DUPLICATION/DELETION VARIANTS OF 2-5 EXONS) ABL1 (C-ABL ONCOGENE 1, RECEPTOR TYROSINE KINASE) (EG, ACQUIRED IMATINIB TYROSINE KINASE INHIBITOR RESISTANCE), VARIANTS IN THE KINASE DOMAIN DAZ/SRY (DELETED IN AZOOSPERMIA AND SEX DETERMINING REGION Y) (EG, MALE INFERTILITY), COMMON DELETIONS (EG, AZFA, AZFB, AZFC, AZFD) GJB1 (GAP JUNCTION PROTEIN, BETA 1) (EG, CHARCOT-MARIE-TOOTH X-LINKED), FULL GENE SEQUENCE JAK2 (JANUS KINASE 2) (EG, MYELOPROLIFERATIVE DISORDER), EXON 12 SEQUENCE AND EXON 13 SEQUENCE, IF PERFORMED KRAS (V-KI-RAS2 KIRSTEN RAT SARCOMA VIRAL ONCOGENE) (EG, CARCINOMA), GENE ANALYSIS, VARIANT(S) IN EXON 2 MPL (MYELOPROLIFERATIVE LEUKEMIA VIRUS ONCOGENE, THROMBOPOIETIN RECEPTOR, TPOR) (EG, MYELOPROLIFERATIVE DISORDER), EXON 10 SEQUENCE VHL (VON HIPPEL-LINDAU TUMOR SUPPRESSOR) (EG, VON HIPPEL-LINDAU FAMILIAL CANCER SYNDROME), DELETION/DUPLICATION ANALYSIS VWF (VON WILLEBRAND FACTOR) (EG, VON WILLEBRAND DISEASE TYPES 2A, 2B, 2M), TARGETED SEQUENCE ANALYSIS (EG, EXON 28)
81404	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 5 (EG, ANALYSIS OF 2-5 EXONS BY DNA SEQUENCE ANALYSIS, MUTATION SCANNING OR DUPLICATION/DELETION VARIANTS OF 6-10 EXONS, OR CHARACTERIZATION OF A DYNAMIC MUTATION DISORDER/TRIPLET REPEAT BY SOUTHERN BLOT ANALYSIS) BTD (BIOTINIDASE) (EG, BIOTINIDASE DEFICIENCY), FULL GENE SEQUENCE CYP11B1 (CYTOCHROME P450, FAMILY 1, SUBFAMILY B, POLYPEPTIDE 1) (EG, PRIMARY CONGENITAL GLAUCOMA), FULL GENE SEQUENCE DMPK (DYSTROPHIA MYOTONICA-PROTEIN KINASE) (EG, MYOTONIC DYSTROPHY TYPE 1), CHARACTERIZATION OF ABNORMAL (EG, EXPANDED) ALLELES EGR2 (EARLY GROWTH RESPONSE 2) (EG, CHARCOT-MARIE-TOOTH), FULL GENE SEQUENCE FKRP (FUKUTIN RELATED PROTEIN) (EG, CONGENITAL MUSCULAR DYSTROPHY TYPE 1C [MDC1C], LIMB-GIRDLE MUSCULAR DYSTROPHY [LGMD] TYPE 2I), FULL GENE SEQUENCE FOXG1 (FORKHEAD BOX G1) (EG, RETT SYNDROME), FULL GENE SEQUENCE FSHMD1A (FACIOSCAPULOHUMERAL MUSCULAR DYSTROPHY 1A) (EG, FACIOSCAPULOHUMERAL MUSCULAR DYSTROPHY), EVALUATION TO DETECT ABNORMAL (EG, DELETED) ALLELES FSHMD1A (FACIOSCAPULOHUMERAL MUSCULAR DYSTROPHY 1A) (EG, FACIOSCAPULOHUMERAL MUSCULAR DYSTROPHY), CHARACTERIZATION OF HAPLOTYPE(S) (IE, CHROMOSOME 4A AND 4B HAPLOTYPES) HBB (HEMOGLOBIN, BETA, BETA-GLOBIN) (EG, THALASSEMIA), FULL GENE SEQUENCE KIT (C-KIT) (V-KIT HARDY-ZUCKERMAN 4 FELINE SARCOMA VIRAL ONCOGENE HOMOLOG) (EG, GIST, ACUTE MYELOID LEUKEMIA, MELANOMA), TARGETED GENE ANALYSIS (EG, EXONS 8, 11, 13, 17, 18) LITAF (LIPOPOLYSACCHARIDE-INDUCED TNF FACTOR) (EG, CHARCOT-MARIE-TOOTH), FULL GENE SEQUENCE

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
	MEFV (MEDITERRANEAN FEVER) (EG, FAMILIAL MEDITERRANEAN FEVER), FULL GENE SEQUENCE NRAS (NEUROBLASTOMA RAS VIRAL ONCOGENE HOMOLOG) (EG, COLORECTAL CARCINOMA), EXON 1 AND EXON 2 SEQUENCES PDGFRA (PLATELET-DERIVED GROWTH FACTOR RECEPTOR ALPHA POLYPEPTIDE) (EG, GASTROINTESTINAL STROMAL TUMOR), TARGETED SEQUENCE ANALYSIS (EG, EXONS 12, 18) RET (RET PROTO-ONCOGENE) (EG, MULTIPLE ENDOCRINE NEOPLASIA, TYPE 2B AND FAMILIAL MEDULLARY THYROID CARCINOMA), COMMON VARIANTS (EG, M918T, 2647_2648DELINSTT, A883F) SDHD (SUCCINATE DEHYDROGENASE COMPLEX, SUBUNIT D, INTEGRAL MEMBRANE PROTEIN) (EG, HEREDITARY PARAGANGLIOMA), FULL GENE SEQUENCE VHL (VON HIPPEL-LINDAU TUMOR SUPPRESSOR) (EG, VON HIPPEL-LINDAU FAMILIAL CANCER SYNDROME), FULL GENE SEQUENCE VWF (VON WILLEBRAND FACTOR) (EG, VON WILLEBRAND DISEASE TYPE 1C), TARGETED SEQUENCE ANALYSIS (EG, EXONS 26, 27, 37)
81405	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 6 (EG, ANALYSIS OF 6-10 EXONS BY DNA SEQUENCE ANALYSIS, MUTATION SCANNING OR DUPLICATION/DELETION VARIANTS OF 11-25 EXONS) CYP21A2 (CYTOCHROME P450, FAMILY 21, SUBFAMILY A, POLYPEPTIDE2) (EG, STEROID 21-HYDROXYLASE ISOFORM, CONGENITAL ADRENAL HYPERPLASIA), FULL GENE SEQUENCE FKTN (FUKUTIN) (EG, LIMB-GIRDLE MUSCULAR DYSTROPHY [LGMD] TYPE 2M OR 2L), FULL GENE SEQUENCE MPZ (MYELIN PROTEIN ZERO) (EG, CHARCOT-MARIE-TOOTH), FULL GENE SEQUENCE NEFL (NEUROFILAMENT, LIGHT POLYPEPTIDE) (EG, CHARCOT-MARIE-TOOTH), FULL GENE SEQUENCE RET (RET PROTO-ONCOGENE) (EG, MULTIPLE ENDOCRINE NEOPLASIA, TYPE 2A AND FAMILIAL MEDULLARY THYROID CARCINOMA), TARGETED SEQUENCE ANALYSIS (EG, EXONS 10, 11, 13-16) SDHB (SUCCINATE DEHYDROGENASE COMPLEX, SUBUNIT B, IRON SULFUR) (EG, HEREDITARY PARAGANGLIOMA), FULL GENE SEQUENCE TGFBR1 (TRANSFORMING GROWTH FACTOR, BETA RECEPTOR 1) (EG, MARFAN SYNDROME), FULL GENE SEQUENCE TGFBR2 (TRANSFORMING GROWTH FACTOR, BETA RECEPTOR 2) (EG, MARFAN SYNDROME), FULL GENE SEQUENCE THRB (THYROID HORMONE RECEPTOR, BETA) (EG, THYROID HORMONE RESISTANCE, THYROID HORMONE BETA RECEPTOR DEFICIENCY), FULL GENE SEQUENCE OR TARGETED SEQUENCE ANALYSIS OF >5 EXONS TP53 (TUMOR PROTEIN 53) (EG, LI-FRAUMENI SYNDROME, TUMOR SAMPLES), FULL GENE SEQUENCE OR TARGETED SEQUENCE ANALYSIS OF >5 EXONS VWF (VON WILLEBRAND FACTOR) (EG, VON WILLEBRAND DISEASE TYPE 2N), TARGETED SEQUENCE ANALYSIS (EG, EXONS 18-20, 23-25)
81406	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 7 (EG, ANALYSIS OF 11-25 EXONS BY DNA SEQUENCE ANALYSIS, MUTATION SCANNING OR DUPLICATION/DELETION VARIANTS OF 26-50 EXONS, CYTOGENOMIC ARRAY ANALYSIS FOR NEOPLASIA) CAPN3 (CALPAIN 3) (EG, LIMB-GIRDLE MUSCULAR DYSTROPHY [LGMD] TYPE 2A, CALPAINOPATHY), FULL GENE SEQUENCE CYTOGENOMIC MICROARRAY ANALYSIS, NEOPLASIA (EG, INTERROGATION OF COPY NUMBER, AND LOSS-OF-HETEROZYGOSITY VIA SINGLE NUCLEOTIDE POLYMORPHISM [SNP]-BASED COMPARATIVE GENOMIC HYBRIDIZATION [CGH] MICROARRAY ANALYSIS) GALT (GALACTOSE-1-PHOSPHATE URIDYLTRANSFERASE) (EG, GALACTOSEMIA), FULL GENE SEQUENCE HEXA (HEXOSAMINIDASE A, ALPHA POLYPEPTIDE) (EG, TAY-SACHS DISEASE), FULL GENE SEQUENCE LMNA (LAMIN A/C) (EG, EMERY-DREIFUSS MUSCULAR DYSTROPHY [EDMD1, 2 AND 3] LIMB-GIRDLE MUSCULAR DYSTROPHY [LGMD] TYPE 1B, DILATED CARDIOMYOPATHY [CMD1A], FAMILIAL PARTIAL LIPODYSTROPHY [FPLD2]), FULL GENE SEQUENCE PAH (PHENYLALANINE HYDROXYLASE) (EG, PHENYLKETONURIA), FULL GENE SEQUENCE POLG (POLYMERASE [DNA DIRECTED], GAMMA) (EG, ALPERS-HUTTENLOCHER SYNDROME, AUTOSOMAL DOMINANT PROGRESSIVE EXTERNAL OPHTHALMOPLÉGIA), FULL GENE SEQUENCE POMGNT1 (PROTEIN O-LINKED MANNOSE BETA1,2-N ACETYLGLUCOSAMINYLTRANSFERASE) (EG, MUSCLE-EYE-BRAIN DISEASE, WALKER-WARBURG SYNDROME), FULL GENE SEQUENCE POMT1 (PROTEIN-O-MANNOSYLTRANSFERASE 1) (EG, LIMB-GIRDLE MUSCULAR DYSTROPHY [LGMD] TYPE 2K, WALKER-WARBURG SYNDROME), FULL GENE SEQUENCE POMT2 (PROTEIN-O-MANNOSYLTRANSFERASE 2) (EG, LIMB-GIRDLE MUSCULAR DYSTROPHY [LGMD] TYPE 2N, WALKER-WARBURG SYNDROME), FULL GENE SEQUENCE RYR1 (RYANODINE RECEPTOR 1, SKELETAL) (EG, MALIGNANT HYPERTHERMIA), TARGETED SEQUENCE ANALYSIS OF EXONS WITH FUNCTIONALLY-CONFIRMED MUTATIONS VWF (VON WILLEBRAND FACTOR) (VON WILLEBRAND DISEASE TYPE 2A), EXTENDED TARGETED SEQUENCE ANALYSIS (EG, EXONS 11-16, 24-26, 51, 52)
81407	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 8 (EG, ANALYSIS OF 26-50 EXONS BY DNA SEQUENCE ANALYSIS, MUTATION SCANNING OR DUPLICATION/DELETION VARIANTS OF >50 EXONS, SEQUENCE ANALYSIS OF MULTIPLE GENES ON ONE PLATFORM) SCN1A (SODIUM CHANNEL, VOLTAGE-GATED, TYPE 1, ALPHA SUBUNIT) (EG, GENERALIZED EPILEPSY WITH FEBRILE SEIZURES), FULL GENE SEQUENCE

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
81408	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 9 (EG, ANALYSIS OF >50 EXONS IN A SINGLE GENE BY DNA SEQUENCE ANALYSIS) FBN1 (FIBRILLIN 1) (EG, MARFAN SYNDROME), FULL GENE SEQUENCE NF1 (NEUROFIBROMIN 1) (EG, NEUROFIBROMATOSIS, TYPE 1), FULL GENE SEQUENCE RYR1 (RYANODINE RECEPTOR 1, SKELETAL) (EG, MALIGNANT HYPERTHERMIA), FULL GENE SEQUENCE VWF (VON WILLEBRAND FACTOR) (EG, VON WILLEBRAND DISEASE TYPES 1 AND 3), FULL GENE SEQUENCE
82045	ALBUMIN; ISCHEMIA MODIFIED
82610	CYSTATIN C
82656	ELASTASE, PANCREATIC (EL-1), FECAL, QUALITATIVE OR SEMI-QUANTITATIVE
82930	GASTRIC ACID ANALYSIS, INCLUDES PH IF PERFORMED, EACH SPECIMEN
83630	LACTOFERRIN, FECAL, QUALITATIVE
83631	LACTOFERRIN, FECAL; QUANTITATIVE
83876	MYELOPEROXIDASE (MPO)
83890	MOLECULAR DIAGNOSTICS; MOLECULAR ISOLATION OR EXTRACTION
83891	MOLECULAR DIAGNOSTICS; ISOLATION OR EXTRACTION OF HIGHLY PURIFIED NUCLEIC ACID
83892	MOLECULAR DIAGNOSTICS; ENZYMATIC DIGESTION
83893	MOLECULAR DIAGNOSTICS; DOT/SLOT BLOT PRODUCTION
83894	MOLECULAR DIAGNOSTICS; SEPARATION BY GEL ELECTROPHORESIS (E.G., AGAROSE, POLYACRYLAMIDE)
83896	MOLECULAR DIAGNOSTICS; NUCLEIC ACID PROBE, EACH
83897	MOLECULAR DIAGNOSTICS; NUCLEIC ACID TRANSFER (E.G., SOUTHERN, NORTHERN)
83898	MOLECULAR DIAGNOSTICS; AMPLIFICATION OF PATIENT NUCLEIC ACID (E.G., PCR, LCR), SINGLE PRIMER PAIR, EACH PRIMER PAIR
83900	MOLECULAR DIAGNOSTICS; AMPLIFICATION OF PATIENT NUCLEIC ACID, MULTIPLEX, FIRST TWO NUCLEIC ACID SEQUENCES
83901	MOLECULAR DIAGNOSTICS; AMPLIFICATION OF PATIENT NUCLEIC ACID, MULTIPLEX, EACH MULTIPLEX REACTION
83902	MOLECULAR DIAGNOSTICS; REVERSE TRANSCRIPTION
83903	MOLECULAR DIAGNOSTICS; MUTATION SCANNING, BY PHYSICAL PROPERTIES (E.G., SINGLE STRAND CONFORMATIONAL POLYMORPHISMS (SSCP), HETERODUPLEX, DENATURING GRADIENT GEL ELECTROPHORESIS (DGGE), RNA'ASE A), SINGLE SEGMENT, EACH
83904	MOLECULAR DIAGNOSTICS; MUTATION IDENTIFICATION BY SEQUENCING, SINGLE SEGMENT, EACH SEGMENT
83905	MOLECULAR DIAGNOSTICS; MUTATION IDENTIFICATION BY ALLELE SPECIFIC TRANSCRIPTION, SINGLE SEGMENT, EACH SEGMENT
83906	MOLECULAR DIAGNOSTICS; MUTATION IDENTIFICATION BY ALLELE SPECIFIC TRANSLATION, SINGLE SEGMENT, EACH SEGMENT
83907	MOLECULAR DIAGNOSTICS; LYSIS OF CELLS PRIOR TO NUCLEIC ACID EXTRACTION (E.G., STOOL SPECIMENS, PARAFFIN EMBEDDED TISSUE)
83908	MOLECULAR DIAGNOSTICS; SIGNAL AMPLIFICATION OF PATIENT NUCLEIC ACID, EACH NUCLEIC ACID SEQUENCE
83909	MOLECULAR DIAGNOSTICS; SEPARATION AND IDENTIFICATION BY HIGH RESOLUTION TECHNIQUE (E.G., CAPILLARY ELECTROPHORESIS)
83912	MOLECULAR DIAGNOSTICS; INTERPRETATION AND REPORT
83913	MOLECULAR DIAGNOSTICS; RNA STABILIZATION
83914	MUTATION IDENTIFICATION BY ENZYMATIC LIGATION OR PRIMER EXTENSION, SINGLE SEGMENT, EACH SEGMENT (E.G., OLIGONUCLEOTIDE LIGATION ASSAY (OLA), SINGLE BASE CHAIN EXTENSION (SBCE), OR ALLELE-SPECIFIC PRIMER EXTENSION (ASPE)
83951	ONCOPROTEIN; DES-GAMMA-CARBOXY-PROTHROMBIN (DCP)
83987	PH; EXHALED BREATH CONDENSATE
83993	CALPROTECTIN, FECAL

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
84145	PROCALCITONIN (PCT)
84431	THROMBOXANE METABOLITE(S), INCLUDING THROMBOXANE IF PERFORMED, URINE
85397	COAGULATION AND FIBRINOLYSIS, FUNCTIONAL ACTIVITY, NOT OTHERWISE SPECIFIED (EG, ADAMTS-13), EACH ANALYTE
86305	HUMAN EPIDIDYMIS PROTEIN 4 (HE4)
86352	CELLULAR FUNCTION ASSAY INVOLVING STIMULATION (EG, MITOGEN OR ANTIGEN) AND DETECTION OF BIOMARKER (EG, ATP)
86356	MONONUCLEAR CELL ANTIGEN, QUANTITATIVE (EG, FLOW CYTOMETRY), NOT OTHERWISE SPECIFIED, EACH ANTIGEN
86386	NUCLEAR MATRIX PROTEIN 22 (NMP22), QUALITATIVE
86480	TUBERCULOSIS TEST, CELL MEDIATED IMMUNITY MEASUREMENT OF GAMMA INTERFERON ANTIGEN RESPONSE
86780	ANTIBODY; TREPONEMA PALLIDUM
86825	HUMAN LEUKOCYTE ANTIGEN (HLA) CROSSMATCH, NON-CYTOTOXIC (EG, USING FLOW CYTOMETRY); FIRST SERUM SAMPLE OR DILUTION
86826	HUMAN LEUKOCYTE ANTIGEN (HLA) CROSSMATCH, NON-CYTOTOXIC (EG, USING FLOW CYTOMETRY); EACH ADDITIONAL SERUM SAMPLE OR SAMPLE DILUTION (LIST SEPARATELY IN ADDITION TO PRIMARY PROCEDURE)
86849	UNLISTED IMMUNOLOGY PROCEDURE
87150	CULTURE, TYPING; IDENTIFICATION BY NUCLEIC ACID (DNA OR RNA) PROBE, AMPLIFIED PROBE TECHNIQUE, PER CULTURE OR ISOLATE, EACH ORGANISM PROBED
87153	CULTURE, TYPING; IDENTIFICATION BY NUCLEIC ACID SEQUENCING METHOD, EACH ISOLATE (EG, SEQUENCING OF THE 16S RRNA GENE)
87389	INFECTIOUS AGENT ANTIGEN DETECTION BY ENZYME IMMUNOASSAY TECHNIQUE, QUALITATIVE OR SEMIQUANTITATIVE, MULTIPLE-STEP METHOD; HIV-1 ANTIGEN(S), WITH HIV-1 AND HIV-2 ANTIBODIES, SINGLE RESULT
87493	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); CLOSTRIDIUM DIFFICILE, TOXIN GENE(S), AMPLIFIED PROBE TECHNIQUE
87500	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); VANCOMYCIN RESISTANCE (EG, ENTEROCOCCUS SPECIES VAN A, VAN B), AMPLIFIED PROBE TECHNIQUE
87809	INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOASSAY WITH DIRECT OPTICAL OBSERVATION; ADENOVIRUS
87900	INFECTIOUS AGENT DRUG SUSCEPTIBILITY PHENOTYPE PREDICTION USING REGULARLY UPDATED GENOTYPIC BIOINFORMATICS
87905	INFECTIOUS AGENT ENZYMATIC ACTIVITY OTHER THAN VIRUS (EG, SIALIDASE ACTIVITY IN VAGINAL FLUID)
88363	EXAMINATION AND SELECTION OF RETRIEVED ARCHIVAL (IE, PREVIOUSLY DIAGNOSED) TISSUE(S) FOR MOLECULAR ANALYSIS (EG, KRAS MUTATIONAL ANALYSIS)
88384	ARRAY-BASED EVALUATION OF MULTIPLE MOLECULAR PROBES; 11 THROUGH 50 PROBES
88385	ARRAY-BASED EVALUATION OF MULTIPLE MOLECULAR PROBES; 51 THROUGH 250 PROBES
88386	ARRAY-BASED EVALUATION OF MULTIPLE MOLECULAR PROBES; 251 THROUGH 500 PROBES
88387	MACROSCOPIC EXAMINATION, DISSECTION, AND PREPARATION OF TISSUE FOR NON-MICROSCOPIC ANALYTICAL STUDIES (EG, NUCLEIC ACID-BASED MOLECULAR STUDIES); EACH TISSUE PREPARATION (EG, A SINGLE LYMPH NODE)
88388	MACROSCOPIC EXAMINATION, DISSECTION, AND PREPARATION OF TISSUE FOR NON-MICROSCOPIC ANALYTICAL STUDIES (EG, NUCLEIC ACID-BASED MOLECULAR STUDIES); IN CONJUNCTION WITH A TOUCH IMPRINT, INTRAOPERATIVE CONSULTATION, OR FROZEN SECTION, EACH TISSUE PREPARATION (EG, A SINGLE LYMPH NODE) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
88720	BILIRUBIN, TOTAL, TRANSCUTANEOUS
88738	HEMOGLOBIN (HGB), QUANTITATIVE, TRANSCUTANEOUS

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
88740	HEMOGLOBIN, QUANTITATIVE, TRANSCUTANEOUS, PER DAY; CARBOXYHEMOGLOBIN
88741	HEMOGLOBIN, QUANTITATIVE, TRANSCUTANEOUS, PER DAY; METHEMOGLOBIN
88749	UNLISTED IN VIVO (EG, TRANSCUTANEOUS) LABORATORY SERVICE
89240	UNLISTED MISCELLANEOUS PATHOLOGY TEST
89250	CULTURE OF OOCYTE(S)/EMBRYO(S), LESS THAN 4 DAYS;
89251	CULTURE OF OOCYTE(S)/EMBRYO(S), LESS THAN 4 DAYS; WITH CO-CULTURE OF OOCYTE(S)/EMBRYOS
89253	ASSISTED EMBRYO HATCHING, MICROTECHNIQUES (ANY METHOD)
89257	SPERM IDENTIFICATION FROM ASPIRATION (OTHER THAN SEMINAL FLUID)
89258	CRYOPRESERVATION; EMBRYO(S)
89259	CRYOPRESERVATION; SPERM
89260	SPERM ISOLATION; SIMPLE PREP (EG, SPERM WASH AND SWIM-UP) FOR INSEMINATION OR DIAGNOSIS WITH SEMEN ANALYSIS
89261	SPERM ISOLATION; COMPLEX PREP (EG, PERCOLL GRADIENT, ALBUMIN GRADIENT) FOR INSEMINATION OR DIAGNOSIS WITH SEMEN ANALYSIS
89264	SPERM IDENTIFICATION FROM TESTIS TISSUE, FRESH OR CRYOPRESERVED
89268	INSEMINATION OF OOCYTES
89272	EXTENDED CULTURE OF OOCYTE(S)/EMBRYO(S), 4-7 DAYS
89280	ASSISTED OOCYTE FERTILIZATION, MICROTECHNIQUE; LESS THAN OR EQUAL TO 10 OOCYTES
89281	ASSISTED OOCYTE FERTILIZATION, MICROTECHNIQUE; GREATER THAN 10 OOCYTES
89329	SPERM EVALUATION; HAMSTER PENETRATION TEST
89330	SPERM EVALUATION; CERVICAL MUCUS PENETRATION TEST, WITH OR WITHOUT SPINNBARKEIT TEST
89342	STORAGE (PER YEAR); EMBRYO(S)
89343	STORAGE (PER YEAR); SPERM/SEMEN
89346	STORAGE (PER YEAR); OOCYTE(S)
89352	THAWING OF CRYOPRESERVED; EMBRYO(S)
89353	THAWING OF CRYOPRESERVED; SPERM/SEMEN, EACH ALIQUOT
89356	THAWING OF CRYOPRESERVED; OOCYTES, EACH ALIQUOT
89398	UNLISTED REPRODUCTIVE MEDICINE LABORATORY PROCEDURE
90283	IMMUNE GLOBULIN (IGIV), HUMAN, FOR INTRAVENOUS USE
90284	IMMUNE GLOBULIN (SCIG), HUMAN, FOR USE IN SUBCUTANEOUS INFUSIONS, 100 MG, EACH
90378	RESPIRATORY SYNCYTIAL VIRUS IMMUNE GLOBULIN (RSV-IGIM), FOR INTRAMUSCULAR USE, 50 MG, EACH
90644	MENINGOCOCCAL CONJUGATE VACCINE, SEROGROUPS C & Y AND HAEMOPHILUS INFLUENZA B VACCINE, TETANUS TOXOID CONJUGATE (HIB-MENCY-TT), 4-DOSE SCHEDULE, WHEN ADMINISTERED TO CHILDREN 2-15 MONTHS OF AGE, FOR INTRAMUSCULAR USE
90665	LYME DISEASE VACCINE
90676	RABIES VACCINE, FOR INTRADERMAL USE
90696	DIPHThERIA, TETANUS TOXOIDS, ACELLULAR PERTUSSIS VACCINE AND POLIOVIRUS VACCINE, INACTIVATED (DTAP-IPV), WHEN ADMINISTERED TO CHILDREN 4 YEARS THROUGH 6 YEARS OF AGE, FOR INTRAMUSCULAR USE
90698	DIPHThERIA, TETANUS TOXOIDS, ACELLULAR PERTUSSIS VACCINE, HAEMOPHILUS INFLUENZA TYPE B, AND POLIOVIRUS VACCINE, INACTIVATED (DTAP - HIB - IPV), FOR INTRAMUSCULAR USE
90869	THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT; SUBSEQUENT MOTOR THRESHOLD RE-DETERMINATION WITH DELIVERY AND MANAGEMENT
90901	BIOFEEDBACK TRAINING BY ANY MODALITY (NOT COVERED FOR COMMERCIAL PLAN MEMBERS)
90911	BIOFEEDBACK TRAINING, PERINEAL MUSCLES, ANORECTAL OR URETHRAL SPHINCTER, INCLUDING EMG AND/OR MANOMETRY (NOT COVERED FOR COMMERCIAL PLAN MEMBERS)
91022	DUODENAL MOTILITY (MANOMETRIC) STUDY

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
91110	GI TRACT IMAGING, INTRALUMINAL, ESOPHAGUS THROUGH ILEUM, WITH PHYSICIAN INTERPRETATION AND REPORT
92025	COMPUTERIZED CORNEAL TOPOGRAPHY, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT
92065	ORTHOPTIC AND/OR PLEOPTIC TRAINING WITH CONTINUING MEDICAL DIRECTION AND EVALUATION
92132	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, ANTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL
92133	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, POSTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL; OPTIC NERVE
92134	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, POSTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL; RETINA
92340	FITTING OF SPECTACLES, EXCEPT FOR APHAKIA; MONOFOCAL
92341	FITTING OF SPECTACLES, EXCEPT FOR APHAKIA; BIFOCAL
92342	FITTING OF SPECTACLES, EXCEPT FOR APHAKIA; MULTIFOCAL, OTHER THAN BIFOCAL
92354	FITTING OF SPECTACLE MOUNTED LOW VISION AID; SINGLE ELEMENT SYSTEM
92355	FITTING OF SPECTACLE MOUNTED LOW VISION AID; TELESCOPIC OR OTHER COMPOUND LENS SYSTEM
92506	EVALUATION OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY PROCESSING
92507	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY PROCESSING DISORDER; INDIVIDUAL
92508	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY PROCESSING DISORDER; GROUP, 2 OR MORE INDIVIDUALS
92540	BASIC VESTIBULAR EVALUATION, INCLUDES SPONTANEOUS NYSTAGMUS TEST WITH ECCENTRIC GAZE FIXATION NYSTAGMUS, WITH RECORDING, POSITIONAL NYSTAGMUS TEST, MINIMUM OF 4 POSITIONS, WITH RECORDING, OPTOKINETIC NYSTAGMUS TEST, BIDIRECTIONAL FOVEAL AND PERIPHERAL STIMULATION, WITH RECORDING, AND OSCILLATING TRACKING TEST, WITH RECORDING
92550	TYMPANOMETRY AND REFLEX THRESHOLD MEASUREMENTS
92570	ACOUSTIC IMMITTANCE TESTING, INCLUDES TYMPANOMETRY (IMPEDANCE TESTING), ACOUSTIC REFLEX THRESHOLD TESTING, AND ACOUSTIC REFLEX DECAY TESTING
92605	EVALUATION FOR PRESCRIPTION OF NON-SPEECH-GENERATING AUGMENTATIVE AND ALTERNATIVE COMMUNICATION DEVICE
92606	THERAPEUTIC SERVICE(S) FOR THE USE OF NON-SPEECH-GENERATING DEVICE, INCLUDING PROGRAMMING AND MODIFICATION
92620	EVALUATION OF CENTRAL AUDITORY FUNCTION, WITH REPORT; INITIAL 60 MINUTES
92621	EVALUATION OF CENTRAL AUDITORY FUNCTION, WITH REPORT; EACH ADDITIONAL 15 MINUTES
92626	EVALUATION OF AUDITORY REHABILITATION STATUS; FIRST HOUR
92627	EVALUATION OF AUDITORY REHABILITATION STATUS; EACH ADDITIONAL 15 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
92630	AUDITORY REHABILITATION; PRE-LINGUAL HEARING LOSS
92633	AUDITORY REHABILITATION; POST-LINGUAL HEARING LOSS
92640	DIAGNOSTIC ANALYSIS WITH PROGRAMMING OF AUDITORY BRAINSTEM IMPLANT, PER HOUR
92700	UNLISTED OTORHINOLARYNGOLOGICAL SERVICE OR PROCEDURE
93025	MICROVOLT T-WAVE ALTERNANS FOR ASSESSMENT OF VENTRICULAR ARRHYTHMIAS (COVERED FOR SENIOR PLAN MEMBERS ONLY)
93228	WEARABLE MOBILE CARDIOVASCULAR TELEMETRY WITH ELECTROCARDIOGRAPHIC RECORDING, CONCURRENT COMPUTERIZED REAL TIME DATA ANALYSIS AND GREATER THAN 24 HOURS OF ACCESSIBLE ECG DATA STORAGE (RETRIEVABLE WITH QUERY) WITH ECG TRIGGERED AND PATIENT SELECTED EVENTS TRANSMITTED TO A REMOTE ATTENDED SURVEILLANCE CENTER FOR UP TO 30 DAYS; PHYSICIAN REVIEW AND INTERPRETATION WITH REPORT

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
93229	WEARABLE MOBILE CARDIOVASCULAR TELEMETRY WITH ELECTROCARDIOGRAPHIC RECORDING, CONCURRENT COMPUTERIZED REAL TIME DATA ANALYSIS AND GREATER THAN 24 HOURS OF ACCESSIBLE ECG DATA STORAGE (RETRIEVABLE WITH QUERY) WITH ECG TRIGGERED AND PATIENT SELECTED EVENTS TRANSMITTED TO A REMOTE ATTENDED SURVEILLANCE CENTER FOR UP TO 30 DAYS; PHYSICIAN REVIEW AND INTERPRETATION WITH REPORT
93580	PERCUTANEOUS TRANSCATHETER CLOSURE OF CONGENITAL INTERATRIAL COMMUNICATION (EG, FONTAN FENESTRATION, ATRIAL SEPTAL DEFECT) WITH IMPLANT
93581	PERCUTANEOUS TRANSCATHETER CLOSURE OF CONGENITAL VENTRICULAR SEPTAL DEFECT WITH IMPLANT
93701	BIOIMPEDANCE, THORACIC, ELECTRICAL
93745	INITIAL SET-UP AND PROGRAMMING BY A PHYSICIAN OF WEARABLE CARДИOVERTER-DEFIBRILLATOR INCLUDES INITIAL PROGRAMMING OF SYSTEM, ESTABLISHING BASELINE ELECTRONIC ECG, TRANSMISSION OF DATA TO DATA REPOSITORY, PATIENT INSTRUCTION IN WEARING SYSTEM AND PATIENT REPORTING OF PROBLEMS OR EVENTS
93750	INTERROGATION OF VENTRICULAR ASSIST DEVICE (VAD), IN PERSON, WITH PHYSICIAN ANALYSIS OF DEVICE PARAMETERS (EG, DRIVELINES, ALARMS, POWER SURGES), REVIEW OF DEVICE FUNCTION (EG, FLOW AND VOLUME STATUS, SEPTUM STATUS, RECOVERY), WITH PROGRAMMING, IF PERFORMED, AND REPORT
93998	UNLISTED NONINVASIVE VASCULAR DIAGNOSTIC STUDY
94011	MEASUREMENT OF SPIROMETRIC FORCED EXPIRATORY FLOWS IN AN INFANT OR CHILD THROUGH 2 YEARS OF AGE
94012	MEASUREMENT OF SPIROMETRIC FORCED EXPIRATORY FLOWS, BEFORE AND AFTER BRONCHODILATOR, IN AN INFANT OR CHILD THROUGH 2 YEARS OF AGE
94013	MEASUREMENT OF LUNG VOLUMES (IE, FUNCTIONAL RESIDUAL CAPACITY [FRC], FORCED VITAL CAPACITY [FVC], AND EXPIRATORY RESERVE VOLUME [ERV]) IN AN INFANT OR CHILD THROUGH 2 YEARS OF AGE
94774	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORY RATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; INCLUDES MONITOR ATTACHMENT, DOWNLOAD OF DATA, PHYSICIAN REVIEW, INTERPRETATION, AND PREPARATION OF A REPORT
94775	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORY RATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; MONITOR ATTACHMENT ONLY (INCLUDES HOOK-UP, INITIATION OF RECORDING AND DISCONNECTION)
94776	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORY RATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; MONITORING, DOWNLOAD OF INFORMATION, RECEIPT OF TRANSMISSION(S) AND ANALYSES BY COMPUTER ONLY
94777	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORY RATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; PHYSICIAN REVIEW, INTERPRETATION AND PREPARATION OF REPORT ONLY
95800	SLEEP STUDY, UNATTENDED, SIMULTANEOUS RECORDING; HEART RATE, OXYGEN SATURATION, RESPIRATORY ANALYSIS (EG, BY AIRFLOW OR PERIPHERAL ARTERIAL TONE), AND SLEEP TIME
95801	SLEEP STUDY, UNATTENDED, SIMULTANEOUS RECORDING; MINIMUM OF HEART RATE, OXYGEN SATURATION, AND RESPIRATORY ANALYSIS (EG, BY AIRFLOW OR PERIPHERAL ARTERIAL TONE)
95806	SLEEP STUDY, SIMULTANEOUS RECORDING OF VENTILATION, RESP EFFORT
95873	ELECTRICAL STIMULATION FOR GUIDANCE IN CONJUNCTION WITH CHEMODENERVATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
95874	NEEDLE ELECTROMYOGRAPHY FOR GUIDANCE IN CONJUNCTION WITH CHEMODENERVATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
95961	FUNCTIONAL CORTICAL AND SUBCORTICAL MAPPING BY STIMULATION AND/OR RECORDING OF ELECTRODES ON BRAIN SURFACE OR DEPTH ELECTRODES, TO PROVOKE SEIZURES OR IDENTIFY VITAL BRAIN STRUCTURES; INITIAL HOUR OF PHYSICIAN ATTENDANCE
95962	FUNCTIONAL CORTICAL AND SUBCORTICAL MAPPING BY STIMULATION AND/OR RECORDING OF ELECTRODES ON BRAIN SURFACE OR DEPTH ELECTRODES, TO PROVOKE SEIZURES OR IDENTIFY VITAL BRAIN STRUCTURES; EACH ADDITIONAL HOUR OF PHYSICIAN ATTENDANCE
95965	MAGNETOENCEPHALOGRAPHY (MEG), RECORDING AND ANALYSIS; FOR SPONTANEOUS BRAIN MAGNETIC ACTIVITY (EG, EPILEPTIC CEREBRAL CORTEX LOCALIZATION) (NOT COVERED FOR COMMERCIAL PLAN MEMBERS)
95966	MAGNETOENCEPHALOGRAPHY (MEG), RECORDING AND ANALYSIS; FOR EVOKED MAGNETIC FIELDS, SINGLE MODALITY (EG, SENSORY, MOTOR, LANGUAGE, OR VISUAL CORTEX LOCALIZATION) (NOT COVERED FOR COMMERCIAL PLAN MEMBERS)
95967	MAGNETOENCEPHALOGRAPHY (MEG), RECORDING AND ANALYSIS; FOR EVOKED MAGNETIC FIELDS, EACH ADDITIONAL MODALITY (EG, SENSORY, MOTOR, LANGUAGE, OR VISUAL CORTEX LOCALIZATION) (NOT COVERED FOR COMMERCIAL PLAN MEMBERS)
95970	ELECTRONIC ANALYSIS OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM; SIMPLE OR COMPLEX BRAIN, SPINAL CORD OR PERIPHERAL NEUROSTIMULATOR PULSE GENERATOR/TRANSMITTER, W/O REPROGRAMMING
95971	ELECTRONIC ANALYSIS OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM; SIMPLE BRAIN, SPINAL CORD OR PERIPHERAL NEUROSTIMULATOR PULSE GENERATOR/TRANSMITTER, WITH INTRAOPERATIVE OR SUBSEQUENT PROGRAMMING
95972	ELECTRONIC ANALYSIS OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM; COMPLEX BRAIN, SPINAL CORD OR PERIPHERAL NEUROSTIMULATOR PULSE GENERATOR/TRANSMITTER, WITH INTRAOPERATIVE OR SUBSEQUENT PROGRAMMING, FIRST HOUR
95973	ELECTRONIC ANALYSIS OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM; COMPLEX BRAIN, SPINAL CORD OR PERIPHERAL NEUROSTIMULATOR PULSE GENERATOR/TRANSMITTER, WITH INTRAOPERATIVE OR SUBSEQUENT PROGRAMMING, EACH ADDITIONAL 30 MINUTES AFTER THE FIRST HOUR
95990	REFILLING OR MAINTENANCE OF IMPLANTABLE PUMP OR RESERVOIR FOR DRUG DELIVERY, SPINAL (INTRATHECAL, EPIDURAL) OR BRAIN (INTRAVENTRICULAR)
96020	NEUROFUNCTIONAL TESTING SELECTION AND ADMINISTRATION DURING NONINVASIVE IMAGING FUNCTIONAL BRAIN MAPPING, WITH TEST ADMINISTERED ENTIRELY BY A PHYSICIAN OR PSYCHOLOGIST, WITH REVIEW OF TEST RESULTS AND REPORT
96101	PSYCHOLOGICAL TESTING (INCLUDES PSYCHODIAGNOSTIC ASSESSMENT OF EMOTIONALITY, INTELLECTUAL ABILITIES, PERSONALITY AND PSYCHOPATHOLOGY, EG, MMPI, RORSHACH, WAIS), PER HOUR OF THE PSYCHOLOGIST'S OR PHYSICIAN'S TIME, BOTH FACE-TO-FACE TIME WITH THE PATIENT AND TIME INTERPRETING TEST RESULTS AND PREPARING THE REPORT
96102	PSYCHOLOGICAL TESTING (INCLUDES PSYCHODIAGNOSTIC ASSESSMENT OF EMOTIONALITY, INTELLECTUAL ABILITIES, PERSONALITY AND PSYCHOPATHOLOGY, EG, MMPI AND WAIS), WITH QUALIFIED HEALTH CARE PROFESSIONAL INTERPRETATION AND REPORT, ADMINISTERED BY TECHNICIAN, PER HOUR OF TECHNICIAN TIME, FACE-TO-FACE
96103	PSYCHOLOGICAL TESTING (INCLUDES PSYCHODIAGNOSTIC ASSESSMENT OF EMOTIONALITY, INTELLECTUAL ABILITIES, PERSONALITY AND PSYCHOPATHOLOGY, EG, MMPI), ADMINISTERED BY A COMPUTER, WITH QUALIFIED HEALTH CARE PROFESSIONAL INTERPRETATION AND REPORT
96105	ASSESSMENT OF APHASIA (INCLUDES ASSESSMENT OF EXPRESSIVE AND RECEPTIVE SPEECH AND LANGUAGE FUNCTION, LANGUAGE COMPREHENSION, SPEECH PRODUCTION ABILITY, READING, SPELLING, WRITING, EG, BY BOSTON DIAGNOSTIC APHASIA EXAMINATION) WITH INTERPRETATION AND REPORT

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
96116	NEUROBEHAVIORAL STATUS EXAM (CLINICAL ASSESSMENT OF THINKING, REASONING AND JUDGMENT, EG, ACQUIRED KNOWLEDGE, ATTENTION, LANGUAGE, MEMORY, PLANNING AND PROBLEM SOLVING, AND VISUAL SPATIAL ABILITIES), PER HOUR OF THE PSYCHOLOGIST'S OR PHYSICIAN'S TIME, BOTH FACE-TO-FACE TIME WITH THE PATIENT AND TIME INTERPRETING TEST RESULTS AND PREPARING THE REPORT
96118	NEUROPSYCHOLOGICAL TESTING (EG, HALSTEAD-REITAN NEUROPSYCHOLOGICAL BATTERY, WECHSLER MEMORY SCALES AND WISCONSIN CARD SORTING TEST), PER HOUR OF THE PSYCHOLOGIST'S OR PHYSICIAN'S TIME, BOTH FACE-TO-FACE TIME WITH THE PATIENT AND TIME INTERPRETING TEST RESULTS AND PREPARING THE REPORT
96119	NEUROPSYCHOLOGICAL TESTING (EG, HALSTEAD-REITAN NEUROPSYCHOLOGICAL BATTERY, WECHSLER MEMORY SCALES AND WISCONSIN CARD SORTING TEST), WITH QUALIFIED HEALTH CARE PROFESSIONAL INTERPRETATION AND REPORT, ADMINISTERED BY TECHNICIAN, PER HOUR OF TECHNICIAN TIME, FACE-TO-FACE
96120	NEUROPSYCHOLOGICAL TESTING (EG, WISCONSIN CARD SORTING TEST), ADMINISTERED BY A COMPUTER, WITH QUALIFIED HEALTH CARE PROFESSIONAL INTERPRETATION AND REPORT
96379	UNLISTED THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INTRAVENOUS OR INTRA-ARTERIAL INJECTION OR INFUSION
96549	UNLISTED CHEMOTHERAPY PROCEDURE
96921	LASER TREATMENT FOR INFLAMMATORY SKIN DISEASE (PSORIASIS); 250 SQ CM - 500 SQ CM (NOT COVERED FOR COMMERCIAL PLAN MEMBERS)
96922	LASER TREATMENT FOR INFLAMMATORY SKIN DISEASE (PSORIASIS); OVER 500 SQ CM (NOT COVERED FOR COMMERCIAL PLAN MEMBERS)
97005	ATHLETIC TRAINING EVALUATION
97006	ATHLETIC TRAINING RE-EVALUATION
97605	NEGATIVE PRESSURE WOUND THERAPY (EG, VACUUM ASSISTED DRAINAGE COLLECTION), INCLUDING TOPICAL APPLICATION(S), WOUND ASSESSMENT, AND INSTRUCTION(S) FOR ONGOING CARE, PER SESSION; TOTAL WOUND(S) SURFACE AREA LESS THAN OR EQUAL TO 50 SQUARE CENTIMETERS
97606	NEGATIVE PRESSURE WOUND THERAPY (EG, VACUUM ASSISTED DRAINAGE COLLECTION), INCLUDING TOPICAL APPLICATION(S), WOUND ASSESSMENT, AND INSTRUCTION(S) FOR ONGOING CARE, PER SESSION; TOTAL WOUND(S) SURFACE AREA GREATER THAN 50 SQUARE CENTIMETERS
97810	ACUPUNCTURE, 1 OR MORE NEEDLES; WITHOUT ELECTRICAL STIMULATION, INITIAL 15 MINUTES OF PERSONAL ONE-ON-ONE CONTACT WITH THE PATIENT
99408	ALCOHOL AND/OR SUBSTANCE (OTHER THAN TOBACCO) ABUSE STRUCTURED SCREENING (EG, AUDIT, DAST), AND BRIEF INTERVENTION (SBI) SERVICES; 15 TO 30 MINUTES
99409	ALCOHOL AND/OR SUBSTANCE (OTHER THAN TOBACCO) ABUSE STRUCTURED SCREENING (EG, AUDIT, DAST), AND BRIEF INTERVENTION (SBI) SERVICES; GREATER THAN 30 MINUTES
99441	TELEPHONE EVALUATION AND MANAGEMENT SERVICE PROVIDED BY A PHYSICIAN TO AN ESTABLISHED PATIENT, PARENT, OR GUARDIAN NOT ORIGINATING FROM A RELATED E/M SERVICE PROVIDED WITHIN THE PREVIOUS 7 DAYS NOR LEADING TO AN E/M SERVICE OR PROCEDURE WITHIN THE NEXT 24
99442	TELEPHONE EVALUATION AND MANAGEMENT SERVICE PROVIDED BY A PHYSICIAN TO AN ESTABLISHED PATIENT, PARENT, OR GUARDIAN NOT ORIGINATING FROM A RELATED E/M SERVICE PROVIDED WITHIN THE PREVIOUS 7 DAYS NOR LEADING TO AN E/M SERVICE OR PROCEDURE WITHIN THE NEXT 24
99443	TELEPHONE EVALUATION AND MANAGEMENT SERVICE PROVIDED BY A PHYSICIAN TO AN ESTABLISHED PATIENT, PARENT, OR GUARDIAN NOT ORIGINATING FROM A RELATED E/M SERVICE PROVIDED WITHIN THE PREVIOUS 7 DAYS NOR LEADING TO AN E/M SERVICE OR PROCEDURE WITHIN THE NEXT 24
99600	UNLISTED HOME VISIT SERVICE OR PROCEDURE
A9276	SENSOR; INVASIVE (E.G. SUBCUTANEOUS) DISPOSABLE, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM, 1 UNIT
A9277	TRANSMITTER; EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM
A9278	RECEIVER (MONITOR); EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
	SYSTEM
A9544	IODINE 1-131 TOSITUMOMAB, DIAGNOSTIC, PER STUDY DOSE
A9545	IODINE 1-131 TOSITUMOMAB, THERAPEUTIC, PER TREATMENT DOSE
B4150	ENTERAL FORMULA, NUTRITIONALLY COMPLETE WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AND ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT
B4152	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, CALORICALLY DENSE (EQUAL TO OR GREATER THAN 1.5 KCAL/ML) WITH INTACT NUTRIENTS, INCLUDES PROTIENS, FATS, CARBOHYDRATES, VITAMINS, MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AND ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT
B4153	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, HYDROLYZED PROTEINS (AMINO ACIDS AND PEPTIDE CHAINS), INCLUDES FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT
B4154	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, FOR SPECIAL METABOLIC NEEDS, EXCLUDES INHERITED DISEASE OF METABOLISM, INCLUDES ALTERED COMPOSITION OF PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND/OR MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE , 100 CALORIES = 1 UNIT
B4155	ENTERAL FORMULA, NUTRITIONALLY INCOMPLETE/MODULAR NUTRIENTS, INCLUDES SPECIFIC NUTRIENTS, CARBOHYDRATES (E.G., GLUCOSE POLYMERS), PROTEINS/AMINO ACIDS (E.G., GLUTAMINE, ARGININE), FAT (E.G., MEDIUM CHAIN TRIGLYCERIDES) OR COMBINATION, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT
B4157	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, FOR SPECIAL METABOLIC NEEDS FOR INHERITED DISEASE OF METABOLISM, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT
B4158	ENTERAL FORMULA FOR PEDI, NUTRITIONALLY COMPLETE
B4159	ENTERAL FORMULA FOR PEDIATRICS, NUTRITIONALLY COMPLETE, CALORIC DENSE
B4160	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE CALORICALLY DENSE (EQUAL TO OR GREATER THAN 0.7 KCAL/ML) WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT.
B4161	ENTERAL FORMULA, FOR PEDIATRICS, HYDROLYZED/AMINO ACIDS AND PEPTIDE CHAIN PROTEINS, INCLUDES FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AND ENTERAL FEEDING TUBE, 100 CALORIES – 1 UNIT
B4162	ENTERAL FORMULA, FOR PEDIATRICS, SPECIAL METABOLIC NEEDS FOR INHERITED DISEASE OF METABOLISM, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AND ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT.
C1300	HYPERBARIC OXYGEN UNDER PRESSURE, FULL BODY CHAMBER, PER 30 MINUTE INTERVAL
C2635	BRACHYTX SOURCE, HA, P-103
C2636	BRACHYTS LINEAR SOURCE, P-10
C8957	IV INFUS TX/DX; INIT PROLNG RQR PORT/IMPL PUMP
C9254	INJECTION, LACOSAMIDE, 1 MG
C9255	INJECTION, PALIPERIDONE PALMITATE, 1 MG
C9256	INJECTION, DEXAMETHASONE INTRAVITREAL IMPLANT, 0.1 MG
C9258	INJECTION, TELEVANCIN, 10MG
C9259	INJECTION, PRALATREXATE, 1 MG
C9260	INJECTION, OFATUMUMAB, 10 MG
C9261	INJECTION, USTEKINUMAB, 1 MG
C9262	FLUDARABINE PHOSPHATE, ORAL, 1 MG
C9263	INJECTION, ECALLANTIDE, 1 MG
C9264	INJECTION, TOCILIZUMAB, 1 MG
C9265	INJECTION, ROMIDEPSIN, 1 MG

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
C9266	INJECTION, COLLAGENASE CLOSTRIDIUM HISTOLYTICUM, 0.1 MG
C9277	INJECTION, ALGLUCOSIDASE ALFA (LUMIZYME), 1 MG
C9278	INJECTION, INCOBOTULINUMTOXINA, 1 UNIT
C9351	ACELLULAR DERMAL TISSUE MATRIX OF NON-HUMN ORIGIN, PER SQUARE CENTIMETER (DO NOT REPORT C9351 IN CONJUNCTION WITH J7345)
C9366	EPIFIX, PER SQUARE CENTIMETER
C9724	ENDOSCOPIC PLICATION GASTRIC CARDIA EPS W/ENDO
C9726	PLCMT REMOVAL APPLICATOR TO BREAST RADIATION TX
C9727	INSERTION IMPL TO SOFT PALATE; MINIMUM 3 IMPL
C9732	INSERTION OF OCULAR TELESCOPE PROSTHESIS INCLUDING REMOVAL OF CRYSTALLINE LENS
D0486	ACCESSION OF BRUSH BIOPSY SAMPLE, MICROSCOPIC EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT
D4210	GINGIVECT/PLSTY 4/>CNTIG/BOUND TEETH SPACES-QUAD
D4211	GINGIVECT/PLSTY 1-3 CNTIG/BOUND TEETH SPACE-QUAD
D4241	GINGL FLP PROC 1-3 CONTIG/BOUND TEETH SPACE-QUAD
D4260	OSSEOUS SURG 4/> CONTIG/BOUND TEETH SPACES-QUAD
D4261	OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE) - ONE TO THREE TEETH, PER QUADRANT
D4263	BONE REPLACEMENT GRAFT - FIRST SITE IN QUADRANT
D4264	BONE REPLACEMENT GRAFT - EACH ADDITIONAL SITE IN QUADRANT
D4265	BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION
D4266	GUIDED TISSUE REGENERATION - RESORBABLE BARRIER, PER SITE
D4267	GUIDED TISSUE REGENERATION - NONRESORBABLE BARRIER, PER SITE (INCLUDES MEMBRANE REMOVAL)
D4268	SURGICAL REVISION PROCEDURE, PER TOOTH
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE
D4271	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY)
D4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY)
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)
D4275	SOFT TISSUE ALLOGRAFT
D4276	COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICLE GRAFT
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE PERIODONTAL EVALUATION AND DIAGNOSIS
D4381	LOCALIZED DELIVERY OF CHEMOTHERAPEUTIC AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH, BY REPORT
D5984	RADIATION SHIELD
D5985	RADIATION CONE LOCATOR
D6012	SURGICAL PLACEMENT OF INTERIM IMPLANT BODY FOR TRANSITIONAL PROSTHESIS: ENDOSTEAL IMPLANT
D6091	REPLACEMENT OF SEMI-PRECISION OR PRECISION ATTACHMENT (MALE OR FEMALE COMPONENT) OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS, PER ATTACHMENT
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)
D7260	OROLANTRAL FISTULA CLOSURE
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION
D7270	TOOTH REIMPLANTATION AND / OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH AND / OR ALVEOLUS
D7272	TOOTH TRANSPLANTATION (INCLUDES REIMPLANTATION FROM ONE SITE TO ANOTHER AND SPLINTING AND / OR STABILIZATION)

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
D7280	SURGICAL EXPOSURE OF IMPACTED OR UNERUPTED TOOTH FOR ORTHODONTIC REASONS (INCLUDING ORTHODONTIC ATTACHMENTS)
D7287	CYTOLOGY SAMPLE COLLECTION
D7290	SURGICAL REPOSITIONING OF TEETH
D7291	TRANSSEPTAL FIBEROTOMY, BY REPORT
D7292	SURGICAL PLACEMENT: TEMPORARY ANCHORAGE DEVICE [SCREW RETAINED PLATE] REQUIRING SURGICAL FLAP
D7293	SURGICAL PLACEMENT: TEMPORARY ANCHORAGE DEVICE REQUIRING SURGICAL FLAP
D7294	SURGICAL PLACEMENT: TEMPORARY ANCHORAGE DEVICE WITHOUT SURGICAL FLAP
D7340	VESTIBULOPLASTY - RIDGE EXTENSION (SECOND EPITHELIALIZATION) (CPT 40840, 40842, 40843, 40844)
D7350	VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENTS, REVISION OF SOFT TISSUE ATTACHMENT AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE). (CPT CODES 40845)
D7410	RADICAL EXCISION - LESION DIAMETER UP TO 1.25CM
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25CM
D7412	EXCISION OF BENIGN LESION, COMPLICATED
D7413	EXCISION OF MALIGNANT LESION, UP TO 1.25CM
D7414	EXCISION OF MALIGNANT LESION, GREATER THAN 1.25 CM
D7415	EXCISION OF MALIGNANT LESION, COMPLICATED
D7440	EXCISION OF MALIGNANT TUMOR - LESION DIAMETER UP TO 1.25CM
D7441	EXCISION OF MALIGNANT TUMOR - LESION DIAMETER GREATER THAN 1.25CM
D7450	REMOVAL OF ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25CM
D7451	REMOVAL OF ODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25CM
D7460	REMOVAL OF NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25CM
D7461	REMOVAL OF NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25CM
D7465	DESTRUCTION OF LESION(S) BY PHYSICAL OR CHEMICAL METHOD, BY REPORT (CPT CODE 41850)
D7472	REMOVAL OF TORUS PALATINUS
D7473	REMOVAL OF TORUS MANDIBULARIS
D7485	SURGICAL REDUCTION OF OSSEOUS TUBEROSITY
D7490	RADICAL RESECTION OF MANDIBLE WITH BONE GRAFT (CPT CODE 21045)
D7510	INCISION AND DRAINAGE OF ABCESS - INTRAORAL SOFT TISSUE (CPT CODE 41800)
D7520	INCISION AND DRAINAGE OF ABCESS - EXTRAORAL SOFT TISSUE (CPT CODE 40800)
D7530	REMOVAL OF FOREIGN BODY, SKIN, OR SUBCUTANEOUS ALVEOLAR TISSUE (CPT CODES 41805, 41828)
D7540	REMOVAL OF REACTION-PRODUCING FOREIGN BODIES, MUSCULOSKELETAL SYSTEM (CPT CODES 20520, 41800, 41806)
D7550	SEQUESTRECTOMY FOR OSTEOMYELITIS (CPT CODE 20999)
D7560	MAXILLARY SINUSOTOMY FOR REMOVAL OF TOOTH FRAGMENT OR FOREIGN BODY (CPT CODE 31020)
D7610	MAXILLA - OPEN REDUCTION (TEETH IMMOBILIZED)
D7620	MAXILLA - CLOSED REDUCTION (TEETH IMMOBILIZED)
D7630	MANDIBLE - OPEN REDUCTION (TEETH IMMOBILIZED)
D7640	MANDIBLE - CLOSED REDUCTION (TEETH IMMOBILIZED)
D7650	MALAR AND / OR ZYGOMATIC ARCH - OPEN REDUCTION
D7660	MALAR AND / OR ZYGOMATIC ARCH - CLOSED REDUCTION
D7670	ALVEOLUS - STABILIZATION OF TEETH, CLOSED REDUCTION SPLINTING
D7671	ALVEOLUS - OPEN REDUCTION, MAY INCLUDE STABILIZATION OF TEETH
D7680	FACIAL BONES - COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES
D7710	MAXILLA - OPEN REDUCTION (CPT CODE 21346)

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
D7720	MAXILLA - CLOSED REDUCTION (CPT CODE 21345)
D7730	MANDIBLE - OPEN REDUCTION (CPT CODES 21461, 21462)
D7740	MANDIBLE - CLOSED REDUCTION (CPT CODE 21455)
D7750	MALAR AND / OR ZYGOMATIC ARCH - OPEN REDUCTION (CPT CODES 21360, 21365)
D7760	MALAR AND / OR ZYGOMATIC ARCH - CLOSED REDUCTION (CPT CODE 21355)
D7770	ALVEOLUS - STABILIZATION OF TEETH, OPEN REDUCTION SPLINTING (CPT CODE 21422)
D7771	ALVEOLUS - CLOSED REDUCTION STABILIZATION OF TEETH
D7780	FACIAL BONES - COMPLICATED REDUCTION W FIXATION & MULTIPLE APPROACHES (CPT 21435, 21436)
D7810	OPEN REDUCTION OF DISLOCATION (CPT CODE 21490)
D7820	CLOSED REDUCTION OF DISLOCATION (CPT CODE 21480)
D7830	MANIPULATION UNDER ANESTHESIA (CPT CODE 00190)
D7840	CONDYLECTOMY (CPT CODE 21050)
D7850	SURGICAL DISCECTOMY WITH OR WITHOUT IMPLANT (CPT CODE 21060)
D7852	DISC REPAIR (CPT CODE 21299)
D7854	SYNOVECTOMY (CPT CODE 21299)
D7856	MYOTOMY (CPT CODE 21299)
D7858	JOINT RECONSTRUCTION (CPT CODES 21242, 21243)
D7860	ARTHROTOMY
D7865	ARTHROPLASTY (CPT CODE 21240)
D7870	ARTHROCENTESIS (CPT CODE 21060)
D7871	NON-ARTHROSCOPIC LYSIS AND LAVAGE
D7872	ARTHROSCOPY - DIAGNOSIS WITH OR WITHOUT BIOPSY (CPT CODE 29800)
D7873	ARTHROSCOPY - SURGICAL: LAVAGE AND LYSIS OF ADHESIONS (CPT CODE 29804)
D7874	ARTHROSCOPY - SURGICAL: DISC REPOSITIONING AND STABILIZATION (CPT CODE 29804)
D7875	ARTHROSCOPY - SURGICAL: SYNOVECTOMY (CPT CODE 29804)
D7876	ARTHROSCOPY - SURGICAL: DISCECTOMY (CPT CODE 29804)
D7877	ARTHROSCOPY - SURGICAL: DEBRIDEMENT (CPT CODE 29804)
D7899	UNSPECIFIED TMD THERAPY, BY REPORT (CPT CODE 21499)
D7911	COMPLICATED SUTURE - UP TO 5 CM (CPT CODES 12051, 12052)
D7912	COMPLICATED SUTURE - GREATER THAN 5CM (CPT CODE 13132)
D7920	SKIN GRAFT (IDENTIFY DEFECT COVERED, LOCATION, AND TYPE OF GRAFT)
D7940	OSTEOPLASTY - FOR ORTHOGNATHIC DEFORMITIES
D7941	OSTEOTOMY - MANDIBULAR RAMI (CPT CODES 21193, 21195, 21196)
D7943	OSTEOTOMY - MANDIBULAR RAMI WITH BONE GRAFT (CPT CODE 21194)
D7944	OSTEOTOMY - SEGMENTED OR SUBAPICAL - PER SEXTANT OR QUADRANT (CPT CODES 21198, 21206)
D7945	OSTEOTOMY - BODY OF MANDIBLE (CPT CODES 21193, 21194, 21195, 21196)
D7946	LEFORT I (MAXILLA - TOTAL) (CPT CODE 21147)
D7947	LEFORT I (MAXILLA - SEGMENTED) (CPT CODES 21145, 21146)
D7948	LEFORT II OR LEFORT III (OSTEOPLASTY OF FACIAL BONES FOR MIDFACE HYPOPLASIA OR RETRUSION) WITHOUT BONE GRAFT (CPT CODE 21150)
D7949	LEFORT II OR LEFORT III (OSTEOPLASTY OF FACIAL BONES FOR MIDFACE HYPOPLASIA OR RETRUSION) WITH BONE GRAFT
D7950	OSSEOUS, OSTEOPERIOSTEAL / CARTILAGE GRAFT OF THE MANDIBLE / FACIAL BONES - AUTOGENOUS OR NONAUTOGENOUS BY REPORT (CPT 21247)
D7951	SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES
D7960	FRENULECTOMY (FRENECTOMY OR FRENOTOMY) - SEPARATE PROCEDURE (CPT CODES 40819, 41010, 41115)

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
D7970	EXCISION OF HYPERPLASTIC TISSUE - PER ARCH
D7971	EXCISION OF PERICORONAL GINGIVA (CPT CODE 41821)
D7972	SURGICAL REDUCTION OF FIBROUS TUBEROSITY
D7980	SIALOLITHOTOMY (CPT CODES 42330, 42335, 42340)
D7981	EXCISION OF SALIVARY GLAND (CPT CODE 42408)
D7982	SIALODOCHOPLASTY (CPT CODE 42500)
D7983	CLOSURE OF SALIVARY FISTULA (CPT CODE 42600)
D7990	EMERGENCY TRACHEOTOMY (CPT CODES 31603, 31605)
D7991	CORONOIDECTOMY (CPT CODE 21070)
D7995	SYNTHETIC GRAFT - MANDIBLE OR FACIAL BONES (CPT CODE 21299)
D7996	IMPLANT - MANDIBLE FOR AUGMENTATION PURPOSES (CPT CODE 21299)
D7998	INTRAORAL PLACEMENT OF A FIXATION DEVICE NOT IN CONJUNCTION WITH A FRACTURE
D9220	GENERAL ANESTHESIA - FIRST THIRTY MINUTES
D9221	GENERAL ANESTHESIA - EACH ADDL 15 M
D9241	INTRAVENOUS SEDATION / ANALGESIA - FIRST THIRTY MINUTES
D9242	INTRAVENOUS SEDATION / ANALGESIA - EACH ADDITIONAL FIFTEEN MINUTES
D9612	THERAPEUTIC PARENTERAL DRUGS, TWO OR MORE ADMINISTRATIONS, DIFFERENT MEDICATIONS
D9930	TREATMENT OF COMPLICATIONS (POST-SURGICAL) - UNUSUAL CIRCUMSTANCES
E0602	BREAST PUMP, MANUAL, ANY TYPE
E1831	STATIC PROGRESSIVE STRETCH TOE DEVICE, EXTENSION AND/OR FLEXION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES
G0248	DEMONSTRATION, USE OF HOME INR MONITOR
G0249	PROVIDE TESTING MATERIAL AND EQUIPMENT FOR HOME INR MONITOR
G0250	MD REVIEW AND INTERPRETATION OF HOME TESTING INR RESULTS
G0267	BONE MARROW OR PERIPHERAL STEM CELL HARVEST, MODIFICATION, OR TREATMENT TO ELIMINATE CELL TYPE(S) (EG, T-CELLS, METASTATIC CARCINOMA)
G0268	REMOVAL OF IMPACTED CERUMEN (ONE OR BOTH EARS) BY PHYSICIAN ON SAME DAY OF SERVICE AS AUDIOLOGIC G0269FUNCTION TESTING
G0281	ELECTRICAL STIMULATION, (UNATTENDED), TO ONE OR MORE AREAS, FOR CHRONIC STAGE III AND STAGE IV PRESSURE ULCERS, ARTERIAL ULCERS, DIABETIC ULCERS, AND VENOUS STASIS ULCERS NOT DEMONSTRATING MEASURABLE SIGNS OF HEALING AFTER 30 DAYS OF CONVENTIONAL CARE, AS PART OF A THERAPY PLAN OF CARE
G0283	ELECTRICAL STIMULATION, (UNATTENDED), TO ONE OR MORE AREAS FOR INDICATIONS OTHER THAN WOUND CARE, AS PART OF A THERAPY PLAN OF CARE
G0288	RECONSTRUCTION, COMPUTED TOPOGRAPHY ANGIOGRAPHY OF AORTA FOR SURGICAL PLANNING FOR VASCULAR SURGERY
G0409	SOCIAL WORK AND PSYCHOLOGICAL SERVICES, DIRECTLY RELATING TO AND/OR FURTHERING THE PATIENT'S REHABILITATION GOALS, EACH 15 MINUTES, FACE-TO-FACE; INDIVIDUAL (SERVICES PROVIDED BY A CORF-QUALIFIED SOCIAL WORKER OR PSYCHOLOGIST IN A CORF)
G0410	GROUP PSYCHOTHERAPY OTHER THAN OF A MULTIPLE-FAMILY GROUP, IN A PARTIAL HOSPITALIZATION SETTING, APPROXIMATELY 45 TO 50 MINUTES
G0411	INTERACTIVE GROUP PSYCHOTHERAPY, IN A PARTIAL HOSPITALIZATION SETTING, APPROXIMATELY 45 TO 50 MINUTES
G0412	OPEN TREATMENT OF ILIAC SPINE(S), TUBEROSITY AVULSION, OR ILIAC WING FRACTURE(S), UNILATERAL OR BILATERAL FOR PELVIC BONE FRACTURE PATTERNS WHICH DO NOT DISRUPT THE PELVIC RING INCLUDES INTERNAL FIXATION, WHEN PERFORMED

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
G0413	PERCUTANEOUS SKELETAL FIXATION OF POSTERIOR PELVIC BONE FRACTURE AND/OR DISLOCATION, FOR FRACTURE PATTERNS WHICH DISRUPT THE PELVIC RING, UNILATERAL OR BILATERAL, (INCLUDES ILIUM, SACROILIAC JOINT AND/OR SACRUM)
G0414	OPEN TREATMENT OF ANTERIOR PELVIC BONE FRACTURE AND/OR DISLOCATION FOR FRACTURE PATTERNS WHICH DISRUPT THE PELVIC RING, UNILATERAL OR BILATERAL, INCLUDES INTERNAL FIXATION WHEN PERFORMED (INCLUDES PUBIC SYMPHYSIS AND/OR SUPERIOR/INFERIOR RAMI)
G0415	OPEN TREATMENT OF POSTERIOR PELVIC BONE FRACTURE AND/OR DISLOCATION, FOR FRACTURE PATTERNS WHICH DISRUPT THE PELVIC RING, UNILATERAL OR BILATERAL, INCLUDES INTERNAL FIXATION, WHEN PERFORMED (INCLUDES ILIUM, SACROILIAC JOINT AND/OR SACRUM)
G0428	INITIAL INPATIENT TELEHEALTH CONSULTATION, TYPICALLY SPENDS 80 MINUTES COMMUNICATING WITH THE PATIENT VIA TELEHEALTH
G0429	INITIAL INPATIENT TELEHEALTH CONSULTATION, TYPICALLY SPENDS 110 MINUTES COMMUNICATING WITH THE PATIENT VIA TELEHEALTH
G3001	ADMINISTRATION AND SUPPLY OF TOSITUMOMAB, 450MG
H0031	MENTAL HEALTH ASSESSMENT, BY NON-PHYSICIAN
H0032	MENTAL HEALTH SERVICE PLAN DEVELOPMENT BY NON-PHYSICIAN
H0033	ORAL MEDICATION ADMINISTRATION, DIRECT OBSERVATION
H0034	MEDICATION TRAINING AND SUPPORT, PER 15 MINUTES
H0038	SELF-HELP / PEER SERVICES, PER 15 MINUTES
H0039	ASSERTIVE COMMUNITY TREATMENT, FACE-TO-FACE, PER 15 MINUTES
H0040	ASSERTIVE COMMUNITY TREATMENT PROGRAM, PER DIEM
H0045	RESPIRE CARE SERVICES, NOT IN THE HOME, PER DIEM
H1010	NON-MEDICAL FAMILY PLANNING EDUCATION, PER SESSION
H2000	COMPREHENSIVE MULTIDISCIPLINARY EVALUATION
H2001	REHABILITATION PROGRAM, PER 1/2 DAY
H2021	COM WRAP-AROUND, SV, 15 MIN
H2022	COM WRAP-AROUND SV, PER DIEM
J0128	ABARELIX INJECTION, 10 MG
J0129	INJECTION, ABATACEPT, 10 MG
J0131	INJECTION, ACETAMINOPHEN, 10 MG
J0132	INJECTION ACETYLCYSTEINE 100 MG
J0133	INJECTION ACYCLOVIR 5 MG
J0180	AGALSIDASE BETA INJECTION, 1MG
J0207	AMIFOSTINE
J0215	INJECTION, ALEFACEPT, 0.5 MG
J0221	INJECTION, ALGLUCOSIDASE ALFA, (LUMIZYME), 10 MG
J0256	ALPHA 1-PROTEINASE INHIBITOR
J0257	INJECTION, ALPHA 1 PROTEINASE INHIBITOR (HUMAN), (GLASSIA), 10 MG
J0278	INJECTION AMIKACIN SULFATE 100 MG
J0287	AMPHOTERCIN B LIPID
J0289	AMPHOTERCIN B LIPOSOME
J0348	INJECTION, ANADULAFUNGIN, 1 MG
J0364	INJECTION, APOMORPHINE HYDROCHLORIDE, 1 MG
J0365	INJECTION APROTONIN 10000 KIU
J0480	INJECTION, BASILIXIMAB, 20 MG
J0490	INJECTION, BELIMUMAB, 10 MG
J0585	BOTULINIUM TOXIN TYPE A

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
J0586	INJECTION, ABOBOTULINUMTOXINA, 5 UNITS
J0587	BOTULINIUM TOXIN TYPE B
J0588	INJECTION, INCOBOTULINUMTOXIN A, 1 UNIT
J0597	INJECTION, C-1 ESTERASE INHIBITOR (HUMAN), BERINERT, 10 UNITS
J0598	INJECTION, C1 ESTERASE INHIBITOR (HUMAN), 10 UNITS
J0638	INJECTION, CANAKINUMAB, 1 MG
J0641	INJECTION, LEVOLEUCOVORIN CALCIUM, 0.5 MG
J0712	INJECTION, CEFTAROLINE FOSAMIL, 10 MG
J0718	INJECTION, CERTOLIZUMAB PEGOL, 1 MG
J0725	INJECTION, CHORIONIC GONADOTROPIN, PER 1,000 USP UNITS
J0775	INJECTION, COLLAGENASE, CLOSTRIDIUM HISTOLYTICUM, 0.01 MG
J0795	INJ CORTICORELIN OVINE TRIFLUTATE 1 MICROGM
J0800	INJECTION, CORTICOTROPIN, UP TO 40 UNITS
J0840	INJECTION, CROTALIDAE POLYVALENT IMMUNE FAB (OVINE), UP TO 1 GRAM
J0878	DAPTOMYCIN INJECTION, 1 MG
J0881	INJECTION DARBEPOETIN ALFA 1 MCG NON-ESRD USE
J0882	INJ DARBEPOETIN ALFA 1 MCG FOR ESRD DIALYSIS
J0885	INJECTION EPOETIN ALFA FOR NON-ESRD 1000 UNITS
J0886	INJECTION, EPOETIN ALFA, 1000 UNITS (FOR ESRD ON DIALYSIS)
J0894	INJECTION, DECITABINE, 1 MG
J0897	INJECTION, DENOSUMAB, 1 MG
J1162	INJECTION DIGOXIN IMMUNE FAB OVINE PER VIAL
J1265	INJECTION DOPAMINE HCL 40 MG
J1267	INJECTION, DORIPENEM, 10 MG
J1290	INJECTION, ECALLANTIDE, 1 MG
J1300	INJECTION ECULIZUMAB 10 MG
J1430	INJECTION ETHANOLAMINE OLEATE 100 MG
J1438	ENTANERCEPT
J1451	INJECTION FOMEPIZOLE 15 MG
J1457	GALLIUM NITRATE INJECTION, 1 MG
J1458	INJECTION, GALSULFASE, 1 MG
J1459	INJECTION, IMMUNE GLOBULIN (PRIVIGEN), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG
J1557	INJECTION, IMMUNE GLOBULIN, (GAMMAPLEX), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG
J1559	INJECTION, IMMUNE GLOBULIN (HIZENTRA), 100 MG
J1561	INJECTION, IMMUNE GLOBULIN, (GAMUNEX), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500MG
J1562	INJECTION, IMMUNE GLOBULIN, SUBCUTANEOUS, 100 MG
J1563	IMMUNE GLOBULIN INTRAVENOUS
J1564	IMMUNE GLOBULIN INTRAVENOUS
J1566	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G. POWDER), 500 MG
J1568	INJ IG OCTOGAM IV NONLYOPHILIZED 500 MG
J1569	INJ IG GAMMAGARD LIQ IV NONLYOPHILIZED 500 MG
J1572	INJ IG FLEBOGAMMA IV NONLYOPHILIZED 500 MG
J1595	INJECTION, GLATIRAMER ACETATE, 20 MG
J1599	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NONLYOPHILIZED (E.G., LIQUID), NOT OTHERWISE SPECIFIED, 500 MG
J1640	INJECTION, HEMIN, 1 MG
J1675	INJECTION HISTRELIN ACETATE 10 MICROGRAMS

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
J1725	INJECTION, HYDROXYPROGESTERONE CAPROATE, 1 MG
J1740	INJECTION, IBANDRONATE SODIUM, 1 MG
J1743	INJECTION IDURSULFASE 1 MG
J1745	INFLIXIMAB
J1786	INJECTION, IMIGLUCERASE, 10 UNITS
J1930	INJECTION, LANREOTIDE, 1 MG
J1945	INJECTION LEPIRUDIN 50 MG
J2170	INJECTION, MECASERMIN, 1 MG
J2248	INJECTION, MICAFUNGIN SODIUM, 1 MG
J2265	INJECTION, MINOCYCLINE HYDROCHLORIDE, 1 MG
J2278	INJECTION ZICONOTIDE 1 MICROGRAM
J2315	INJECTION, NALTREXONE, DEPOT FORM, 1 MG
J2323	INJECTION NATALIZUMAB 1 MG
J2325	INJECTION, NESIRITIDE, 0.1 MG
J2353	INJECTION, OCTREOTIDE, DEPOT FORM FOR INTRAMUSCULAR INJECTION, 1 MG
J2354	INJECTION, OCTREOTIDE, NON-DEPOT FORM FOR SUBCUTANEOUS OR INTRAVENOUS INJECTION, 25 MCG
J2357	OMALIZUMAB INJECTION, 5 MG
J2425	INJECTION, PALIFERMIN, 50 MICROGRAMS
J2503	INJECTION, PEGAPTANIB SODIUM, 0.3 MG
J2504	INJECTION, PEGADEMASE BOVINE, 25 IU
J2507	INJECTION, PEGLOTICASE, 1 MG
J2513	INJECTION PENTASTARCH 10% SOLUTION 100 ML
J2562	INJECTION, PLERIXAFOR, 1 MG
J2675	INJECTION, PROGESTERONE, PER 50 MG
J2724	INJECTION PROTEN C CONCENTRATE IV HUMAN 10 IU
J2793	INJECTION, RILONACEPT, 1 MG
J2796	INJECTION, ROMIPILOSTIM, 10 MICROGRAMS
J2850	INJECTION SECRETIN SYNTHETIC HUMAN 1 MICROGRAM
J3101	INJECTION, TENECTEPLASE, 1 MG
J3110	TERIPARATIDE INJECTION, 10 MCG
J3243	INJECTION, TIGECYCLINE, 1 MG
J3262	INJECTION, TOCILIZUMAB, 1 MG
J3285	INJECTION, TREPROSTINIL, 1 MG
J3355	INJECTION, UROFOLLITROPIN, 75 IU
J3357	INJECTION, USTEKINUMAB, 1 MG
J3385	INJECTION, VELAGLUCERASE ALFA, 100 UNITS
J3488	INJECTION ZOLEDRONICCID RECLAST 1 MG
J7131	HYPERTONIC SALINE SOLUTION, 1 ML
J7180	INJECTION, FACTOR XIII (ANTIHEMOPHILIC FACTOR, HUMAN), 1 I.U.
J7183	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, 1 I.U. VWF:RCO
J7189	FACTOR VIIA 1 MICROGRAM
J7303	CONTRACEPTIVE SUPPLY, HORMONE CONTAINING VAGINAL RING, EACH
J7319	HYALURONAN (SODIUM HYALURONATE) OR DERIVATIVE, INTRA-ARTICULAR INJECTION, PER INJECTION
J7321	HYALURONAN/DERIV HYALGAN/SUPARTZ IA INJ PER DOSE
J7323	HYALURONAN/DERIVATIVE EUFLEXXA IA INJ PER DOSE
J7324	HYALURONAN/DERIV ORTHOVISC IA INJ PER DOSE

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
J7325	HYALURONAN OR DERIVATIVE, SYNVISCO OR SYNVISCO-ONE, FOR INTRA-ARTICULAR INJECTION, 1 MG
J7326	HYALURONAN OR DERIVATIVE, GEL-ONE, FOR INTRA-ARTICULAR INJECTION, PER DOSE
J7335	CAPSAICIN 8% PATCH, PER 10 SQ CM
J7605	ARFORMOTEROL INHAL SOL NONCOMP UNIT DOSE 15 MG
J7606	FORMOTEROL FUMARATE, INHALATION SOLUTION, FDA APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 20 MICROGRAMS
J7686	TREPROSTINIL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NONCOMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 1.74 MG
J8498	ANTIEMETIC DRUG RECTAL/SUPPOSITORY NOS
J8515	CABERGOLINE ORAL 0.25 MG
J8540	DEXAMETHASONE ORAL 0.25 MG
J8561	EVEROLIMUS, ORAL, 0.25 MG
J8565	GEFITINIB ORAL, 250 MG
J8597	ANTIEMETIC DRUG ORAL NOT OTHERWISE SPECIFIED
J8650	NABILONE, ORAL, 1 MG
J8705	TOPOTECAN, ORAL, 0.25 MG
J9025	INJECTION, AZACITIDINE, 1 MG
J9027	INJECTION CLOFARABINE 1 MG
J9033	INJECTION, BENDAMUSTINE HCL, 1 MG
J9043	INJECTION, CABAZITAXEL, 1 MG
J9160	INJECTION, DENILEUKIN DIFTITOX, 300 MCG
J9175	INJECTION ELLIOTTS B SOLUTION 1 ML
J9179	INJECTION, ERIBULIN MESYLATE, 0.1 MG
J9207	INJECTION, IXABEPILONE, 1 MG
J9216	INTERFERON GAMMA-1B 3 MILLION UNITS
J9228	INJECTION, IPILIMUMAB, 1 MG
J9261	INJECTION, NELARABINE, 50 MG
J9302	INJECTION, OFATUMUMAB, 10 MG
J9303	INJECTION PANITUMUMAB 10 MG
J9307	INJECTION, PRALATREXATE, 1 MG
J9315	INJECTION, ROMIDEPSIN, 1 MG
L5703	ANKLE, SYMES, MOLDED TO PATIENT MODEL, SOCKET WITHOUT SOLID ANKLE CUSHION HEEL (SACH) FOOT, REPLACEMENT ONLY
L5706	CUSTOM SHAPED PROTECTIVE COVER, KNEE DISARTICULATION
L5961	ADDITION, ENDOSKELETAL SYSTEM, POLYCENTRIC HIP JOINT, PNEUMATIC OR HYDRAULIC CONTROL, ROTATION CONTROL, WITH OR WITHOUT FLEXION AND/OR EXTENSION CONTROL
L5971	ALL LOWER EXTREMITY PROSTHESIS, SOLID ANKLE CUSHION HEEL (SACH) FOOT, REPLACEMENT ONLY
L8400	PROSTHETIC SHEATH, BELOW KNEE, EACH
L8410	PROSTHETIC SHEATH, ABOVE KNEE, EACH
L8415	PROSTHETIC SHEATH, UPPER LIMB, EACH
L8417	PROSTHETIC SHEATH/SOCK, INCLUDING A GEL CUSHION LAYER, BELOW KNEE OR ABOVE KNEE, EACH
L8420	PROSTHETIC SOCK, MULTIPLE PLY, BELOW KNEE, EACH
L8430	PROSTHETIC SOCK, MULTIPLE PLY, ABOVE KNEE, EACH
L8435	PROSTHETIC SOCK, MULTIPLE PLY, UPPER LIMB, EACH
L8440	PROSTHETIC SHRINKER, BELOW KNEE, EACH
L8460	PROSTHETIC SHRINKER, ABOVE KNEE, EACH
L8465	PROSTHETIC SHRINKER, UPPER LIMB, EACH

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
L8470	PROSTHETIC SOCK, SINGLE PLY, FITTING, BELOW KNEE, EACH
L8480	PROSTHETIC SOCK, SINGLE PLY, FITTING, ABOVE KNEE, EACH
L8485	PROSTHETIC SOCK, SINGLE PLY, FITTING, UPPER LIMB, EACH
L8604	INJECTABLE BULKING AGENT, DEXTRANOMER/HYALURONIC ACID COPOLYMER IMPLANT, URINARY TRACT, 1 ML, INCLUDES SHIPPING AND NECESSARY SUPPLIES
L8620	LITHIUM ION BATTERY FOR COCH. IMPLANT, REPLACE, EA.
L8693	AUDITORY OSSEOINTEGRATED DEVICE ABUTMENT, ANY LENGTH, REPLACEMENT ONLY
Q0137	INJECTION, DARBEPOETIN ALFA, 1 MCG (NON-ESRD USE)
Q0138	INJECTION, FERUMOXYTOL, FOR TREATMENT OF IRON DEFICIENCY ANEMIA, 1 MG (NON-ESRD USE)
Q0139	INJECTION, FERUMOXYTOL, FOR TREATMENT OF IRON DEFICIENCY ANEMIA, 1 MG (FOR ESRD ON DIALYSIS)
Q0162	ONDANSETRON 1 MG, ORAL, FDA APPROVED PRESCRIPTION ANTIEMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTIEMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN
Q0478	POWER ADAPTER FOR USE WITH ELECTRIC OR ELECTRIC/PNEUMATIC VENTRICULAR ASSIST DEVICE, VEHICLE TYPE
Q0479	POWER MODULE FOR USE WITH ELECTRIC OR ELECTRIC/PNEUMATIC VENTRICULAR ASSIST DEVICE, REPLACEMENT ONLY
Q2025	FLUDARABINE PHOSPHATE ORAL 1 MG
Q2026	INJECTION, RADIESSE, 0.1ML
Q2027	INJECTION, SCULPTRA, 0.1ML
Q4074	ILOPROST, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 20 MICROGRAMS
Q4081	INJECTION, EPOETIN ALFA, 100 UNITS (FOR ESRD ON DIALYSIS)
Q4082	DRUG OR BIOLOGICAL, NOT OTHERWISE CLASSIFIED, PART B DRUG COMPETITIVE ACQUISITION PROGRAM (CAP)
Q4100	SKIN SUBSTITUTE, NOT OTHERWISE SPECIFIED
Q4101	SKIN SUBSTITUTE, APLIGRAF, PER SQUARE CENTIMETER
Q4102	SKIN SUBSTITUTE, OASIS WOUND MATRIX, PER SQUARE CENTIMETER
Q4103	SKIN SUBSTITUTE, OASIS BURN MATRIX, PER SQUARE CENTIMETER
Q4104	SKIN SUBSTITUTE, INTEGRA BILAYER MATRIX WOUND DRESSING (BMWD), PER SQUARE CENTIMETER
Q4105	SKIN SUBSTITUTE, INTEGRA DERMAL REGENERATION TEMPLATE (DRT), PER SQUARE CENTIMETER
Q4106	SKIN SUBSTITUTE, DERMAGRAFT, PER SQUARE CENTIMETER
Q4107	SKIN SUBSTITUTE, GRAFTJACKET, PER SQUARE CENTIMETER
Q4108	SKIN SUBSTITUTE, INTEGRA MATRIX, PER SQUARE CENTIMETER
Q4109	SKIN SUBSTITUTE, TISSUEMEND, PER SQUARE CENTIMETER
Q4110	SKIN SUBSTITUTE, PRIMATRIX, PER SQUARE CENTIMETER
Q4111	SKIN SUBSTITUTE, GAMMAGRAFT, PER SQUARE CENTIMETER
Q4112	ALLOGRAFT, CYMETRA, INJECTABLE, 1CC
Q4113	ALLOGRAFT, GRAFTJACKET EXPRESS, INJECTABLE, 1CC
Q4114	ALLOGRAFT, INTEGRA FLOWABLE WOUND MATRIX, INJECTABLE, 1CC
Q4115	SKIN SUBSTITUTE, ALLOSKIN, PER SQUARE CENTIMETER
Q4116	SKIN SUBSTITUTE, ALLODERM, PER SQUARE CENTIMETER
Q4117	HYALOMATRIX, PER SQ CM
Q4118	MATRISTEM MICROMATRIX, 1 MG
Q4119	MATRISTEM WOUND MATRIX, PER SQ CM
Q4120	MATRISTEM BURN MATRIX, PER SQ CM
Q4121	THERASKIN, PER SQ CM

All services are subject to network, coverage, benefit and contract policies and exclusions.

**PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS**

Code	Description
Q4122	DERMACELL, PER SQUARE CENTIMETER
Q4123	ALLOSKIN RT, PER SQUARE CENTIMETER
Q4124	OASIS ULTRA TRI-LAYER WOUND MATRIX, PER SQUARE CENTIMETER
Q4125	ARTHROFLEX, PER SQUARE CENTIMETER
Q4126	MEMODERM, PER SQUARE CENTIMETER
Q4127	TALYMED, PER SQUARE CENTIMETER
Q4128	FLEXHD OR ALLOPATCH HD, PER SQUARE CENTIMETER
Q4129	UNITE BIOMATRIX, PER SQUARE CENTIMETER
Q4130	STRATTICE TM, PER SQUARE CENTIMETER
Q9956	INJECTION OCTAFLUOROPROPANE MICROSPHERES PER ML
S0119	ONDANSETRON, ORAL, 4 MG (FOR CIRCUMSTANCES FALLING UNDER THE MEDICARE STATUTE, USE HCPCS Q CODE)
S0133	HISTELIN, IMPLANT, 50 MG
S0145	INJECTION, PEGYLATED INTERFERON ALFA-2A, 180 MCG PER ML
S0158	INJECTION, LARONIDASE, 0.58 MG
S0159	INJECTION, AGALSIDASE BETA, 35 MG
S0160	DEXTROAMPHETAMINE SULFATE, 5 MG
S0162	INJECTION, EFALIZUMAB, 125 MG
S0198	INJECTION, PEGAPTANIB SODIUM, 0.3 MG
S0812	PHOTOTHERAPEUTIC KERATECTOMY (PTK)
S2068	BREAST RECONSTRUCTION WITH DEEP INFERIOR EPIGASTRIC PERFORATOR (DIEP) FLAP, INCLUDING MICROVASCULAR ANASTOMOSIS AND CLOSURE OF DONOR SITE, UNILATERAL
S2080	LASER-ASSISTED UVULOPALATOPLASTY (LAUP)
S2082	LAPAROSCOPY, SURGICAL; GASTRIC RESTRICTIVE PROCEDURE, ADJUSTABLE GASTRIC BAND INCLUDES PLACEMENT OF SUBCUTANEOUS PORT)
S2112	ARTHROSCOPY, KNEE, SURGICAL, FOR HARVESTING OF CARTILAGE
S2115	OSTEOTOMY, PERIACETABULAR, WITH INTERNAL FIXATION
S2250	UTERINE ARTERY EMBOLIZATION FOR UTERINE FIBROIDS
S2370	INTRADISCAL ELECTROTHERMAL THERAPY; SINGLE INTERSPACE
S2371	INTRADISCAL ELECTROTHERMAL THERAPY; EACH ADDITIONAL INTERSPACE
S2400	REPAIR, CONGENITAL HERNIA IN THE FETUS, PROCEDURE PERFORMED IN UTERO
S2401	REPAIR URINARY TRACT OBSTRUCTION IN THE FETUS, PROCEDURE PERFORMED IN UTERO
S2402	REPAIR, CONGENITAL CYSTIC ADENOMATOID MALFORMATION IN THE FETUS, PROCEDURE PERFORMED IN UTERO
S2403	REPAIR, EXTRALOBAR PULMONARY SEQUESTRATION IN THE FETUS, PROCEDURE PERFORMED IN UTERO
S2404	REPAIR, MYELOMENINGOCELE IN THE FETUS, PROCEDURE PERFORMED IN UTERO
S2409	REPAIR, CONGENITAL MALFORMATION OF FETUS, PROCEDURE PERFORMED IN UTERO, NOT OTHERWISE CLASSIFIED
S2411	FETOSCOPIC LASER THERAPY FOR TREATMENT OF TWIN-TO-TWIN TRANSFUSION SYNDROME
S3854	GENE EXPRESSION PROFILING PANEL FOR USE IN THE MANAGEMENT OF BREAST CANCER TREATMENT
S3855	GENETIC TESTING FOR DETECTION OF MUTATIONS IN THE PRESENILIN - 1 GENE
S5561	INSULIN REUSE PEN 3 ML
S5570	INSULIN DISPOS PEN 1.5 ML
S5571	INSULING DISPOS PEN 3 ML
S9434	MOD SOLID FOOD SUPPL

All services are subject to network, coverage, benefit and contract policies and exclusions.

---



---

## PCP REFERRAL AND PLAN PREAUTHORIZATION PROCESS

---



---

Code	Description
S9590	HOME THERAPY, IRRIGATION THERAPY (EG STERILE IRRIGATION OF AN ORGAN OR ANATOMICAL CAVITY); INCLUDING ADMINISTRATIVE SERVICES, PROFESSIONAL PHARMACY SERVICES, CARE COORDINATION, AND ALL NECESSARY SUPPLIES AND EQUIPMENT (DRUGS AND NURSING VISITS CODED SEPARATELY), PER DIEM
V2299	SPECIALTY BIFOCAL (BY REPORT)
V2399	SPECIALTY TRIFOCAL (BY REPORT)
V2599	CONTACT LENS - OTHER TYPE
V2630	ANTERIOR CHAMBER INTRAOCULAR LENS
V2631	IRIS SUPPORTED INTRAOCULAR LENS
V2756	EYE GLASS CASE
V2761	MIRROR COAT TYPE SOLID GRADENT/= LENS MATL-LENS
V2785	PROCESSING, PRESERVING AND TRANSPORTING CORNEAL TISSUE
V2785	PROCESSING, PRESERVING AND TRANSPORTING CORNEAL TISSUE
V2787	ASTIGMATISM CORRECTING FUNCTION INTRAOCULAR LENS
V2788	PRESBYOPIA CORRECTION FUNCTION INTRAOCULAR LENS
V2797	VISION SUPPLY, ACCESSORY AND/OR SERVICE COMPONENT OF ANOTHER HCPCS VISION CODE
V5298	HEARING AID, NOT OTHERWISE CLASSIFIED
V5336	REPAIR/MOD AUGMENTATIV COMMUNICAT SYSTEM/DEVICE
V5362	SPEECH SCREENING
V5363	LANGUAGE SCREENING
V5364	DYSPHAGIA SCREENING

The following services do not require an additional PCP referral or plan preauthorization when provided by a contracted, in-network provider and within the member network option:

- Allergy injections
- Cardiac nuclear medicine testing
- Cardiac rehabilitation outpatient
- Chemotherapy outpatient
- Diabetes education
- Dialysis
- EMG/NCV
- Interventional cardiology (cardiac catheterization, angiography, PTCA, electronic pacing study)
- Pacemaker/defibrillator check
- Pulmonary rehabilitation outpatient
- PUVA
- Radiation therapy outpatient
- Sleep studies

All services are subject to network, coverage, benefit and contract policies and exclusions.

---

---

## PEACE OF MIND PROGRAM

---

---

### Referring for the Peace of Mind Program™

Fallon Community Health Plan's Peace of Mind Program™ (POM) is a referral program that allows plan members\* (see Exclusions note at the end of this section) to receive specialty care at one of the following affiliated medical centers in Boston:

- Brigham and Women's Hospital
- Children's Hospital\*\* (see note at the end of this section)
- Dana Farber Cancer Institute
- Mass General Hospital
- Tufts Medical Center\*\* (see note at end of this section)

Patients can receive plan prior authorization to consult Peace of Mind Program providers as long as the following conditions are met:

- Care is only covered for specialty services as described in the *Member Handbook/Evidence of Coverage*. The same copayments and benefit limits apply\* (see Exclusions note at the end of this section).
- Patients must have seen an FCHP in-plan specialist in the same specialty as the Peace of Mind Program physician within the past three months.
- A request for prior authorization to a specific Peace of Mind Program physician is made by the patient's FCHP primary care physician and authorized by FCHP.
- The Peace of Mind Program physician you choose must be on staff at one of the five Peace of Mind Program facilities.
- The specialty service is ordinarily available in your network.

*Note: Your patients have the right to elect the Peace of Mind Program as long as the criteria above are met. As a primary care physician or specialist, you cannot deny patients their right to a Peace of Mind Program referral.*

### Preauthorization process for services:

- Patients must have seen an FCHP in-plan specialist for the same condition within the past three months.

\* All unlisted/unspecified CPT/HCPCS codes require preauthorization.

\*\* Please refer to the FCHP Provider Manual for a comprehensive list of services which require pre-auth

- Patients may then request a Peace of Mind Program prior authorization from their PCP and FCHP to one of the five Peace of Mind Program facilities.
- The referring physician sends in a request for prior authorization.
- The referring physician should provide assistance to the patient in selecting a specific Peace of Mind Program provider. If the referring physician is unfamiliar with Peace of Mind Program options, he or she may direct the patient to call our Care Services Department for assistance at 508-799-2100 or 866-ASK-FCHP, ext. 69138.
- The patient will receive a letter notifying him or her if the Peace of Mind Program prior authorization has been approved.
- If a request to a Peace of Mind Program specialist is approved for treatment of a particular condition, the patient may continue with the Peace of Mind Program specialist for a period of one year or until treatment for this presenting condition is complete, whichever comes first, as long as the patient's PCP submits the appropriate referral(s) or request for prior authorization.

**Continuation of services at an FCHP POM facility:**

- For the period of time that the patient is authorized treatment with the Peace of Mind Program provider for a particular condition, the Peace of Mind Program provider may order X-rays, laboratory tests and other tests to evaluate that condition without preauthorization if these services would normally be covered and would require no preauthorization when ordered by an in-plan provider. All inpatient care or inpatient, outpatient or office-based surgery requires prior authorization from the plan. Note: All PET scans and genetic testing require prior authorization.
- If the patient needs physical therapy or occupational therapy for the same condition for which the Peace of Mind Program specialist is treating him or her, the patient's Peace of Mind Program specialist may refer him or her for such physical and occupational therapy without prior authorization at the Peace of Mind Program facility, or the patient may return to an in-plan therapist if he or she wants.
- The patient and his or her primary care physician are responsible for contacting FCHP about any further services and requesting additional assistance with ongoing care needs.

**\* Exclusions**

- Requests for services to out-of-plan physicians for specialty services not available in the member's plan option are not considered Peace of Mind Program referrals. If a patient is referred to one of the five Peace of Mind Program facilities because services are not available within their immediate plan option, a Request for Services form should be sent by the referring physician to the Care Services Department.
- Peace of Mind Program is **not available** for members enrolled in FCHP MassHealth, FCHP Independent Care, FCHP Flex Care, Fallon Preferred Care or Fallon Senior Plan™. The Peace of Mind Program may be used for all specialty care except infertility services, mental health, substance abuse, chiropractic services, dental care or speech therapy. Patients may not use the Peace of Mind Program for any primary care services, including internal medicine, family practice, pediatrics or obstetrics.
- Services are subject to coverage, benefit and contract policies and exclusions.
- If the patient has not met the conditions listed above and neither the patient nor the physician has obtained FCHP preauthorization for a Peace of Mind Program service, the service will not be covered by FCHP.

\*\*Children's Hospital and Tufts Medical Center are contracted FCHP Select Care hospitals and are available to patients with FCHP Select Care with a PCP referral. **However, Select Care members that do not receive a referral from their PCP, they can still use their Peace of Mind benefit to access a second opinion and specialty care at both Children's Hospital, Tufts Medical Center and the other three Boston facilities within the program.**

## COMMERCIAL PLANS

Fallon Community Health Plan has a formulary drug list that includes medications from every drug class except for those medications specified in the evidence of coverage document that each member receives. These medications are the member's responsibility and include the following:

- Drugs for which no prescription is required by law
- Vitamins, whether or not a prescription is required (except certain pre-natal vitamins available through the FCHP *Oh Baby!* program)
- Devices for birth control that are not on the FCHP formulary
- Drugs that are investigational or that have not been approved for general sale and distribution by the U.S. Food and Drug Administration
- Drugs that are not listed in the FCHP formulary (except as approved through the FCHP exception process)
- Cosmetic, body building or weight loss products

The FCHP formulary can be found on the FCHP Web site, [www.fchp.org](http://www.fchp.org), in the Physicians and providers section, under "Pharmacy". Any medication requiring prior authorization will be designated with "PA" in the requirements column. FCHP will notify practitioners whenever there is a change in the formulary. These notifications are by direct mailings, through the *Connection* newsletter, and by email.

### **New-To-Market Policy**

FCHP follows a new-to-market medication evaluation policy and usage determination for medications newly approved by the FDA. FCHP has a waiting period of up to 180 days for all new medications, in order to ensure enough time to determine true dosing parameters, side-effect profiles, drug-drug interactions, drug-disease state interactions, and age-related issues.

### **Quantity and duration limits**

To further ensure patient safety, Fallon Community Health Plan has established quantity and duration of use limits for a specific list of medications. The limits and duration will appear in the quantity limits column in the online drug formulary. If a physician would like an exception to this rule for a specific member, he/she can submit a completed prior authorization request form to the Department of Pharmacy Services. This form must state the medical reason why more doses are needed, as well as the duration that is needed. Quantity limits are based upon the Food and Drug Association's maximum recommended doses.

### **Drug utilization review**

We conduct drug utilization reviews for all of our members to make sure they are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribe medications. These reviews are conducted each time a prescription is filled by a member and on a regular basis by reviewing our records.

During these reviews we look for the following:

- Possible medication errors
- Duplicate drugs treating same condition
- Age-gender related issues
- Drug-drug interactions
- Drug-disease state interactions
- Drug allergies
- Drug dosage errors
- Over-usage of narcotic drugs

### **Prescription process**

Pharmacies should process member prescriptions through the claims adjudication system at the point of service. When there is a generic version of a brand-named drug available, the pharmacies will automatically give the member the generic version unless the prescribing physician states that the member must have the brand-named drug only (Generic Drug Law St.1976, C.470, Sec.13).

---

---

## PHARMACY

---

---

Prescriptions written for Fallon Community Health Plan members must conform to the FCHP formulary. If the prescribed drug is not a preferred formulary drug, the pharmacist may call the provider to discuss a substitution or send notification by fax that the prescribed drug requires prior authorization. The pharmacist will not provide a substitution without the physician's approval. If the physician feels that there is no clinically appropriate substitution, he/she should follow the prior authorization request procedure described below to request approval for the medication. It is recommended that every effort be made to utilize formulary medications before requesting non-formulary products. FCHP provides prior authorization approval criteria for most medications listed on the formulary that require prior authorization. If the medication is urgently needed, the pharmacy may provide up to a three-day supply at the member's expense. If the request is approved, the member will be reimbursed by Fallon Community Health Plan.

The following information is necessary and mandatory by Massachusetts law when documenting prescriptions (written and oral):

1. Correct spelling of name and address of member
2. Name and address of physician
3. Physician registration number (DEA)
4. Date of writing the prescription
5. Name, dosage and strength of medication
6. Directions of usage
7. Number of refills allowed

Other information that ensures a speedier processing of prescriptions includes the member's date of birth and home telephone number.

### **Prior authorization request policy**

Prior authorization is required for any medication costing more than \$1,000 per 90 day supply and any medication noted with a "PA" on the FCHP formulary, regardless of the quantity being prescribed.

### **Prior authorization request procedure**

1. Fill out FCHP prescription prior authorization form. This form can be found on the Physicians and providers area of the FCHP Web site, [www.fchp.org](http://www.fchp.org), in the "Forms and materials" section.
2. Send completed form to the Pharmacy Services Department  
By mail: 10 Chestnut Street, Worcester, MA 01608  
By fax: (508) 791-5101
3. Review by FCHP clinical pharmacist.

Please note: To facilitate the process, we recommend reviewing the criteria documents that are available on the FCHP website. The criteria can be found on the Physicians and providers area of the FCHP Web site, [www.fchp.org](http://www.fchp.org), in the "Pharmacy" section. Clinical review criteria are also available to all practitioners upon request.

Routine requests are processed within three days from the date of request.

Urgent/emergency requests are processed within one day of the date of request.

Requests are reviewed in the order of arrival, with the exception of emergency medications, which are reviewed according to the urgency of the clinical situation.

Emergency medications are noted to be: antibiotic medications, antipsychotic medications and pain medications.

If the prior authorization is approved, the provider will be notified by fax. If the prior authorization is not approved, the provider will be notified immediately through a phone call, followed by fax. Finally, the physician will receive a letter citing denial reasons, alternative medications if indicated, a reference to the guideline, protocol or other similar criterion on which the denial decision is based, and information on the appeal process.

### **Mail order prescriptions from CVS/CAREMARK**

The following are rules that pertain to ordering medications from mail order pharmacy.

Please look at these rules to make sure you know what you are receiving, and how much

the prescription costs. If you have any questions you may always call: FCHP Customer

Service; CVS Caremark Specialty Pharmacy mail order at 1-877-287-1234 or CVS Caremark customer service at 1-800-237-2767.

---

---

## PHARMACY

---

---

Please note: Mail Order Pharmacy program is not available to all members. Please check your Evidence of Coverage for specific benefit coverage. FCHP MassHealth members are not enrolled in the Mail Order Pharmacy or Specialty Pharmacy programs.

### How to order medications through mail order

Listed below are a few reminders to ensure that the mail order process goes smoothly for your patients:

- **First-time prescriptions are not candidates for mail order.** It's advisable to write new prescriptions for a one-month supply for pickup at a local pharmacy. This ensures that your patient gets the prescription quickly and allows you time to determine the medicine's effect before ordering larger quantities.
- **Physician may fax a prescription for mail order to 1-800-243-9582.** Please be sure to include the dosage, physician signature, name and address.
- Members can mail in the prescription via a pre-paid envelope. Members must obtain a prescription from their physician. The prescription must include the dosage, physician signature, name and address.
  - Members must complete the Mail Service Enrollment form.
  - Medicare members must complete the Medicare Part D Mail Service Enrollment form (only need to do this with the first order)
- The prescription must be written for a 90-day supply. If the physician writes for anything less than a 90-day supply, your patient will be charged the maximum amount of copayments that they would normally pay for a 90-day supply. **Maintenance medications (e.g., for diabetes and high blood pressure) are best.** These are more suited to the larger quantity and mailing timeframes (10 to 14 days).
- **Please review the prescription and its destination (mail order vs. retail) with your patient.** *Once your patient receives the medication, it can't be returned.* Federal and state laws prohibit it, and the member will be charged the prescription copayment.

---



---

**PHARMACY**

---



---

**Diabetic supplies**

	Commercial Plan with Rx (includes FSP retiree group with 28% subsidy)	Commercial Plan Without Rx
Insulin	Prescription copayment, deductible and/or coinsurance per 30 day supply	Not covered
Insulin syringes (includes needles)	Prescription copayment, deductible and/or coinsurance per 30 day supply	Not covered
Blood glucose meter	Covered in full	Covered in full
Blood glucose test strips	Prescription copayment, deductible and/or coinsurance per 30 day supply	Not covered
Blood ketone test strips	Prescription copayment, deductible and/or coinsurance per 30 day supply	Not covered
Spring-powered lancet device	Prescription copayment, deductible and/or coinsurance applies	Not covered
Lancets	Prescription copayment, deductible and/or coinsurance per 30 day supply	Not covered
Urine glucose test strips	Prescription copayment, deductible and/or coinsurance per 30 day supply	Not covered
Urine ketone test strips	Prescription copayment, deductible and/or coinsurance per 30 day supply	Not covered
Insulin pens (includes pre-filled insulin pen cartridges; needles sold separately)	Prescription copayment, deductible, and/or coinsurance per 30-day supply	Not covered
Insulin pen needles	Prescription copayment, deductible, and/or coinsurance per 30-day supply	Not covered
Prescribed oral medications that influence blood sugar levels	Prescription copayment, deductible, and/or coinsurance per 30-day supply	Not covered

The following diabetic supplies require prior authorization through Pharmacy Services:

- Quantities of blood glucose test strips in excess of 150 per 30-day supply
- Blood glucose meters with adaptive features, such as an integrated voice synthesizer or integrated lancing device
- Insulin pens and insulin pen needles

### **Diabetic supply procedure**

1. The physician writes a prescription for the diabetic supply.
2. The member fills the prescription at an FCHP contracted pharmacy. The retail pharmacy collects any applicable co-payment.

### **Injectables**

Injectables are defined as sterile medications given with the aid of a needle/syringe and administered parenterally. Certain medications may be supplied by an FCHP-contracted pharmacy for patient self-use. Other medications are obtained by the contracted health care provider or by the specialty injectable pharmacy for in-office use. Many injections require prior authorization.

Note: Call the Pharmacy Service Department Service Line (1-866-275-3247, prompt 5) for any questions regarding whether a medication can be self administered or must be administered in the office.

### **Injectable supply procedure**

A. Injectable medication to be self-administered (or by a family member) at home:

1. Provider writes prescription.
2. The member fills the prescription at an FCHP-contracted pharmacy. A co-payment is charged.

B. Injectable medication to be administered in the physician office:

1. Provider supplies the medication from their own stock and bills FCHP directly for both the medication and the administration of the medication.
2. Provider calls one of FCHP's contracted suppliers. The contracted supplier will bill FCHP directly for the medication.
3. Provider fills out FCHP prior authorization form if necessary and follows above prior authorization procedure.
4. Provider may bill FCHP for the administration of the medication only.

Note: CVS/CAREMARK Specialty Pharmacy is Fallon Community Health Plan's Pharmacy Benefits Manager and contracted supplier for many of the drugs that are classified by FCHP as medical benefits. Medical benefit drugs are items such as injectable vaccines or infused items.

---

---

## PHARMACY

---

---

A prescription form for CVS/CAREMARK Specialty Pharmacy is included in this manual (see "Forms" section). To obtain services from CVS/CAREMARK Specialty Pharmacy, please fax the completed enrollment form to the number provided on the form or call 888-900-3232.

### **FCHP MASSHEALTH Standard/CommonHealth, Basic, Essential, and Family Assistance**

Prescription medications are covered under the same policy as outlined above. In addition, members are eligible to receive some over-the-counter medications when deemed medically necessary by the physician and accompanied by a written prescription. Fallon Community Health Plan does not cover any medication that is excluded from coverage by MassHealth. In accordance with MassHealth regulations, most covered medications are restricted to a 30-day supply.

### **FALLON SENIOR PLAN (MEDICARE PART D PRESCRIPTION COVERAGE)**

Fallon Senior Plan has a formulary drug list that includes medications from every drug class except for certain medications excluded by Medicare. These medications are the member's responsibility and include the following:

- Agents when used for anorexia, weight loss, or weight gain
- Agents when used to promote fertility.
- Agents when used for cosmetic purposes or hair growth
- Agents when used for the symptomatic relief of cough and colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Nonprescription drugs
- Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.

Please Note: For 2009, Fallon Senior Plan's Medicare Part D prescription coverage includes coverage of barbiturates and benzodiazepines.

---

---

## PHARMACY

---

---

If a member receives their health care coverage through an employer group, their formulary may include more covered prescription drugs than those normally covered by Medicare Part D (beyond barbiturates and benzodiazepines).

The FCHP formulary and the Fallon Senior Plan formularies can be found on the FCHP Web site, [www.fchp.org](http://www.fchp.org) in the Physicians and providers area, in the "Pharmacy" section. Any medication requiring prior authorization will be designated with "PA" in the requirements column. FCHP will notify practitioners whenever there is a change in the formulary. These notifications are by direct mailings, through the *Connection* newsletter, and by email.

### **New to market policy**

FCHP follows a new-to-market medication evaluation policy and usage determination for medications newly approved by the FDA. FCHP has a waiting period of up to 180 days for all new medications, in order to ensure enough time to determine true dosing parameters, side-effect profiles, drug-drug interactions, drug-disease state interactions, and age-related issues. Medications or new indications of medications that fall within one of the following classes of clinical concern, antidepressants, anti-psychotics, anticonvulsants, anti-cancer, immunosuppressive or HIV/AIDS, will be subject to the expedited review process. This process involves evaluation and usage determination for the preceding medications within 90 days of approval by the FDA. During this period, a physician can request the medication via the prior authorization process.

### **Quantity and duration limits**

To further ensure patient safety, Fallon Community Health Plan has established quantity and duration-of-use limits for a specific list of medications. The limits and duration will appear in the quantity limits column in the on-line formulary. If a physician would like an exception to this rule for a specific member, he/she can submit a completed prior authorization request form to the Department of Pharmacy Services. This form must state the medical reason why more doses are needed, as well as the duration that is needed. Quantity limits are based upon the Food and Drug Administrations maximum recommendation doses.

### **Drug utilization review**

We conduct drug utilization reviews for all of our members to make sure they are getting safe and appropriate care. These reviews are especially important for members who have

---

---

## PHARMACY

---

---

more than one doctor who prescribe medications. These reviews are conducted each time a prescription is filled by a member and on a regular basis by reviewing our records. During these reviews we look for the following:

- Possible medication errors
- Duplicate drugs treating same condition
- Age-gender related issues
- Drug-drug interactions
- Drug-disease state interactions
- Drug allergies
- Drug dosage errors
- Over-usage of narcotic drugs

### **Prescription process**

Pharmacies should process member prescriptions through the claims adjudication system at the point of service. When there is a generic version of a brand-named drug available, the pharmacies will automatically give the member the generic version unless the prescribing physician states that the member must have the brand-named drug only (Generic Drug Law St.1976, C.470, Sec.13).

Prescriptions written for Fallon Community Health Plan members must conform to the FCHP formulary. If the prescribed drug is not a preferred formulary drug, the pharmacist may call the provider to discuss a substitution or send notification by fax that the prescribed drug requires prior authorization. The pharmacist will not provide a substitution without the physician's approval. If the physician feels that there is no clinically appropriate substitution, he/she should follow the prior authorization request procedure described below to request approval for the medication. It is recommended that every effort be made to utilize formulary medications before requesting non-formulary products. FCHP provides prior authorization approval criteria for most medications listed on the formulary that require prior authorization. If the medication is urgently needed, the pharmacy may provide up to a three-day supply at the member's expense. If the request is approved, the member will be reimbursed by Fallon Community Health Plan.

The following information is necessary and mandatory by Massachusetts law when documenting prescriptions (written and oral).

1. Correct spelling of name and address of member
2. Name and address of physician
3. Physician registration number (DEA)

---

---

## PHARMACY

---

---

4. Date of writing the prescription
5. Name, dosage and strength of medication
6. Directions of usage
7. Number of refills allowed

Other information that ensures a speedier processing of prescriptions includes the member's date of birth and home telephone number.

FCHP encourages practitioners to write prescriptions. Prescriptions should be called in to the pharmacy only when it is not possible to give a written prescription, e.g., physician is on-call.

### **Prior authorization request policy**

Prior authorization is required for any medication costing more than \$1,000 per 90 day supply and any medication noted with a "PA" on the FCHP formulary, regardless of the quantity being prescribed.

### **Prior authorization request procedure**

1. Fill out FCHP prescription prior authorization form. This form can be found on the Physicians and providers area of the FCHP Web site, [www.fchp.org](http://www.fchp.org), in the "Forms and materials" section.
2. Send completed form to the Pharmacy Services Department  
By mail: 10 Chestnut Street, Worcester, MA 01608  
By fax: (508) 791-5101
3. Review by FCHP clinical pharmacist.

Please note: To facilitate the process, we recommend reviewing the criteria documents that are available on the FCHP website. The criteria can be found on the Physicians and providers area of the FCHP Web site, [www.fchp.org](http://www.fchp.org), in the "Pharmacy" section. Clinical review criteria are also available to all practitioners upon request.

Routine requests are processed within three days from the date of request.

Urgent/emergency requests are processed within one day of the date of request.

Requests are reviewed in the order of arrival, with the exception of emergency medications, which are reviewed according to the urgency of the clinical situation.

Emergency medications are noted to be: antibiotic medications, antipsychotic medications and pain medications.

---

---

## PHARMACY

---

---

If the prior authorization is approved, the provider will be notified by fax. If the prior authorization is not approved, the provider will be notified immediately through a phone call, followed by fax. Finally, the physician will receive a letter citing denial reasons, alternative medications if indicated, a reference to the guideline, protocol or other similar criterion on which the denial decision is based, and information on the appeal process.

In accordance with federal regulations, members of both Fallon Senior Plan and Fallon™ Senior Plan with Medicare Part D prescription coverage are covered, with a required co-payment, for the following mandated medications:

Note: The following Medicare mandated medications are not applied to the Medicare Part D accumulators.

- Epoetin (EPO), even when self-administered, when indicated in the treatment of anemia in connection with the drug AZT or chronic renal failure, with appropriate lab values
- Immunosuppressive medications:
  - Immunosuppressive drugs are prescribed following a corneal, kidney, heart, liver, bone marrow/stem cell, lung, or heart/lung transplant, whole organ pancreas transplant performed concurrent with or subsequent to a kidney transplant because of a diabetic nephropathy (performed on or after July 1, 1999), or intestinal and multi-visceral transplant (performed on or after April 1, 2001).
  - The transplant met Medicare coverage criteria in effect at the time (e.g., approved transplant facility for heart, kidney, liver, lung, heart/lung or intestinal/multi-visceral transplants; national and/or local medical necessity criteria).
  - The member was enrolled in Medicare Part A at the time of the transplant and is enrolled in Part B at the time immunosuppressive drugs are dispensed.
  - The drugs are medically necessary to prevent or treat rejection of an organ transplant in the particular members.
  - The drugs are furnished on or after the date of discharge from the hospital following a covered organ transplant.
  - There is no time limit for immunosuppressive drug coverage for Medicare-approved transplants.

---

---

## PHARMACY

---

---

- Immunosuppressive drugs are non-covered for the treatment of patients with non-transplant and related diagnoses (e.g., rheumatoid arthritis, connective tissue diseases, and vasculitis).
- Immunosuppressive drugs for conditions other than covered organ transplants are subject to the pharmacy benefit cap.
- Oral drugs prescribed for anticancer chemotherapy if (a.) the drugs have the same active ingredient(s) as anticancer drugs covered by Medicare, which are not injectable; (b.) the drugs have the same active ingredients in the body.
- Intravenous or oral antiemetic drugs as part of an anticancer chemotherapeutic regimen, limited to 72 hours.
- Injectable drugs required by Medicare (such as blood clotting factors, calcitonin, influenza vaccine).
- Drugs that are administered through durable medical equipment, for example injectable drugs used in an insulin pump, if Medicare criteria are met.

---



---

## PHARMACY

---



---

### Diabetic supplies

	Fallon Senior Plan™ with Part D	Fallon Senior Plan™ without Part D
Insulin	Prescription copayment per 30 day supply	Not covered
Insulin syringes (includes needles)	Prescription copayment per 30 day supply	Not covered
Blood glucose meter	Covered in full	Covered in full
Blood glucose test strips	Covered in full	Covered in full
Blood ketone test strips	Covered in full	Covered in full
Spring-powered lancet device	Covered in full	Covered in full
Lancets	Covered in full	Covered in full
Urine glucose test strips	Covered in full	Covered in full
Urine ketone test strips	Covered in full	Covered in full
Insulin pens (includes pre-filled insulin pen cartridges; needles sold separately)	Prescription copayment per 30 day supply	Not covered
Insulin pen needles	Prescription copayment per 30 day supply	Not covered
Prescribed oral medications that influence blood sugar levels	Prescription copayment per 30 day supply	Not covered

The following diabetic supplies require prior authorization through Pharmacy Services:

- Quantities of blood glucose test strips in excess of 150 per 30-day supply
- Blood glucose meters with adaptive features, such as an integrated voice synthesizer or integrated lancing device
- Insulin pens and insulin pen needles

### Diabetic supply procedure

1. The physician writes a prescription for the diabetic supply.
2. The member fills the prescription at an FCHP-contracted pharmacy. The retail pharmacy collects any applicable copayment.

### **Injectables**

Injectables are defined as sterile medications given with the aid of a needle/syringe and administered parenterally. Certain medications may be supplied by an FCHP contracted pharmacy for patient self use. Other medications are obtained by the contracted health care provider or by the specialty injectable pharmacy for in-office use. Many injections require prior authorization. For Fallon Senior Plan™ members with Medicare Part D prescription coverage, some injectable medications are covered under the members Medicare Part B benefits.

Note: Call the Pharmacy Service Department Service Line (866-275-3247) for any questions regarding whether a medication can be self-administered or must be administered in the office.

### **Injectable supply procedure**

A. Injectable medication to be self-administered (or by a family member) at home:

1. Provider writes prescription.
2. The member fills the prescription at an FCHP-contracted pharmacy. A copayment is charged.

B. Injectable medication to be administered in the physician office:

1. Provider supplies the medication from their own stock and bills FCHP directly for both the medication and the administration of the medication.
2. Provider calls one of FCHP's contracted suppliers. The contracted supplier will bill FCHP directly for the medication.
3. Provider fills our FCHP prior authorization form if necessary and follows above prior authorization procedure.
4. Provider may bill FCHP for the administration of the medication only.

Note: CVS/CAREMARK Specialty Pharmacy is Fallon Community Health Plan's Pharmacy Benefits Manager and contracted supplier for many of the drugs that are classified by FCHP as medical benefits. Medical benefit drugs are items such as injectable vaccines or infused items.

A prescription form for CVS/CAREMARK Specialty Pharmacy is included in this manual (see "Forms" section). To obtain services from CVS/CAREMARK Specialty Pharmacy,

please fax the completed enrollment form to the number provided on the form or call (888-900-3232).

### **Transitional medications process**

The transitional process is for Fallon Senior Plan™ members who are new to FCHP or new to Medicare. This process is designed to provide temporary medication coverage for FCHP non-formulary medications until a prior authorization can be obtained by the prescriber. The qualifying member can obtain a 30-day temporary supply of medications (within the first 90 days of their enrollment) at a copayment cost. Meanwhile, an FCHP clinical pharmacist will contact the provider to obtain the pertinent prior authorization information to make a decision on continuation of the therapy or to discuss FCHP formulary alternatives.

### **Medication therapy management program**

As a Medicare Part D plan sponsor, FCHP is required to offer a medication therapy management program (MTMP) to our Medicare-eligible members who are considered high-risk. FCHP's medication therapy management program is for Fallon Senior Plan™ members who are managing at least 9 prescriptions, have three or more chronic conditions\* and are spending more than \$4,000 on prescriptions each year. The program is free and voluntary. Once members meet the criteria, they are contacted and if they are interested in joining this program, their primary care provider will be notified.

To better assist members who enroll, a clinical pharmacist will work with the member's PCP to address any significant clinical changes—to help monitor drug-drug and drug-disease interactions, adverse drug effects and over- or under-utilization of drugs or resources. The pharmacist can also help educate the enrolled members on proper use of their prescriptions or over-the-counter medications, all with the goal of improving drug regimen adherence. The MTMP Pharmacist will also be available to answer any medication-related questions that you may have regarding these members.

\* Targeted disease conditions are: COPD, diabetes, hypertension, hyperlipidemia, depression, osteoporosis

### **Podiatry services**

A PCP referral is required for Podiatry services. Fallon Community Health Plan (FCHP) is responsible for determining whether a member is entitled to covered services.

### **FCHP HMO/MCO coverage**

FCHP HMO/MCO members are covered for some non-routine foot care services based on medical criteria. Routine foot care services such as trimming of corns and calluses, treatment of flat feet or partial dislocations of the feet are not covered.

### **Covered items**

1. Office visit with a plan affiliated podiatrist or orthopedist.
2. Office based procedures (subject to the medical criteria defined below).
3. Inpatient or facility based procedures (subject to the medical criteria defined below) provided within the provider's legal scope of practice.

### **Foot Care Policy Overview:**

This policy relates to both routine (e.g., trimming of corns and calluses) and non-routine (e.g., treatment of foot ulcers) foot care.

### **Policy & Criteria**

#### **Referral:**

Covered podiatry services require a PCP referral. Some procedures may still require a plan preauthorization. For a list of procedures requiring preauthorization, please see the [Procedure Code List](#).

#### **Policy:**

**Routine foot care** services must be provided by a contracted podiatrist whether in an office setting or in a facility that is providing the patient skilled level of care (e.g., skilled nursing facility). Routine foot care (subject to the routine foot care criteria defined below) is limited to the following services once in each 60-day period.

1. Cutting or removal of corns and calluses
2. Trimming, cutting clipping or debriding of nails
3. Other hygienic and preventive maintenance care considered self-care (i.e., cleaning and soaking the feet and the use of skin creams to maintain skin tone of both ambulatory and bedridden patients), and
4. Any services performed in the absence of localized illness, injury or symptoms involving the foot.

---

---

## PODIATRY

---

---

### Please note that:

1. Attending physician must submit documentation satisfying the routine foot care clinical criteria (below)
2. Authorization for routine foot care is provided once in each 60-day period. More frequent treatment requires supporting documentation indicating the medical necessity for this service.
3. In all cases, the medical record must support the medical necessity and frequency of this treatment including specific evidence that all requirements for coverage are met.
4. The patient must be seen by the physician (MD or DO) treating the systemic illness at least every six (6) months to be considered active care.

### Non-routine foot care coverage is limited to:

1. Office visit with a plan contracted podiatrist or orthopedist
2. Office based procedures (subject to the non-routine foot care clinical criteria defined below)
3. Inpatient or facility based procedures (subject to the non-routine foot care clinical criteria defined below) provided within the providers' legal scope of practice.

### Routine foot care clinical criteria:

The patient has a complicating systemic disease indicated by a diagnosis of any of the following criteria:

1. Diabetes mellitus\*\* with complications, including:
  - a. Diabetes with renal manifestations (ICD-9-CM 250.40 to 250.43)
  - b. Diabetes with ophthalmic manifestations (ICD-9-CM 250.50 to 250.53)
  - c. Diabetes with neurological manifestations\*\*\* (ICD-9-CM 250.60 to 250.63)
  - d. Diabetes with peripheral vascular disorders (ICD-9-CM 250.70 to 250.73)
2. Arteriosclerosis obliterans (ASO) of lower extremities with manifestation as indicated by ICD-9-CM 440.20 to 440.24 (intermittent claudication, rest pain, ulceration, gangrene)
3. Buerger's disease (ICD-9-CM 443.1)
4. Chronic thrombophlebitis\*\* (ICD-9-CM 451.11, 451.19)
5. Peripheral neuropathies involving feet associated with:
  - a. Malnutrition and vitamin deficiency,\*\* such as:

---

---

## PODIATRY

---

---

- i. Malnutrition (general, pellagra) (ICD-9-CM 265.2, 357.4)
  - ii. Alcoholism (ICD-9-CM 357.5)
  - iii. Malabsorption (celiac disease, tropical sprue)
  - iv. (ICD-9-CM 579.0, 579.1, 357.4)
  - v. Pernicious anemia (ICD-9-CM 281.0)
- b. Carcinoma\*\* (ICD-9-CM 357.3)
  - c. Diabetes mellitus\*\* (ICD-9-CM 357.2)
  - d. Drugs and toxins\*\* (ICD-9-CM 357.6, 357.7)
  - e. Multiple sclerosis\*\* (ICD-9-CM 340)
  - f. Uremia\*\* (chronic renal disease) (ICD-9-CM 585, 357.4)
  - g. Traumatic injury (ICD-9-CM 956.0 to 956.9)
  - h. Leprosy or neurosyphilis (ICD-9-CM 030.1, 094.0 to 094.9, 357.4)
  - i. Hereditary disorders, including hereditary sensory radicular neuropathy (ICD-9-CM 356.2); Fabry's disease (ICD-9-CM 272.7, 357.4); amyloid neuropathy (ICD-9-CM 277.3, 357.4)

\*\* For diagnoses marked with two asterisks (\*\*), routine foot care is covered only if the patient is under the active care of a doctor of medicine or osteopathy who documents the condition.

\*\*\* Diabetes with neurological manifestations (ICD-9-CM 250.60 to 250.63) does not require Class Findings (see below).

### **Class findings:**

Signs and symptoms fall into three (3) classes: A, B and C. To fulfill the coverage requirement for routine foot care, there must be:

- One Class A Finding, or
- Two Class B Findings, or
- One Class A and Two Class C findings.

---



---

**PODIATRY**

---



---

Class Findings A	Class Findings B	Class Findings C
<ul style="list-style-type: none"> <li>• Non-traumatic amputation of foot or integral skeleton portion</li> </ul>	<ul style="list-style-type: none"> <li>• Absent posterior tibial pulse</li> </ul>	<ul style="list-style-type: none"> <li>• Claudation</li> </ul>
	<ul style="list-style-type: none"> <li>• Absent dorsalis pedis pulse</li> </ul>	<ul style="list-style-type: none"> <li>• Temperature changes (e.g., cold feet)</li> </ul>
	<ul style="list-style-type: none"> <li>• <i>*Advanced trophic changes such as:</i></li> </ul>	<ul style="list-style-type: none"> <li>• Edema</li> </ul>
	<ol style="list-style-type: none"> <li>1. Hair Growth</li> <li>2. Nail changes (thickening)</li> <li>3. Pigmentation changes (discoloration)</li> <li>4. Skin texture (thin, shiny)</li> <li>5. Skin color (rubor or redness)</li> </ol>	<ul style="list-style-type: none"> <li>• Paresthesia (abnormal spontaneous sensations in the feet)</li> </ul>
		<ul style="list-style-type: none"> <li>• Burning</li> </ul>

*\*Three (3) trophic changes are required to meet one (1) Class Finding*

**Non-routine foot care clinical criteria:**

The following conditions / diagnoses satisfy criteria for services (note that the list is not all-inclusive and that other acute podiatry conditions may apply):

1. Bunions (bunionectomy)
2. Bursitis and capsulitis
3. Diabetic foot ulcers
4. Ganglion
5. Release of hammer toes
6. Heel spurs and plantar fasciitis
7. Ischemic ulcers
8. Neuroma and neuralgia
9. Osteoarthritis
10. Osteomyelitis
11. Sprains and ligamentous injuries

---

---

## PODIATRY

---

---

12. Tendinitis and synovitis
13. Treatment of fractures and dislocations of the feet or ankles
14. Skin and selected soft tissue trauma
15. Infected callosities
16. Plantar warts
17. Treatment of ingrown toenails with paronychia or subungual abscess
18. Treatment of painful mycotic toenails (including fungal cultures of toenail clippings) with:
  - a. Marked limitation of ambulation; or
  - b. Causing pain in non-ambulatory patients.
19. Avulsion or excision of toenail plate
20. Cellulitis and or abscess of the foot
21. Treatment of symptomatic or painful onychiauxis or onychogryposis

***What is not covered:***

The following items are not covered:

1. Routine foot care such as cutting or removal of corns, calluses or trimming of toenails for individuals not meeting the above criteria.
2. Routine foot care meeting the above criteria within 60 days of the previously covered office visit unless medically necessary and approved by the plan.
3. Orthopedic shoes unless permanently attached to a brace.
4. Other support devices for the foot (e.g., arch supports, UCB's & orthotics\* see note below regarding FCHP MassHealth members, except Essential members, who are not covered for orthotics) unless for the treatment of severe diabetic foot disease.

**NOTE: For FCHP MassHealth Standard/CommonHealth, Basic, and Family Assistance coverage types orthotics are covered as follows:** braces (non dental) and other mechanical or molded devices to support or correct any defect of form or function of the human body. For individuals over age 21, certain limitations apply. See Subchapter 6 of the MassHealth Orthotics Manual.

**Routine foot care codes:**

Codes	Number	Description
CPT	11055	Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); single lesion

---



---

**PODIATRY**

---



---

	11056	Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); two to four lesions
	11057	Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); more than four lesions
	11719	Trimming of nondystrophic nails, any number
HCPCS	G0127	Trimming of dystrophic nails, any number

Copyright © 2004 American Medical Association, Chicago, IL

**Non-routine Foot Care Codes:**

(Note that certain codes are only covered if certain conditions are met. Please refer to the *Provider Manual* for a list of procedures requiring pre-authorization.)

Codes	Number	Description
CPT	11720	Debridement of nail(s) by any method(s); one to five
	11721	Debridement of nail(s) by any method(s); six or more
	11730	Avulsion of nail plate, partial or complete, simple; single
	11732	Avulsion of nail plate, partial or complete, simple; each additional nail plate (List separately in addition to code for primary procedure)
	11750	Excision of nail and nail matrix, partial or complete, (e.g., ingrown or deformed nail) for permanent removal;
	11765	Wedge excision of skin of nail fold (e.g., for ingrown toenail)
	10060	Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
	10061	Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple
	10160	Puncture aspiration of abscess, hematoma, bulla, or cyst
	11040	Debridement; skin, partial thickness
	11041	Debridement; skin, full thickness
	11042	Debridement; skin, and subcutaneous tissue
	11043	Debridement; skin, subcutaneous tissue, and muscle
	11044	Debridement; skin, subcutaneous tissue, muscle, and bone
	87102	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; other source (except blood)
	87106	Culture, fungi, definitive identification, each organism; yeast
	87220	Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (e.g., scabies)

Copyright © 2004 American Medical Association, Chicago, IL

## Radiology/Imaging

### *Radiology prior notification program*

MedSolutions, Inc. (MedSolutions) will administer Fallon Community Health Plan's Prior Authorization Program for all outpatient MR, CT, Nuclear Cardiac, and PET imaging studies for most Fallon Community Health Plan (FCHP) members. This program is effective for all Fallon Community Health Plan members except MassHealth, Summit ElderCare, Major Medical, Ultrabenefits, and Fallon Companion Care.

Note: Imaging procedures performed during an inpatient admission or emergency room visit are not included in this program.

All outpatient MR, CT and PET imaging services will be evaluated based on the applicable terms of the health benefit plan (including but not limited to medical necessity) and require a prior notification number by MedSolutions. Covered imaging studies must be performed at a facility within the FCHP participating provider network based on the member's benefit plan.

MedSolutions will process and respond to requests for a notification number within two business days once the required information is received.

### *Prior notification process*

There are three ways physicians can request a notification number for an imaging procedure from MedSolutions:

#### *Web portal*

<https://www.medsolutionsonline.com>. See the "Web Portal Quick Reference Guide" found on the Web site for specific instructions on creating an account and using the advanced features of the MedSolutions web portal for providers.

#### *Call*

Contact MedSolutions toll-free, 8:00 a.m. to 9:00 p.m. Eastern Time at 1-888-693-3211 and give all pertinent information over the telephone. Outside of normal business hours, you may call MedSolutions and leave a voice mail for a return call the next business day. When calling MedSolutions with a request for a notification number, please have the following information available:

- Patient demographic information, including Health Plan member ID and date of birth.
- Current diagnosis and clinical information, including treatment history, treatment plan and medications.

***Fax***

Complete a request form (Universal or Body Part Specific), for the patient and fax your request to MedSolutions at 1-888-693-3210. Fax forms are available at [www.medsolutionsonline.com](http://www.medsolutionsonline.com) or by calling the MedSolutions' Customer Service Department toll-free at 1-888-693-3211.

***Notification numbers***

Your request for a notification number will be processed within two business days after the receipt of all necessary information. A notification number will be faxed to the ordering physician and requested facility. Please note: MedSolutions will approve the facility performing the imaging study and the CPT code or codes for the diagnostic imaging.

It is the responsibility of the rendering/performing provider to confirm the requesting/referring provider completed the prior notification and consultation process for these imaging procedures. Verification of a valid notification is available via MedSolutions Web site at [www.medsolutionsonline.com](http://www.medsolutionsonline.com).

Claims submitted for procedures without prior notification are subject to rejection and the member must be held harmless. Imaging procedures rendered as part of a hospital emergency room, observation stay, surgical care or inpatient services are not subject to the new notification requirements.

***Expedited requests***

Medically urgent requests: For those situations where advanced imaging is required in less than two business days due to a medically urgent condition, call MedSolutions at 1-888-693-3211 for prior notification. Please have all pertinent information available for reference during the call. MedSolutions will respond within four hours of receipt of all necessary information. Please clearly indicate that the prior notification request is for medically urgent care.

***Emergent imaging***

Medically emergent requests: For those situations in which advanced outpatient imaging was required immediately due to a medically emergent condition call MedSolutions at 1-888-693-3211 within two business days of completing the test to provide notification. Please have the pertinent information available for reference during the call. MedSolutions' physician reviewers will retrospectively review the request and the clinical documentation supporting the nature of the medical emergency.

***Decision support services***

As an added service, referring physicians and radiologists are welcome to request a clinical discussion with one of MedSolutions' physicians on any case to assist in considering imaging study options. To request a clinical discussion, call MedSolutions at 1-888-693-3211 during normal business hours of 8:00 a.m. to 9:00 p.m., Eastern Time, Monday through Friday.

*MedSolutions web-based services*

To sign up for MedSolutions on-line services, go to [www.medsolutionsonline.com](http://www.medsolutionsonline.com) for access to a variety of MedSolutions services. Click the "First Time User Help" link for details. Please be sure to watch the Web site for news of future online initiatives.

---

---

## SLEEP MANAGEMENT

---

---

Effective January 1, 2010, Fallon Community Health Plan (FCHP) has partnered with Sleep Management Solutions (SMS) to provide sleep diagnostic and therapy management services for selected FCHP product lines, as listed below. This partnership with SMS in conjunction with CareCore National (CCN) is designed to improve the overall quality of sleep services and ensure appropriate use of such services. This program will provide Home Sleep Testing for appropriate patients as identified by the new Sleep Criteria. Utilizing guidelines consistent with the American Academy of Sleep Medicine (AASM) and CMS, CCN will review your request for a sleep study and make recommendations for those studies that can be performed in the member's home. If the member is not appropriate for a home sleep study, the member will be directed to a FCHP contracted sleep facility. The sleep program provided by SMS and CCN uses evidence-based criteria to ensure all requests meet quality standards. SMS's medical necessity criteria can be reviewed at <http://www.sleepmanagementsolutions.com> or at <http://www.carecorenational.com>.

Products included in the Prior Authorization Utilization Management Program for Sleep Studies and Therapy are:

- FCHP Direct Care/FCHP Select Care
- Commonwealth Care
- Major Medical
- Fallon Preferred Care (PPO)
- Fallon Senior Plan™ HMO
- Fallon Senior Plan Preferred (PPO)

Effective for dates of service beginning January 2, 2010, FCHP requires authorization from CCN prior to an FCHP Member receiving a sleep study (Polysomnography) and/or sleep therapy (CPAP, Bi-level, Bi-level ST, and all PAP supplies) services. Failure to notify CCN in advance of delivering a sleep study will result in administrative service and claims payment denials.

Services that DO  
Require Prior-Authorization

---

Sleep Diagnostics (94660, 94799, 95805, 95806, 95808, 95810, 95811)

Therapy ( E0470, E0471, E0561, E0562, E0601)

Supplies (A4604, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046)

---

---

## SLEEP MANAGEMENT

---

---

As the referring Primary Care Physician you are responsible for obtaining the required authorization number prior to performance of requested sleep studies. Upon review of the request, CCN will make medical necessity and site of service determinations within two business days for standard requests after submission of all requested clinical documentation (three hours for urgent requests). You will receive the authorization or denial by fax. Approvals will contain a CCN authorization number and a CPT code specific to the requested procedure.

If the requested sleep study can be performed in the FCHP member's home, SMS will provide the HST distribution, patient education, study interpretation, recommendation to the PCP who ordered the test, and the initiation of APAP therapy when appropriate. All patients receiving PAP therapy will be enrolled in the SMS *iComply* Compliance Program.

If the sleep study is to be performed at a sleep lab, SMS recommends sleep lab facilities obtain the authorization number from the referring physician at the time the procedure is scheduled. If you do not have an authorization number, please call CCN Monday through Friday, 8 a.m. to 5:30 p.m. Eastern Time, at 1-800-630-3493 or via fax at 1-866-999-3510, by utilizing the CCN secure web portal at [www.carecorenational.com](http://www.carecorenational.com).

NOTE: Accurate claims payment requires matching of the billed CPT codes to the authorized CPT codes.

There are three methods to obtain prior authorization from CCN; by internet (at [www.carecorenational.com](http://www.carecorenational.com)), phone and fax. Please note that the authorization number must be submitted with the claim in order to be paid. Claims for services that require prior authorization which are lacking an authorization number will be denied, effective 1/2/2010.

For questions regarding Sleep Management Solutions, please contact the Customer Service Department at 1-888-693-3211 option # 3, or the FCHP Provider Relations Department Monday through Friday, 8:30 a.m. to 5:00 p.m. at 1-866-ASK-FCHP, prompt 4.

---

---

## TREATMENT OF A MINOR WITHOUT PARENTAL CONSENT

---

---

### Treatment of a minor without parental consent

A minor is any individual 18 years of age or younger. In general, a minor cannot consent to treatment, and the parent or guardian must be notified of the treatment.

A minor may give consent for treatment under the following circumstances:

- a. If the minor is married, widowed, divorced;
- b. If the minor is a parent of a child;
- c. If the minor is a member of the armed forces;
- d. If the minor is pregnant or believes herself to be pregnant (except in cases of abortion services);
- e. If the minor is living separate and apart from his/her parent or legal guardian; or
- f. If the minor believes he/she is suffering from a disease dangerous to the public health (as defined from time to time by the Massachusetts Department of Health), to the extent of treatment for that disease.

Any minor under 18 who requests an abortion must either have the consent of her parents or guardian. If the minor chooses not to seek the consent of her parents or guardians, the minor may petition a court for the right to give her own consent.

A minor who is 12 years or older, and who is found to be drug dependent by two or more physicians may give consent for care and treatment related to the drug dependency.

---

---

## TREATMENT OPTIONS

---

---

### Treatment options

Fallon Community Health Plan (FCHP) supports providers, acting within the lawful scope of practice, to advise and advocate on behalf of an individual who is a member of FCHP regarding the following:

- The medical care or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options
- The risks, benefits and consequences of treatment or non-treatment
- The opportunity for the individual to refuse treatment and to express preferences about future decisions
- The member's health status

FCHP contracted providers are required to provide information regarding treatment options, including the option of no treatment, to FCHP members, including those with limited English proficiency or reading skills, diverse cultural backgrounds and physical or mental disabilities, in a culturally competent manner. The provider shall ensure that individuals with disabilities have effective communication with participants through the plan in making decisions regarding treatment options. The provider shall educate patients regarding their health needs, share findings of history and physical examinations, side effects of treatment, management of symptoms and recognize the patient has the final course of action among clinically acceptable choices.

---

---

## UTILIZATION STATEMENT

---

---

Utilization decision-making is based on appropriateness of care and service and existence of coverage. Fallon Community Health Plan does not specifically reward practitioners or other individuals for issuing denials of coverage for service or care. The plan does not provide financial incentives for utilization decision makers that encourage decisions that result in underutilization.